University of Massachusetts Law Review

Volume 11 | Issue 2 Article 5

Extracting Medical Injury Information from the Legal System to Improve Patient Safety in the Health System: A Social Utility Approach

Mary Chaffee

UMass Law Review

Extracting Medical Injury Information from the Legal System to Improve Patient Safety in the Health System: A Social Utility Approach

Mary Chaffee

11 U. MASS L. REV. 372

ABSTRACT

As many as 400,000 people die each year, and a million are injured, by preventable medical injuries sustained in the U.S. health system. Collection of data to enhance understanding of how unintended medical injuries happen is an essential part of harm-reduction strategies. While health system data collection and reporting processes have improved in recent years, the scope and intractability of the medical injuries problem demands new efforts. The legal system could contribute valuable medical injury data to patient safety efforts but current practices largely prevent it. In medical malpractice claims where parties settle, case information is routinely protected from disclosure by confidentiality agreements thus any medical injury information is inaccessible. Parties who litigate may convince a court to seal their case files, thereby keeping data out of investigator's reach. Insurers have extensive claim files, rich with information, but provide access only at their discretion. Most notably, fewer than 3% of patients who are injured in the health system ever bring a claim. Therefore, a vast pool of medical injury information lies dormant, never developed through legal claims. This Note argues that the tort system's social utility purpose would be better served if more information about medical harm were exposed. Though numerous barriers would need to be overcome, data of value to the health system, and the patients who depend on it, could be extracted from (1) out-of-court settlements, (2) sealed court records, (3) medical malpractice insurance claims, and (4) by stimulating medical malpractice claims to create a larger data pool.

AUTHOR NOTE

Mary Chaffee is a second year law student at the University of Massachusetts School of Law Dartmouth. She received bachelors' degrees in nursing and public health from the University of Massachusetts Amherst, a PhD and master's degree in nursing from the University of Maryland Baltimore, and a master's in professional writing from the University of Massachusetts Dartmouth. The University of Massachusetts Amherst conferred an honorary doctorate on the author for her service to the profession of nursing and leadership in homeland security. The author extends her gratitude to faculty mentor Judge George Jacobs and thanks UMass Law Review Editor-in-Chief Alexander Rovzar for his conscientious leadership. The author is

most appreciative for the expert guidance and support from her husband, Don Arthur, also a UMass Law student.

I. Introduction

It is a capital mistake to theorize before one has data.[1]

–Sir Arthur Conan Doyle

Ana Jimenez-Salgado had a bilateral mastectomy to treat breast cancer but, after the surgery, she discovered she had never had cancer.[2] She filed a successful lawsuit.[3]

The newborn twins of actor Dennis Quaid and his wife received, in error, one thousand times the ordered dose of the blood thinner heparin.[4] The babies survived and their parents settled a lawsuit with the hospital.[5]

While Rebecca Fielding waited two hours for an emergency Caesarean section to deliver her son, Enzo, his brain was deprived of oxygen resulting in cerebral palsy and a seizure disorder.[6] The family received one of the largest medical malpractice judgments in Maryland history.[7]

These cases demonstrate the intersection of two complex entities, the U.S. health and legal systems. It is this nexus, where a medical injury[8] becomes a medical malpractice claim, that is the focus of this Note.

---

1 ARTHUR CONAN DOYLE, THE MEMOIRS OF SHERLOCK HOLMES 7 (1892).

2 Letter from John F. Krattli, Senior Assistant Cnty. Counsel, Cnty. of L. A., to Sachi A. Hamai, Exec. Officer, L.A. Cnty. Bd. of Supervisors, Re: Ana Jiminez-Salgado v. Cnty. of Los Angeles (July 26, 2010), http://file.lacounty.gov/bos/supdocs/56035.pdf [http://perma.cc/2PSR-8CE5].

3 *Id.*

4 Scott Hensley, *Dennis Quaid Acts on Medical Errors*, WSJ BLOGS (Mar. 28, 2008, 10:04 AM), http://blogs.wsj.com/health/2008/03/28/dennis-quaid-acts-on-medical-errors [http://perma.cc/N45T-YKUC].

5 *Dennis Quaid Settles with Hospital on Twins Overdose*, REUTERS (Dec. 16, 2008, 3:55 PM), http://www.reuters.com/article/2008/12/16/us-quaid-idUSTRE4BF6S920081216 [http://perma.cc/B5G5-BXCK].

6 Yvonne Wenger & Kevin Rector, *Jury Awards Waverly Family $55 Million in Hopkins Malpractice Case*, BALTIMORE SUN, June 26, 2012, http://articles.baltimoresun.com/2012-06-26/health/bs-md-ci-malpractice-award-20120626_1_malpractice-awards-in-state-history-gary-stephenson [http://perma.cc/4NGC-FUFW].

7 *Id.*

8 A word about words: The language used to describe medical errors has grown cumbersome. Healthcare providers sometimes make mistakes (errors). Those

The bombshell. The health system, like many patients entrusted to its care, is afflicted. Medical errors were the focus of the Institute of Medicine's 1999 "To Err is Human: Building a Safer Health System."[9] The book "dropped a bombshell" by reporting that up to 98,000 people die each year in U.S. hospitals due to medical mistakes.[10] With the medical error problem quantified and squarely in the public eye, the health system launched system-wide patient safety improvement efforts. At the foundation of these efforts to reduce harm is comprehensive collection and analysis of data.[11] Valid data is required to help researchers, healthcare providers, and other stakeholders grasp how errors occur so remedies can be designed to reduce them, as well as to measure how effective solutions are.[12]

Learning from malpractice litigation. But despite extensive efforts within the health system to reduce medical errors and injuries,

---

errors may result in a physical harm (an injury) but not all errors cause injuries. The patient safety literature now calls errors that result in harm "preventable adverse events" but this Note will use "medical injury." Patients do experience harm from medical care even in the absence of errors. For example, patients experience pain following surgery–an expected outcome. Patients may also experience a side effect from treatment. For example, an intended outcome of cold medications is relief of nasal congestion. A side effect of the medication may be drowsiness. The side effect was not caused by an error and is not an injury. This Note uses "medical negligence" and "medical malpractice" interchangeably to refer to substandard care that results in an injury even though not all instances of negligent care result in an injury. This Note refers to "claims" instead of "lawsuits" because not all claims become lawsuits.

9 Institute of Medicine, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 26 (Linda T. Kohn et al. eds., 1999) [hereinafter TO ERR IS HUMAN] (estimating between 44,000 and 98,000 Americans die each year from preventable medical errors).

10 Marshall Allen, *How Many Die From Medical Mistakes in U.S. Hospitals?*, PROPUBLICA (Sep. 19, 2013, 10:03 AM), http://www.propublica.org/article /how-many-die-from-medical-mistakes-in-us-hospitals [http://perma.cc/3KRF-QDY6].

11 TO ERR IS HUMAN, *supra* note 9, at 4 ("Much can be learned from the analysis of errors. All adverse events resulting in serious injury or death should be evaluated to assess whether improvements in the delivery system can be made to reduce the likelihood of similar events occurring in the future").

12 Joanna C. Schwartz, *A Dose of Reality for Medical Malpractice Reform*, 88 N.Y.U. L. REV. 1226 (2013) (citing TO ERR IS HUMAN, *supra* note 9, at 5-15 (summarizing the Institute of Medicine's recommendations for reducing medical error in U.S. hospitals)).

progress has been "sluggish."[13] Since gathering data is vital to progress, the health system could benefit by seeking new sources of data from an entity sometimes perceived as the "enemy"—the legal system.

Medical malpractice litigation reveals information.[14] It can help a hospital (or other healthcare organization) understand where it is prone to problems as well as to guide change.[15] Medical malpractice claims[16] can reveal medical errors not reported through other means, and the information developed through discovery and trial is often more complete than what appears in medical records alone.[17] In fact, anesthesia malpractice claims studies are credited with stimulating change that reduced the danger of receiving anesthesia.[18]

But, much malpractice data is not accessible. Most medical malpractice information remains beyond the reach of health care leaders, researchers, providers, and others because (1) information is often sealed in court records or settlements with non-disclosure provisions, (2) insurance carriers provide limited access to data in malpractice claim records, and (3) only about 3% of medical injury cases are ever litigated so no records are generated in most instances.[19] These barriers to producing medical injury data could be overcome.

---

13 Robert Wachter, *The 'Must Do' List: Certain Patient Safety Rules Should Not be Elective*, HEALTH AFFAIRS BLOG, (Aug. 20, 2015), http://healthaffairs.org/blog/2015/08/20/the-must-do-list-certain-patient-safety-rules-should-not-be-elective [http://perma.cc/FV9T-EXKP].

14 Schwartz, *supra* note 12, at 1246.

15 *Id.* at 1266.

16 This Note uses the term "claim" to describe a demand for compensation made to a health care provider's insurer by a claimant who alleges negligent medical treatment resulting in an injury. After a claim is filed, the insurer may settle the case, negotiate over the compensation amount or refuse to compensate the claimant. If the parties do not arrive at a resolution, and the claimant desires to pursue the case, the claimant's lawyer may file a lawsuit. Not all claims ripen into lawsuits; they can be abandoned prior to proceeding to the court system. Thomas H. Cohen & Kristen A. Hughes, *Medical Malpractice Insurance Claims in Seven States, 2000-2004*, U.S. DEP'T OF JUST., BUREAU OF JUST. STATS. SPECIAL REPORT (Mar. 2007), http://www.bjs.gov/content/pub/pdf/mmicss04.pdf[http://perma.cc/52EA-VJKF].

17 Schwartz, *supra* note 12, at 1297.

18 George J. Annas, *The Patient's Right to Safety–Improving the Quality of Care through Litigation against Hospitals*, 354 NEW ENG. J. MED. 2065 (2006).

19 See *infra* part III for a description of the inaccessibility of medical malpractice insurance data.

Less litigation secrecy would increase data availability. When malpractice cases are settled, payment to the claimant is generally conditioned on a nondisclosure agreement[20] that prohibits injured parties from discussing their case.[21] Additionally, parties engaged in malpractice litigation can request judicial sealing of court records, thereby barring access.[22]

Placing limits on nondisclosure agreements in settlements, or on a court's ability to seal records, is controversial and impassioned advocates exist on both sides of the debate. Those who support confidentiality argue it is vital to the viability of the courts[23] and that lack of confidentiality would impinge on litigants' ability to resolve disputes with minimal intrusion from external forces.[24] In turn, if settlement were less attractive, limited court resources would be overwhelmed.[25] Further, some secrecy advocates view the civil litigation system solely as a forum for private parties to resolve private disputes—not as a tool of social justice.[26]

Advocates of greater transparency ("sunshine") argue that litigation records should not be sealed if they contain information that adversely affects public health and safety.[27] They contend that, in cases like the Agent Orange settlement, the exploding Firestone tires settlement, and the Johns-Manville asbestos settlement, danger to the public would have been revealed sooner, and many lives saved, if documents had not been sealed.[28]

---

[20] A non-disclosure agreement is also referred to as a confidentiality clause or agreement.

[21] William M. Sage et al., *Use of Nondisclosure Agreements in Medical Malpractice Settlements by a Large Academic Health Care System*, 175 JAMA INTERN. MED. 1130, 1131 (2015).

[22] Joseph W. Doherty et al. eds., CONFIDENTIALITY, TRANSPARENCY, AND THE U.S. CIVIL JUSTICE SYSTEM xvii (2012).

[23] David S. Sanson, *The Pervasive Problem of Court-Sanctioned Secrecy and the Exigency of National Reform*, 53 DUKE L.J. 807, 809 (2003).

[24] Arthur R. Miller, *Confidentiality, Protective Orders, and Public Access to the Courts*, 105 HARV. L. REV. 427, 432 (1991).

[25] Adam Liptak, *Judges Seek to Ban Secret Settlements in South Carolina*, N.Y. TIMES, Sep. 2, 2002, http://www.nytimes.com/2002/09/02/us/judges-seek-to-ban-secret-settlements-in-south-carolina.html [http://perma.cc/YL47-ACZ3].

[26] Miller, *supra* note 24, at 441.

[27] Jillian Smith, *Secret Settlements: What You Don't Know Can Kill You!*, 2004 MICH. ST. L. REV. 237, 240 (2004).

[28] Sanson, *supra* note 23, at 813.

More access to insurance claims data would uncover problems. Liability insurance, including medical liability insurance, is a cog in the civil justice system as well as a window through which to observe the system."[29] Malpractice insurance claims data can be used to detect problematic clinical processes and devise strategies to reduce negligence.[30] However, the process for obtaining access to insurance data is time-consuming and uncertain.[31]

More litigation would generate more data. The biggest barrier to extracting data from the legal system to inform health system change is that most is merely "potential" data. About 97% of patients who experience a medical injury do not pursue a legal remedy.[32] Therefore, there are no records from which to extract information, sealed or otherwise, in the great majority of medical injury cases.

The social utility of malpractice litigation. Legal scholars have debated the aims of tort law and most agree on two: (1) compensation for injured parties and (2) deterrence of undesired behavior.[33] This Note adopts the perspective that these aims are subsumed under social utility, a broader societal goal. Social utility incorporates justice to the individual as a goal, but its primary concern is rules that work toward the good of society.[34]

In the 1960s, common law torts started to serve a quasi-regulatory and public law function in resolving intractable social problems where regulation or criminal law failed.[35] Medical injuries have proved to be just such an intractable social problem. Therefore, the tort system, as purveyor of social justice, has a valid and appropriate role to play in advancing the goal of reducing the epidemic of patient injuries.[36]

---

29 Tom Baker, *Transparency through Insurance: Mandates Dominate Discretion*, *in* CONFIDENTIALITY, TRANSPARENCY, AND THE U.S. CIVIL JUSTICE SYSTEM 185 (Joseph W. Doherty et al. eds., 2012).

30 Richard Kravitz et al., *Malpractice Claims Data as a Quality Improvement Tool: I. Epidemiology of Error in Four Specialties*, 266 JAMA 2087, 2087 (1991).

31 Baker, *supra* note 29, at 186.

32 See *infra* part II for a description of medical malpractice litigation rates.

33 DAN B. DOBBS, THE LAW OF TORTS 12 (2000).

34 *Id.*

35 Michael L. Rustad, *Torts as Public Wrongs*, 38 PEPP. L. REV. 433, 522 (2011).

36 The Ford Explorer/exploding Firestone tires case illustrates how tort law serves a larger purpose beyond the plaintiff and defendant. The National Highway Traffic Administration (NHTSA) acted only after trial lawyers used discovery to

The Argument. Due to the extent of harm befalling patients, efforts should be made to gather data that enhances understanding of why medical injuries occur—including excavating data from medical injury claims and lawsuits. This Note argues that (1) secrecy in out-of-court settlements and judicial records should be minimized when public health risks are involved; 2) greater access to medical malpractice insurance claims data would illuminate medical injury problems, and 3) the pool of untapped medical injury data in dormant claims—the 97% that are never brought–could be accessible if more claims are brought. These proposals, of course, will meet resistance. But each day, 600 to 1200 people die as a result of harm they encounter in the health system[37] and over 2700 are injured.[38]

The remainder of this Note proceeds as follows. Part II—The Health System Grapples with the Medical Injury Epidemic—describes the complexity of U.S. health services and the extent of medical injuries. Part III—How the Legal System Deals with Medical Malpractice—describes the tort of medical malpractice and barriers in the legal system that prevent access to medical harm data. Part IV—Medical Malpractice Litigation Has Improved Patient Safety—describes examples of how medical malpractice litigation has improved patient safety. Part V—Recommendations for Extracting Malpractice Data from the Legal System—identifies strategies for increasing the access to medical injury data in the legal system. Part VI—Conclusions—summarizes key elements in the Note.

---

uncover that Firestone tires on Explorers had caused hundreds of rollover accidents due to tread separation. *See id.* at 535-36.

[37] John T. James, *A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care*, 9 J. PATIENT SAF. 122, 122 (2013).

[38] Lucian L. Leape, *Preventing Medical Accidents: Is "Systems Analysis" The Answer?*, 27 AM. J.L. & MED. 145, 146 (2001).

II. THE HEALTH SYSTEM GRAPPLES WITH MEDICAL INJURIES

> *[I]t does not matter whether the deaths of 100,000, 200,000, or 400,000 Americans each year are associated with preventable adverse events in hospitals. Any of the estimates demands assertive action on the part of providers, legislators and people who will one day become patients.*[39]

–Dr. John T. James

A. Scope of U.S. Health System Services

The U.S. health system provides an enormous volume of services annually via 35 million inpatient hospital stays, 51 million medical procedures, 126 million clinic visits, and 136 million emergency department visits.[40] Health services are delivered in more than 5,600 hospitals,[41] 5,300 ambulatory surgery centers,[42] and 15,400 nursing care facilities.[43] Because of the sophisticated nature of care provided in the American "medical-industrial complex,"[44] and the number of

---

39 James, *supra* note 37, at 127.

40 *Hospital Utilization (in Non-Federal Short-Stay Hospitals)*, CENTERS FOR DISEASE CONTROL AND PREVENTION (2015), http://www.cdc.gov/nchs/fastats/hospital.htm [http://perma.cc/MLL6-KMTT]. These numbers include only non-federal healthcare so care provided in U.S. military, veteran's hospitals and Bureau of Prisons entities are not reflected. *Id.*

41 *Fast Facts on U.S. Hospitals,* AMERICAN HOSPITAL ASSOCIATION (2015), http://www.aha.org/research/rc/stat-studies/fast-facts.shtml [http://perma.cc/D8BY-7WVT].

42 *Report to the Congress: Medicare Payment Policy, Ambulatory Surgical Center Services*, ch. 3 115 MEDPAC (March 2015), http://www.medpac.gov/documents/reports/chapter-5-ambulatory-surgical-center-services-(march-2015-report).pdf?sfvrsn=0 [http://perma.cc/YLP6-7NRE].

43 *Total Number of Certified Nursing Facilities*, KAISER FAMILY FOUNDATION (2015), http://kff.org/other/state-indicator/number-of-nursing-facilities [http://perma. cc/HKQ4-F3A9].

44 The term "medical-industrial complex" is a play on President Dwight Eisenhower's use of "military-industrial complex"—language he used as a caution to the American people that the military would distort social policy because of its bent toward producing more elaborate and expensive military equipment. *See* Edward Goldsmith, *The Medical Industrial Complex* (June 1, 1990), http://www.edwardgoldsmith.org/53/the-medical-industrial-complex [http://perma.cc/DMF3-GFXV]. Similarly, "medical industrial complex" has been used to refer to the increasing expense and technological complexity of the

people involved with diverse backgrounds and training, healthcare is prone to errors, especially when there is little time to react to unexpected events.[45] Early medical error studies focused on hospitals, but medical misadventures occur in all clinical settings, including outpatient clinics, nursing facilities, and patient's homes.[46]

B. Scope of Medical Injuries: "Erring" the Health System's Dirty Laundry

When "To Err is Human" reported that up to 98,000 people die in U.S. hospitals each year due to avoidable medical error, a media frenzy erupted.[47] The book received front-page coverage in The New York Times, The Washington Post, and other major papers as well as television news coverage.[48] Congressional hearings ensued as government agencies, healthcare groups, healthcare accrediting organizations, and insurers demanded change.[49] But patient safety experts now say it's time to stop citing the Institute of Medicine's figure of 98,000 annual deaths.[50] Why? Because it's too conservative. A 2013 study found that, based on more recent data, 210,000 to 400,000 deaths result from preventable harm each year in hospitals.[51] This pegs medical error as the third leading cause of death in the U.S.[52]

---

health system. *See* Arnold S. Relman, *The New Medical-Industrial Complex*, 303 NEW ENG. J. MED 963 (1980).

45 Molla S. Donaldson, *An Overview of To Err is Human: Re-emphasizing the Message of Patient Safety*, *in* PATIENT SAFETY AND QUALITY: AN EVIDENCE-BASED HANDBOOK FOR NURSES ch. 3 1 (Ronda G. Hughes ed., 2008), http://www.ncbi.nlm.nih.gov/books/NBK2673 [http://perma.cc/DK5P-9TYL].

46 *Id.*

47 Susan Dentzer, *Media Mistakes in Coverage of the Institute of Medicine's Report*, 6 EFFECTIVE CLINICAL PRACTICE (Nov./Dec. 2000), http://ecp. acponline .org/novdec00/dentzer.htm [http://perma.cc/C9QW-ANRB].

48 *Id.*

49 Donaldson, *supra* note 45.

50 Allen, *supra* note 10 (describing the experts who have confidence in James' data including Dr. Lucian Leape, a Harvard physician who is considered the "father of patient safety." Leape served on the Institute of Medicine Committee responsible for writing "TO ERR IS HUMAN.").

51 James, *supra* note 37, at 122.

52 Cheryl Clark, *Medical Errors Third Leading Cause of Death, Senators Told*, HEALTH LEADERS MEDIA (July 14, 2014), http://healthleadersmedia.com/

Fatalities are only part of the problem. More than a million people are injured each year by medical treatments.[53] The economic impact associated with these preventable adverse events was $17 billion for one year as measured by healthcare expenses, lost income, lost household production, and disability costs.[54]

C. Patient Safety Efforts—and Their Limits

A flourish of efforts to diminish medical injuries was implemented after the 1999 publication of "To Err is Human." The tactics included changing culture within healthcare organizations by adopting approaches used in "high reliability" organizations that are relatively mistake-free, like nuclear power plants and air traffic control.[55]

The new approaches joined those used for many years like hospital "morbidity and mortality" conferences, an educational forum where physicians discuss clinical problems.[56] Internal reporting systems ("incident reports"), a staple in hospitals for decades, are used to identify errors and near-errors. Incident reports have limited usefulness because they are voluntary,[57] providers are known not to report all errors (they "under-report"),[58] and errors rates cannot be derived from

---

content.cfm?content_id=306564&page=1&topic=QUA [http://perma.cc/F2RQ-ZT44].

53 Leape, *supra* note 38, at 146. Dr. Leape, a visionary leader in the patient safety field, contended that the million injuries figure was an underestimate–in 2001. *Id.*

54 Jill Van Den Bos et al., *The $17.1 Billion Problem: The Annual Cost of Measurable Medical Errors*, 30 HEALTH AFF. 596 (2011) (describing how researchers used actuarial techniques to measure the frequency and costs of measurable medical errors identified in nearly nine years of insurance claims data. The most common errors were pressure ulcers (bed sores), post-operative infections, and post-laminectomy syndrome, and persistent pain following back surgery).

55 ROBERT M. WACHTER, UNDERSTANDING PATIENT SAFETY 255 (2012).

56 *See e.g.*, ATUL GAWANDE, COMPLICATIONS: A SURGEON'S NOTES ON AN IMPERFECT SCIENCE 57-70 (2002) (describing the process used in morbidity and mortality conferences to learn from patients' cases).

57 *See* WACHTER, *supra* note 55, at 234-35 (describing that errors are so common that a report made on each error would capsize the system; for example, an average intensive care unit patient experiences 1.7 errors per day in their care and an average hospitalized patient has one medication error each day.).

them.[59] Since both morbidity and mortality conferences and incident reports are confidential internal activities, what one facility uncovers remains protected within that organization.

Hospitals also use patient chart reviews, computerized surveillance, review of multiple source data (e.g., medical records, laboratory, pharmacy, and billing), observation of patient care, and walking rounds on patients-each has weaknesses in detecting and monitoring patient safety issues.[60]

Sentinel events, serious errors such as surgery on the wrong limb, trigger a search for underlying "root" causes of the errors and produce recommendations to prevent similar errors in the future.[61] The Joint Commission, the quality agency that collects these analyses, encourages healthcare organizations to report major errors but reporting data is voluntary and thus this data also has limited value.[62]

Significant personnel and financial resources have been invested to improve patient safety and nearly all healthcare organizations have

---

58 David M. Studdert et al., *Medical Malpractice*, 350 N. ENG. J. MED. 283, 287 (2004) (describing that a feature of physician's unwillingness to participate in certain patient safety activities is manifested by underreporting to adverse-event reporting systems).

59 *See* WACHTER, *supra* note 55, at 235. If reports of medication errors were to drop from one month to the next in a hospital for example, there is no way to know if the actual number of errors dropped or the voluntary reports decreased. *Id.*

60 Fang Sun, *Monitoring Patient Safety Problems*, AHRQ, No. 211, MAKING HEALTH CARE SAFER II: AN UPDATED CRITICAL ANALYSIS OF THE EVIDENCE FOR PATIENT SAFETY PRACTICES 2-3 (2013), http://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/evidence-based-reports/services/quality/ptsafetyII-full.pdf [http://perma.cc/4Y5E-VV4J].

61 WACHTER, *supra* note 55, at 244-45.

62 *Sentinel Event Data*, THE JOINT COMMISSION, (2015), http://www.jointcommission.org/assets/1/18/Root_Causes_Event_Type_2004-2Q_2015.pdf [http://perma.cc/9AR4-UDWS] (describing that sentinel event reporting to The Joint Commission is voluntary and since it represents a small proportion of actual events conclusions should not be drawn from it). The Joint Commission is an independent, not-for-profit organization that plays a major role in assessing and setting quality standards in the U.S. health system. It accredits and certifies nearly 21,000 healthcare organizations and programs in the United States. The Joint Commission, http://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx [http://perma.cc/GM3C-RQAG] (last visited Dec. 18, 2015).

made patient safety a primary strategic priority.[63] But progress has not matched the level of effort and investment,[64] in fact, it has been described as "sluggish."[65] Three studies in the decade after the publication of "To Err is Human" found high rates of preventable harm continued largely unabated in U.S. hospitals.[66]

III. MISSING IN ACTION: MEDICAL MALPRACTICE DATA

> *Many liability doctrines shine a light on less than salutary health care practices.*[67]
>
> –Barry Furrow, J.D.

A. The Tort Liability System

The civil justice system provides opportunity for redress to individuals harmed in a manner considered compensable through tort or other civil liability law.[68] In American society, tort law is the default regulator of safety and economic power.[69] Distinguished legal scholar Roscoe Pound described tort law as weighing individual interests in order to advance social interests.[70] Tort law's "signature" has been characterized as its flexibility in enabling consumers to uncover emerging dangers or risks affecting them and others in society.[71]

Additionally, Americans use their court systems not just as a means of resolving disputes, but also to produce information useful to

---

63 AGENCY FOR HEALTHCARE RESEARCH AND QUALITY [hereinafter AHRQ], No. 211, MAKING HEALTH CARE SAFER II: AN UPDATED CRITICAL ANALYSIS OF THE EVIDENCE FOR PATIENT SAFETY PRACTICES ii, ES-1 (2013).

64 *Id.*

65 Wachter, *supra* note 13.

66 AHRQ, *supra* note 63.

67 Barry R. Furrow, *The Patient Injury Epidemic: Medical Malpractice Litigation as a Curative Tool*, 4 DREXEL L. REV. 41, 63 (2011).

68 Baker, *supra* note 29, at 185. This Note uses Baker's definition of the American civil justice system: the courts, law firms, government legal agencies, the organized bar, organizations that assist claimants and defendants, and liability insurance firms. *Id.*

69 John T. Nockleby & Shannon Curreri, *100 Years of Conflict: The Past and Future of Tort Retrenchment*, 38 LOY. L.A. L. REV. 1021, 1036 (2005).

70 Roscoe Pound, *A Survey of Social Interests*, 57 HARV. L. REV. 1, 4 (1943).

71 Rustad, *supra* note 35, at 526.

society.[72] But the civil justice system is increasingly opaque.[73] Less than five percent of the millions of tort injury claims filed each year are resolved through public trial; most are settled in private forums like mediation and arbitration with undisclosed terms.[74] As the proportion of cases going to trial declines, courts are less able to serve as "revealers" of societally useful information.[75] Therefore, it's necessary to look to other strategies to reveal socially valuable medical injury information.

B. The Tort of Medical Malpractice

Introduction. Medical malpractice is a form of tort liability with two prime objectives: (1) to compensate patients who sustain an injury due to healthcare provider negligence, and (2) to deter providers from negligent practice.[76] A medical malpractice claim arises when a plaintiff alleges negligent medical treatment caused an injury.[77] In a medical negligence claim, the plaintiff has the burden of proving by a preponderance of the evidence that:

1) The relationship between the plaintiff/patient and defendant/healthcare provider gave rise to a duty;

2) The defendant's care fell below the applicable standard;

3) The plaintiff suffered an injury; and

4) The injury was caused by the defendant's negligence.[78]

Other liability doctrines can form the basis of claims, including informed consent doctrine that recognizes patients' informational

---

72 Andrew D. Goldstein, *Sealing and Revealing: Rethinking the Rules Governing Public Access to Information Generated Through Litigation*, 81 CHI.-KENT L. REV. 375, 402 (2006).

73 Doherty, *supra* note 22, at ix.

74 *Id.*

75 Goldstein, *supra* note 72, at 403.

76 Daniel P. Kessler, *Evaluating the Medical Malpractice System and Options for Reform*, 25 J. ECON. PERSPECT. 93, 93 (2011).

77 *Medical Malpractice Insurance Claims in Seven States,* U.S. DEP'T OF JUST., BUREAU OF JUST. STATS., 2000-2004 (March, 2007), http://www.bjs.gov/content/pub/pdf/mmicss04.pdf [http://perma.cc/2NQT-ENW9].

78 MICHELLE M. MELLO & DAVID M. STUDDERT, *The Medical Malpractice System-Structure and Performance*, *in* MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM 11-12 (William M. Sage & Rogan Kersh eds., 2006).

needs, provisions in the Emergency Medical Treatment and Active Labor Act (EMTALA) that mandate stabilizing treatment before a patient can be transferred to another hospital, and duty to warn.[79]

A medical malpractice claim may be brought against a nurse, pharmacist, psychologist, or other health professional but physicians most frequently face claims.[80] Hospitals and other health organizations may be claimed against and the law in most states permits health professionals and health facilities to be held jointly and severally liable.[81]

Disposal of malpractice claims. A medical malpractice claim can be disposed of in a settlement prior to or after a lawsuit filing, or when a lawsuit is closed after a verdict or judgment is reached at trial.[82] Most are resolved outside of courtrooms—only 7.8% of medical malpractices cases were disposed of by jury or bench trials in 2005.[83]

C. What Prevents Access to Medical Malpractice Data?

There is a well-known parable involving an elephant and three blind men.[84] Each of the men attempts to describe the entirety of an elephant through only the small part of the elephant that each feels. One touches a tusk, one the elephant's side, and so on. Each "knows" what an elephant is based on the little they know individually, and each is right—to a point.

Like the men in the parable, what is now known about medical harm is only a portion of the problem. More information would provide a clearer picture of the complexities of medical injuries, thereby contributing to the development of strategies to improve patient safety. But three barriers currently prevent this.

Barrier #1: Most injured parties do not bring claims so legal data does not exist in a form that can be used. In contrast to the

---

79 Barry R. Furrow, *The Patient Injury Epidemic: Medical Malpractice Litigation as a Curative Tool*, 4 DREXEL L. REV. 41, 63 (2011).

80 MELLO, *supra* note 78, at 12.

81 *Id.* at 12.

82 DEP'T OF JUST., *supra* note 77.

83 U.S. DEP'T OF JUST., BUREAU OF JUST. STATS., PUB. NO. NCJ 228129, Tort Bench and Jury Trials in State Courts, 2005 14 (Nov. 2009), http://www.bjs.gov/content/pub/pdf/tbjtsc05.pdf [http://perma.cc/BVG3-XJQ5] (noting that 2005 is the most recent year data are available from the U.S. Dep't of Justice).

84 An update of the tale would preferably refer to the parties as vision-impaired and include gender diversity.

extent of medical malpractice that occurs in the U.S. each year, there is little litigation in response to it. Tom Baker, an insurance and medical malpractice expert, explained that, depending on how statistics are analyzed, there is one medical malpractice lawsuit for every seven to twenty-five serious medical injuries.[85] In contrast, Baker points out, nearly everyone injured by a negligent driver files an insurance claim or lawsuit.[86] Baker's malpractice math rests on highly regarded studies that bear out his claim. In the 1990 Harvard Medical Practice Study, researchers reviewed over 30,000 patient records in New York hospitals. Of the 280 patients identified who had adverse events caused by medical negligence, eight filed malpractice claims thus about 97% did not sue.[87] When the Harvard researchers replicated the study in Utah and Colorado, they got the same result: 97% of patients who suffered a negligent injury did not sue.[88] A third study in Chicago produced consistent findings: less than 4% of injured patients filed claims.[89]

Barrier #2: Secrecy in settlements and court records bars access. Courts can sanction secrecy through protective orders on discovery materials, by sealing court records, and through confidentiality provisions in settlement agreements.[90] Alternatively, parties may settle out of court and a court then has no control over the agreement.[91] While a court may reserve the right to open a sealed record or settlement, sealed records and settlements generally remain permanently closed to all nonparties.[92]

---

85 TOM BAKER, THE MEDICAL MALPRACTICE MYTH 23 (2007).

86 *Id.*

87 A. 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. 345, 345 (1991).

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

89 BAKER, *supra* note 85, at 69. Baker describes one study that indicated about 10% of injured patients filed a lawsuit. However, the 2-3% rate of medical malpractice claiming appears to be accepted by most experts and scholars. Thus, this Note will use 3%. *Id.*

90 Alison Lothes, *Quality, Not Quantity: An Analysis of Confidential Settlements and Litigants' Economic Incentives*, 154 U. PA. L. REV. 433, 435 (2005).

91 *Id.*

92 Sanson, *supra* note 23, at 808.

Most civil litigation, including medical malpractice, ends in settlement.[93] When medical malpractice claims are settled, payment to a plaintiff is generally conditioned on a signed release that includes a nondisclosure agreement (also referred to as a confidentiality agreement or a "gag order").[94] Healthcare providers and organizations have compelling reasons to seek confidential resolution to medical malpractice claims. Several means are available to shield information from disclosure.[95] Many defendants wish to avoid the embarrassment of a public trial, are concerned about reputational harm, or prefer the expediency of a settlement.[96] They may believe that public news of a settlement will trigger other claims against them.[97]

Confidential, or "secret" settlements related to sexual abuse by priests, asbestos, tobacco, and silicone breast implants have garnered significant public attention.[98] The term "secret settlement" refers to:

> *a range of practices that result in a settlement between disputing parties on terms not subject to public scrutiny. The secrecy of many settlements is achieved simply by a private contract between the parties that is not filed with the court. Some settlement agreements however, are filed under seal with the court, ensuring judicial enforcement of the parties' obligation to maintain secrecy regarding settlement terms. Judicially mandated secrecy may extend not only to the terms and amount of the settlement but also to other court documents, such as filed discovery papers.*[99]

---

93 Barry R. Furrow, *The Patient Injury Epidemic: Medical Malpractice Litigation as a Curative Tool*, 4 DREXEL L. REV. 41, 76 (2011).

94 William M. Sage, et al., *Use of Nondisclosure Agreements in Medical Malpractice Settlements by a Large Academic Health Care System*, 175 JAMA INTERN. MED. 1130, 1131 (2015).

95 Smith, *supra* note 27, at 240-41.

96 Hannah V. Meisen-Vehrs, *Opening Medical Settlements for the Public Good: Why Medical Cases Justify Secrecy in Settlement*, 87 OR. L. REV. 671, 682 (2008).

97 Michelle M. Mello & Jeffrey N. Catalano, *Should Malpractice Settlements Be Secret?*, 175 JAMA INTERN. MED. 1135, 1135 (2015).

98 Christopher R. Drahozal & Laura J. Hines, *Secret Settlement Restrictions and Unintended Consequences*, 54 U. KAN. L. REV. 1457, 1457 (2006).

99 *Id.* at 1458.

Though secrecy in settlement agreements draws criticism, the majority of states don't prohibit it.[100] But confidential settlement of private litigation can be contrary to public interest where harm may reoccur.[101]

Medical malpractice settlements are frequently confidential.[102] A 2015 study in a Texas university hospital system found that 89% of medical malpractice settlement agreements used nondisclosure agreements.[103] All of the agreements in the study prohibited disclosure of settlement terms, half prohibited disclosure that an agreement had been reached, and 26% prohibited the claimant from reporting the matter to regulatory agencies.[104]

Confidential settlement may encourage rapid resolution, but that is obtained at the cost of permanently barring access to potentially valuable information that could improve patient safety and the quality of care.[105] The Joint Commission contends that secret settlements deprive injured patients of the opportunity to advocate for change and deprive healthcare providers of the opportunity to learn from sealed cases.[106]

Barrier #3: Limited access to insurance data. The liability insurance industry has a history of providing certain information to researchers on a voluntary basis, including some medical liability closed claims data.[107] For example, five malpractice insurers provided data to Harvard researcher Dr. David Studdert for analysis aimed at determining the value of closed insurance claims data in patient safety

---

100 Meisen-Vehrs, *supra* note 96, at 675.

101 Sage, *supra* note 94, at 1133.

102 *Id.* at 1132.

103 *Id.*

104 *Id.* The University of Texas stopped restricting regulatory reporting in settlement agreements in response to the findings of this study. *Id.* at 1134.

105 *Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury*, THE JOINT COMMISSION 37 (2005), http://www.jointcommission.org/assets/1/18/Medical_Liability.pdf [http://perma.cc/5S4U-5M5V].

106 *Id.*

107 Baker, *supra* note 29, at 186. A "closed claim" is one that has been settled or otherwise disposed of by the insurer, self-insurer, facility or provider. *Medical Professional Liability Closed Claim Reporting Model Law* 77-1, NAT'L ASS'N INS. COMM'RS (Oct. 2008), http://www.naic.org/store/free/MDL-77.pdf.

efforts.[108] Studdert and colleagues found closed malpractice claims were a rich source of data describing errors and factors that contributed to their occurrence.[109]

Malpractice insurers use their own data to improve patient safety (they are, after all, highly motivated to minimize malpractice claims and payouts). For example, in the 1990s when many physicians were being sued for failure to diagnose breast cancer, CRICO[110] found their insured physicians had no uniform approach to monitoring breast lumps.[111] The insurance firm developed a standard treatment algorithm, offered insured physicians who used it an insurance premium discount, and dramatically reduced litigation.[112]

However, due to the nature of the insurance industry, there are limits to what has been provided to researchers, and to what can be expected.[113] Currently, access to medical malpractice insurance data is provided at the discretion of the insurer and that access is not easy or certain.[114] Insurers derive competitive advantage by protecting their data, and they have a significant interest in public policy debates that could be affected by research derived from their data.[115] Also, a researcher whose conclusions do not support an insurer's agenda may be less likely to obtain access to future data than one whose research is supportive.[116]

---

108 *See* David M. Studdert, *MIMESPS: Learning from Malpractice Cases*, CRICO CLINICIAN RESOURCES (June 1, 2005), https://www.rmf.harvard.edu/Clinician-Resources/Article/2005/MIMESPS-Learning-from-Malpractice-Cases# [http://perma.cc/Z69D-782V].

109 *Id.*

110 The Controlled Risk Insurance Company is a not-for-profit firm that insures claims from Harvard-affiliated hospitals. CRICO, https://www.rmf.harvard.edu/About-CRICO [http://perma.cc/P72H-Q3EQ] (last visited Dec. 18, 2015).

111 Darshak Sanghavi, *Medical Malpractice: Why is it So Hard for Doctors to Apologize?*, BOSTON GLOBE MAG. 11 (Jan. 27, 2013), https://www.bostonglobe.com/magazine/2013/01/27/medical-malpractice-why-hard-for-doctors-apologize/c65KIUZraXekMZ8SHlMsQM/story.html [http://perma.cc/Y4BQ-XEBY].

112 *Id.*

113 Baker, *supra* note 29, at 186.

114 *Id.*

115 *Id.* at 186-87.

116 *Id.* at 187.

A limitation on the value of closed claims analysis is the data were collected by the insurer for the purpose of resolving an insurance claim, not for patient safety research.[117] Additionally, medical malpractice closed claims data does not reflect information about claims that are still unresolved.[118]

American malpractice insurance companies must file two types of closed claim reports. First, any payment made in satisfaction of a medical malpractice claim against a healthcare practitioner must be reported to the National Practitioner Data Bank (NPDB).[119] The NPDB is a nationwide flagging system designed to alert employers such as hospitals or state licensing bodies to a healthcare provider's malpractice record.[120] The NPDB has a public use data file, containing de-identified data, available for researchers, journalists, and others to analyze patient safety trends.[121] However, the databank does not contain extensive information regarding the circumstances leading to a malpractice payment, only certain data mandated by federal law.[122] Some states require insurance providers to report medical malpractice payments to a state agency.[123] However, the data reported concerns financial aspects of the claim—not detailed clinical data that would be of value to patient safety researchers.

Second, medical malpractice payments also must be reported to state professional licensing agencies that license physicians, nurses, and others.[124] While professional licensing has a patient safety and protection function by establishing academic standards and monitoring

---

117 Frederick W. Cheney, *The American Society of Anesthesiologists Closed Claims Project*, 91 ANESTHESIOLOGY 552, 553 (1999).

118 American Academy of Actuaries, *Important Considerations When Analyzing Medical Malpractice Insurance Closed-Claim Databases (2005)*, http://www.actuary.org/pdf/casualty/medmal_042005.pdf [http://perma.cc/4LJS-VQVH].

119 Reporting Medical Malpractice Payments, 45 C.F.R. § 60.7(a) (2013).

120 U.S. DEP'T OF HEALTH AND HUMAN SERVS. [hereinafter HHS], HEALTH RES. AND SERVS. ADMIN., NPDB GUIDEBOOK A-5 (2015), http://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp [http://perma.cc/5M7C-PMR8].

121 *Id.* at D-1.

122 Reporting Medical Malpractice Payments, 45 C.F.R. § 60.7(b) (2013).

123 U.S. Dep't of Just. Bureau of Just. Stat., *Medical Malpractice Insurance Claims in Seven States, 2000-2004* (March 25, 2007), http://www.bjs.gov/content/pub/pdf/mmicss04.pdf [http://perma.cc/CRW7-7MQJ].

124 HHS, *supra* note 120, at E-38.

clinical competency,[125] the data reported do not entail detailed clinical records that would be of value in patient safety research.

Conclusion. Detailed information is developed in the course of medical malpractice litigation, but little is accessible due to the broad use of nondisclosure agreements in settlements and, occasionally, in judicial sealing. Only limited access to closed malpractice insurance claims exists, and claims present a narrow perspective since only about 3% of injured parties ever bring claims. The combination of these factors means the legal system currently plays a minimally useful role in revealing information that could be applied to the dire social problem of medical harm.

IV. HOW MEDICAL MALPRACTICE LITIGATION HAS REDUCED PATIENT HARM

> *[T]he real problem is too much medical malpractice, not too much litigation.*[126]
>
> –Tom Baker

A. The Health System Can Learn from Malpractice Litigation

The value of medical malpractice litigation to the health system has been demonstrated in studies including some that transformed a highly risky medical specialty. Researcher Joanna Schwartz studied the influence of medical malpractice claims on the health system and discovered malpractice lawsuits offer safety improvement benefits, including:

---

125 HHS, HEALTH RES. AND SERVS. ADMIN., HEALTH LICENSING BOARD REPORT TO CONGRESS, http://www.hrsa.gov/ruralhealth/about/telehealth/licenserpt10.pdf [http://perma.cc/F2HR-FSSZ] (last visited Dec. 18, 2015) (report of Health Resources and Services Administrator Mary K. Wakefield).

126 BAKER, *supra* note 85, at 3.

1) Lawsuits reveal allegations of medical negligence and related patient safety issues not revealed in hospital reporting systems;
2) Previously unknown details of adverse events are exposed in discovery and depositions;
3) Analysis of malpractice claim trends can identify problematic procedures and hospital departments; and
4) Closed insurance claims are important teaching tools.[127]

The remedy for dangerous anesthesia care was malpractice litigation. The history of anesthesia care provides a particularly instructive illustration of how tort liability can motivate healthcare providers to root out and correct safety problems in healthcare delivery systems.[128] The practice of anesthesia today is exceptionally safe but that was not always so, and lessons from malpractice litigation sparked the transformation.[129] From the 1950s into the 1980s, surgical anesthesia put patients at risk of serious injury and death–and about half the deaths were preventable.[130] The widespread harm from anesthesia exposed anesthesiologists to a high likelihood of malpractice lawsuits and they paid among the highest malpractice insurance premiums.[131] In response to its malpractice fiasco, and disturbing media reports surrounding it, the American Society of Anesthesiologists launched studies in 1984 using malpractice claim data.[132]

The anesthesia "Closed Claims Project" examined medical malpractice insurance companies' closed anesthesia malpractice litigation files.[133] A typical file contained the hospital record,

---

127 Schwartz, *supra* note 12, at 1230-31.

128 David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 917 (2005).

129 *Id.* at 918.

130 Cheney, *supra* note 117, at 552 (describing how anesthesiologists were viewed as bad insurance risks because they represented 3% of insured physicians, but anesthesia litigation resulted in 11% of insurance payouts for patient injuries); Hyman, *supra* note 128, at 918.

131 Hyman, *supra* note 128, at 918.

132 Cheney, *supra* note 117, at 552.

133 *Id.*

anesthesia record, statements from personnel involved in the case, expert statements, deposition summaries, and the settlement or jury award.[134] The analysis was alarming: human error caused a large number of the anesthesia injuries.[135] In response, the American Society of Anesthesiologists overhauled anesthesia practice by implementing patient monitoring standards, redesigning care procedures, shortening resident physicians' hours on duty, standardizing equipment operation, and requiring use of patient monitoring devices.[136]

The 25-year effort to make anesthesia safe for patients worked. The risk of death from anesthesia dropped from 1 in 5000 anesthesia administrations to 1 in 250,000.[137] Less anesthetic harm meant fewer lawsuits. As anesthesia malpractice litigation dissipated, anesthesia providers' malpractice insurance rates, once among the highest in medicine, fell to among the lowest.[138]

It bears attention that the pressure to protect patients came from outside the health system[139] and the health system changed because of malpractice litigation.[140] The anesthesia safety transformation demonstrates a system feedback process. Serious anesthesia errors harmed patients and generated lawsuits that in turn burdened anesthesia providers with litigation costs and high malpractice insurance premiums.[141] Anesthesia practice changes led to lower error rates, fewer lawsuits, lower malpractice premiums, and the recognition of anesthesia as an exceptionally safe discipline.[142]

Other researchers have uncovered the value in examining malpractice claims data. Dr. Thomas Glick, a Harvard Medical School professor, published a study of malpractice claims against neurologists and concluded that claims against physicians could educate them about medical errors and thereby improve patient safety and the quality of

---

134 *Id.*

135 Hyman, *supra* note 128, at 918.

136 *Id.* at 920.

137 Annas, *supra* note 18, at 2065.

138 *Id.*

139 Hyman, *supra* note 128, at 920.

140 *Id.* at 918.

141 *Id.* at 922.

142 Schwartz, *supra* note 12, at 1273-74.

care.[143] A primary care malpractice claims study had a similar finding. The primary care researchers concluded that claims data identified conditions where primary healthcare is prone to "go awry"[144] and called the use of claims data "one of the richest opportunities for future research and efforts to help good doctors prevent lapses in care."[145]

V. OPTIONS FOR EXTRACTING MALPRACTICE DATA FROM THE LEGAL SYSTEM TO ENHANCE PATIENT SAFETY EFFORTS

> *Those on the cutting edge of malpractice reform focus on the 2 percent of mistakes that enter the court system, in hopes of applying what they find to the 98 percent of errors that quietly send tens of thousands of Americans to the grave each year.*[146]

—Dr. Darshak Sanghavi

A. Overview of Argument

Extracting data from medical malpractice insurance claims can improve patient safety. The anesthesia studies demonstrated how data from litigation can spur change in the health system that prevents

---

143 Thomas H. Glick, *Malpractice Claims: Outcome Evidence to Guide Neurologic Education?*, 56 NEUROLOGY 1099, 1100 (2001). Despite Dr. Glick's conclusion that malpractice claims data offers a valuable learning opportunity for neurologists, the journal *Neurology* also published an editorial undermining Glick's research findings. The editorial authors paid tribute to the "conventional wisdom" that the legal system is the problem, not part of the solution to addressing medical harm. The editorial authors stated, "to prevent and mitigate the effects of medical error and to develop evidence-based programs to reduce it, we need to collect, analyze, and understand very different data that those found in medical malpractice claims filed by insurance carriers" and "Unfortunately, one of the major reasons we know so little about the epidemiology of medical near misses and errors is because of our current legal system. The potential for litigation deters physicians and other care providers from furnishing information that could reveal mistakes in the system, because this information also could be used against them in a lawsuit." Robert G. Holloway & Robert J. Panzer, *Lawyers, Litigation, and Liability: Can They Make Patients Safer?*, 56 NEUROLOGY 991, 992 (2001).

144 Robert L. Phillips et al., *Learning from Malpractice Claims about Negligent, Adverse Events in Primary Care in the United States*, 13 QUAL. SAF. HEALTH CARE 121, 121 (2004).

145 *Id.* at 126.

146 Sanghavi, *supra* note 111.

injuries and saves lives. And, Schwartz' 2013 study identified how litigation can reveal previously unknown patient safety problems.

The intractability of the medical injuries issue indicates resolution will likely not take place solely by change initiated from within the health system. Therefore, this Note argues that efforts to enhance extraction of data from medical malpractice litigation can help shape knowledge of medical injuries and thereby influence change. But the ability to extract data, that will in turn provide feedback to the health system, is dependent on the accessibility of that data.

Several strategies could increase access to patient data. First, the increasing the flow of medical malpractice claiming would increase the pool of data. When only about 3% of injured patients pursue a claim, about 97% of the potential legal information about medical injuries is inaccessible. Additionally, extracting data from confidential records could reveal valuable data. Finally, greater access to medical malpractice insurance claims could be used to improve patient safety as it has in the past. The following sections explore these strategies for enhancing access to data.

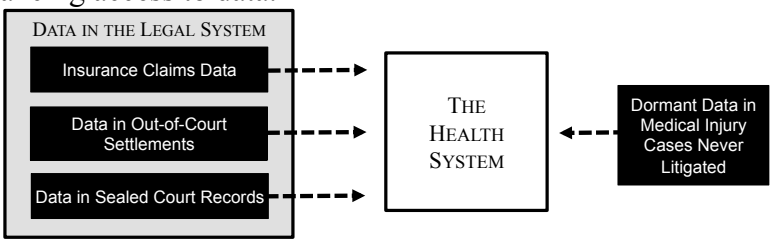

FIGURE 1. Sources of medical injury data that could benefit patient safety improvements in the health system.

B. To Harvest More Malpractice Data, Bring More Malpractice Claims

Barriers to claiming. The barriers to bringing malpractice claims are daunting and include access to justice, tort reform measures, and the stress that accompanies litigation. To increase the volume of medical malpractice claims, these barriers must be reduced. A major barrier to increased claiming is access to the justice system. Many patients who have experienced harm are unable to obtain legal representation, and not having an attorney effectively means no lawsuit.[147] Medical malpractice lawsuits are expensive to litigate and

---

147 David A. Hyman & Charles Silver, *Medical Malpractice and Tort Reform: It's the Incentives, Stupid*, 59 VAND. L. REV. 1085, 1117 (2006).

studies show attorneys reject 70% to 90% of medical malpractice cases they screen.[148] In a 2014 national study of attorneys, a researcher determined that 95% of potential medical malpractice plaintiffs would find it extremely difficult to locate an attorney willing to take on a case unless expected damages are at least $250,000 (even when the case is almost certain to win on the merits).[149]

High litigation costs mean attorneys refuse to represent patients with "smaller" claims, and because the majority of medical negligence events do not lead to serious harm, many patients are thus unable to secure legal representation.[150] Even claimants initially accepted by an attorney may be dropped as information is developed—not because there was no negligence but because damages appear insufficient to proceed.[151]

Some states have implemented tort reform measures that make it more difficult for claimants to bring medical malpractice claims. Wisconsin is a case in point. Despite reports that medical errors are increasing, Wisconsin malpractice lawsuits dropped 50% from 1999-2014.[152] Wisconsin lawmakers capped several types of damages available in malpractice (as have about 34 other states).[153] Caps limiting damage awards discourage lawyers from taking cases.[154] Wisconsin even caps fees lawyers can receive if successful in medical malpractice cases.[155] A powerful physician's lobby is credited with

---

148 Joanna Shepherd, *Uncovering the Silent Victims of the American Medical Liability System*, 67 VAND. L. REV. 151, 167 (2014).

149 *Id.* at 151.

150 *Id.* at 174.

151 Hyman, *supra* note 147, at 1121.

152 *Wisconsin Should Make Medical Malpractice Law Fairer*, MILWAUKEE J. SENTINEL, July 12, 2014, http://www.jsonline.com/news/opinion/wisconsin-should-make-medical-malpractice-law-fairer-b99309264z1-266823261.html [http://perma.cc/WA6B-ZXUS].

153 Cary Spivak, *Medical Malpractice Lawsuits Plummet in Wisconsin*, MILWAUKEE J. SENTINEL, June 28, 2014, 5:00 PM, http://www.jsonline.com/watchdog/watchdogreports/medical-malpractice-lawsuits-plummet-in-wisconsin-b99290329z1-264436841.html [http://perma. cc/ZP5K-FH6A].

154 MILWAUKEE J. SENTINEL, *supra* note 152.

155 Spivak, *supra* note 153.

exerting influence on the Wisconsin legislature to craft the malpractice laws that favor physicians, not patients.[156]

At least thirty states have adopted medical malpractice laws, reflecting a shift toward statutory control of medical malpractice litigation and away from governance by court-made common law.[157] These tort reforms include immunity provisions for healthcare providers and institutions, notice requirements for plaintiffs, pretrial screening to discourage cases without merit, prohibitions on *ad damnum* clauses (the suggested dollar amounts a plaintiff requests a court to award), collateral source rules requiring money damages be offset by payments from sources such as health or disability insurance, and limits on damages (as in Wisconsin).[158] In jurisdictions that have enacted medical malpractice tort reform to tighten compensation rules, the measures do nothing to encourage quality improvement in the health system.[159]

In all jurisdictions, there are practical considerations that dissuade potential claimants from bringing a malpractice action. Patients considering a claim may be sick or injured as a result of their

---

156 *See generally* Cary Spivak & Kevin Crowe, *Medical Lobby is a Powerhouse in Wisconsin Capitol*, MILWAUKEE J. SENTINEL, June 28, 2014, 5:00 PM, http://www.jsonline.com/watchdog/watchdogreports/medical-lobby-is-a-powerhouse-in-wisconsin-capitol-b99291106z1-265030841.html [http://perma.cc/FY5V-4S4Z].

157 Teresa M. Waters et al., *Impact of State Tort Reforms on Physician Malpractice Payments*, 26 HEALTH AFFAIRS 500, 500-01 (2007).

158 *Id.* at 503-04.

159 *Id.* at 508. Powerful special interest groups have been involved in pressing for health care industry-friendly medical malpractice tort reform initiatives. The American Tort Reform Association (ATRA) website identifies some of its members as the American Medical Association, the American College of Obstetricians and Gynecologists, the American Association of Orthopedic Surgeons, Doctors' Company, Medical Mutual, Physician Insurers Association of America, and Preferred Physician Medical. American Tort Reform Association, http://www.atra.org/about/sample-members (last visited Nov. 11, 2015). The website further states that the organization "supports an aggressive civil justice reform agenda" and the first area identified on a list of eleven targets is "health care liability reform." The ATRA website also states that their programs "shine a media spotlight on lawsuit abuse," the "pernicious political influence of the personal injury bar," redefine[s] the victim and show "how lawsuit abuse affects all of us." AMERICAN TORT REFORM ASSOCIATION, http://www.atra.org/about [http://perma.cc/CGE5-WZKQ] (last visited Dec. 18, 2015).

treatment[160] and the system itself has been characterized as expensive, burdensome, slow, and stingy.[161] The average tried malpractice case can last over three years.[162]

The process of civil litigation is stressful for plaintiffs.[163] Justice Learned Hand commented, "as a litigant I should dread a lawsuit beyond almost anything short of sickness and death."[164] And, even when a patient can secure an attorney and withstand the stress of the legal process, the odds are against plaintiffs who go to trial. Healthcare provider-defendants win most malpractice jury trials.[165] Two malpractice trial studies found defendants prevailed in 81% and 73% of cases.[166]

Strategies to increase malpractice claiming and data availability. Malpractice researcher Rogan Kersh observed, "Among the few self-evident truths about the U.S. medical malpractice system is that it desperately needs reforming."[167] There is no simple reform that would encourage malpractice claiming and thereby create access to dormant data. While medical malpractice reform measures have been brandished, little political will to pursue comprehensive system reform has been observed.[168]

---

160 BAKER, *supra* note 85 at 91.

161 David A. Hyman & Charles Silver, *Medical Malpractice and Tort Reform: It's the Incentives, Stupid*, 59 VAND. L. REV. 1085, 1114-15 (2006).

162 Michael Heise, *Justice Delayed? An Empirical Analysis of Civil Case Disposition Time*, 50 CASE W. RES. L REV. 813, 834 (2000) (showing that medical malpractice litigation averaged 38.2 months, exceeding the overall jury trial disposition time of 30.2 months).

163 Larry H. Strasburger, *The Litigant-Patient: Mental Health Consequences of Civil Litigation*, 27 J. AM. ACAD. PSYCHIATRY LAW 203, 204 (1999).

164 *Id.* (citing Learned Hand, *Deficiencies of Trial to Reach the Heart of the Matter: Three Lectures on Legal Topics*, 89 ASSOCIATION OF THE BAR OF THE CITY OF NEW YORK 105 (1926)).

165 Hyman, *supra* note 147, at 1107.

166 *Id.*

167 ROGAN KERSH, *Medical Malpractice and the New Politics of Health Care, in* MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM 43 (William M. Sage & Rogan Kersh eds. 2006). Experts call for medical malpractice reform for many reasons that are beyond the scope of this Note.

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

Overcoming the "malpractice myth." A conventional wisdom has infused many conversations about medical malpractice litigation and has shaped policy initiatives such as tort reform that favors healthcare providers and organizations. It's been termed the "malpractice myth" by insurance and medical malpractice expert Tom Baker.[169] The myth espouses the view that there's too much malpractice litigation, most claims are frivolous, and undeserving patients get unjustified damage awards ("jackpot justice").[170] Other facets of the myth are that malpractice insurance rates are driven up by high rates of litigation, physicians are one malpractice verdict away from bankruptcy, and physicians flee to states that have adopted malpractice award damages caps.[171] Medical malpractice researchers Dr. David Hyman and attorney Charles Silver call these views "mistaken and misleading."[172]

The reality is that there is an epidemic of medical malpractice and actually very little malpractice litigation.[173] Any "patient-centered" public policy proposal aimed at increasing the volume of medical malpractice claims would need to overcome the "malpractice myth." Policy change could only succeed if too much medical injury is acknowledged as the primary problem, not too much medical malpractice litigation.

Assuming the malpractice myth can be dispelled, policy options that could streamline the litigation process, resolve more malpractice claims and therefore generate more data, include the use of health courts, mediation, arbitration, and administrative compensation boards. These are briefly discussed here.

Health Courts. The concept of a "health court," an administrative entity that would process malpractice claims outside the tort system,

---

169 *See* BAKER, *supra* note 85. Tom Baker is William Maul Measey Professor of Law and Health Sciences at the University of Pennsylvania Law School, previously directed the Insurance Law Institute at the University of Connecticut School of Law, and is the author of publications including *The Medical Malpractice Myth* published by the University of Chicago Press.

170 Shepherd, *supra* note 148, at 168.

171 David A. Hyman & Charles Silver, *Five Myths of Medical Malpractice*, 143 CHEST 222, 222 (2013).

172 *Id.*

173 BAKER, *supra* note 85 at 19.

has been advanced by reform advocates.[174] Specially qualified judges would determine compensation decisions in what would arguably be a faster, more reliable, more transparent process that would increase the number of patients who recover.[175] However, health courts would invite constitutional challenges because they would abrogate the traditional role of the judiciary and the right to a trial by jury.[176]

Mediation. In mediation, an impartial third party works with parties to resolve a dispute.[177] It is a confidential, voluntary process where the resolution is negotiated by the parties offers some advantages over other dispute resolution processes.[178] When used soon after injury, parties can resolve claims promptly and the parties themselves make decisions rather than having a resolution imposed on them by an arbitrator or judge.[179] Mediation provides cost savings by shortening the litigation process and, in theory, information that emerges could be used to improve patient care.[180]

Arbitration. A less complex version of litigation, arbitration utilizes simplified rules of evidence and there is no discovery.[181] Like mediation, arbitration is less costly than litigation and offers more flexibility than a trial.[182] Arbitration, unlike mediation, results in a binding resolution that can be overturned only if malfeasance during the arbitration process is shown.[183]

---

174 Michelle M. Mello et al., *Health Courts and Accountability for Patient Safety*, 84 MILBANK Q. 459, 460 (2006).

175 Schwartz, *supra* note 12, at 1241-42.

176 Michelle M. Mello et al., *Policy Experimentation with Administrative Compensation for Medical Injury: Issues under State Constitutional Law*, 45 HARV. J. ON LEGIS. 59, 59 (2008).

177 CAROL B. LIEBMAN & CHRIS S. HYMAN, *Disclosure and Fair Resolution of Adverse Events*, *in* MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM 205 (William M. Sage & Rogan Kersh eds., 2006).

178 *Id.*

179 *Id.*

180 Chris Stern Hyman et al., *Interest-based Mediation of Medical Malpractice Lawsuits: A Route to Improved Patient Safety?*, 35 J. HEALTH POL. POL'Y & L. 797, 797 (2010).

181 Frank Sloan & Lindsey Chepke, *From Medical Malpractice to Quality Assurance*, 24 ISSUES IN SCIENCE AND TECH. (2008).

182 *Id.*

183 *Id.*

No-Fault Administrative Compensation. One reform proposal involves creating a malpractice resolution system modeled on Workers' Compensation that removes negligence as the eligibility qualification.[184] In one version of this model, an administrative body would evaluate injury claims that are carved out of the tort system and fast-tracked for compensation.[185] Claimants would not require legal representation, and claims would be resolved by neutral adjudicators and medical experts.[186] Patients might receive compensation according to a schedule for reasonable healthcare, rehabilitation expenses not covered by insurance, and lost wages up to a maximum amount.[187] This process would replace a negligence determination with an avoidability standard (whether a problem could have been avoided), a more permissive standard than negligence that would result in a larger pool of claimants eligible for compensation.[188] The U.S. has some experience with this model. The Federal Vaccine Injury Compensation Program handles specified vaccine-related injuries, and two states use administrative systems to resolve certain birth-related neurological injuries.[189]

Repeal tort reforms that dissuade claims. Conventional tort reforms aim to winnow the number of potential lawsuits as well as the amount of damages awarded.[190] Most tort reforms will not improve error reporting or health system safety and quality.[191] The most frequently-discussed reforms (e.g., damage caps, credits for collateral source payments, and contingency fee limits) are targeted at reducing insurance costs—not improving unsafe care or reducing medical errors.[192] Repealing any of these conventional tort reform measures would likely enhance litigation volume.

In summary, these options could remove barriers to malpractice claims so patients with legitimate medical injury cases would enjoy improved access to justice. This, in turn, would create records

---

184 Studdert, *supra* note 58, at 289.

185 *Id.*

186 Shepherd, *supra* note 148, at 195.

187 BAKER, *supra* note 85 at 163.

188 Studdert, *supra* note 58, at 289.

189 Shepherd, *supra* note 148, at 195.

190 Studdert, *supra* note 58, at 288.

191 Hyman, *supra* note 128, at 899.

192 *Id.*

documenting medical malpractice cases, and that would add data to the pool of knowledge about medical injuries. These strategies could open the doors to the justice system for some of the 97% of injured patients who never bring a malpractice claim.

However, increasing the volume of litigation has major implications for an already stressed justice system. For example, across the nation, federal district courts have experienced a rise in recent years in the time required to get civil cases to trial as judges' workloads have increased.[193] Chief District Judge Fred Biery of the Western District of Texas remarked, "It would be nice to get some help. We are pedaling as fast as we can on an increasingly rickety bicycle."[194] Additional resources would be essential to manage any increase in malpractice litigation in the courts. The political complexities of enacting "patient-centered" change would require overcoming the "malpractice myth" as well as powerful interest groups. (A full discussion of the complexities of interest group politics is beyond the scope of this Note.)

C. Reduce Secrecy in Settlements and Litigation to Improve Access to Data

Civil litigation has the power to uncover otherwise hidden information about practices that result in injury.[195] But common legal practices such as protective orders, sealing orders, and confidential settlements deprive the public of information that might be helpful in preventing such injuries and deaths.[196]

Public health refers to measures to prevent disease, promote health, and prolong life in a population as a whole.[197] A main function of

---

193 Sudhin Thanawala, *Wheels of Justice Slow at Overloaded Federal Courts*, ASSOCIATED PRESS (Sep. 27, 2015, 3:47 PM), http://bigstory.ap.org/article/54175de3d735409ab99a2f10e872d58e/wheels-justice-slow-overloaded-federal-courts [http://perma.cc/53MV-4R2X].

194 Gary Martin, *Vacancies, Backlogs Plague Federal Judiciary*, HOUSTON CHRON. (Mar. 2, 2013, 9:17 PM), http://www.chron.com/news/politics/article/Vacancies-backlogs-plague-federal-judiciary-4321484.php [http://perma.cc/5W3P-8WUW].

195 Daniel J. Givelber & Anthony Robbins, *Public Health Versus Court-Sponsored Secrecy*, 69-SUM L. & CONTEMP. PROBLS. 131, 131 (2006).

196 *Id.*

197 *Public Health*, WORLD HEALTH ORG., http://www.who.int/trade/glossary/story076/en [http://perma.cc/ZL8A-ACAV] (last visited Dec. 18, 2015).

public health is formulating public policies designed to solve identified local and national health problems.[198] Medical errors were labeled a serious public health problem as early as 2001.[199] This Note argues that, when considering approaches to increasing access to medical malpractice data, medical injuries in the U.S. should be viewed as a public health and safety hazard demanding a policy response. Advocates of public access to information argue that secrecy covers up unexposed danger, that the public has a right to information concerning a public risk, and that private parties' rights to confidentiality should be subordinated to public safety. [200] Additionally, they contend that if disclosure allows the justice system to better protect and serve the public by, for example warning of harms, then secrecy must be minimized.[201]

Anti-secrecy advocates also argue that suppressing information about dangers inherent in corporate behavior in healthcare deprives regulators, other litigants, and consumers of important safety information.[202] Certain factors weigh in favor of public disclosure such as when a high degree of harm or a risk of death is involved, a high likelihood that unknown third parties will be harmed, and when the secret settlement will conceal a harm from others.[203]

Recent legislative initiatives aimed at increasing "sunshine" by prohibiting or reducing secret settlements of civil lawsuits demonstrate the public's discomfort with confidential settlements. [204] Several approaches to increase transparency in the resolution of claims include:

---

198 *Id.*

199 David P. Phillips & Charlene C. Bredder, *Morbidity and Mortality from Medical Errors: An Increasingly Serious Public Health Problem*, 23 ANN. REV. PUB. HEALTH 135 (2001).

200 Lothes, *supra* note 90, at 436-37.

201 JOSEPH W. DOHERTY ET AL., CONFIDENTIALITY, TRANSPARENCY, AND THE U.S. CIVIL JUSTICE SYSTEM at xiv (Joseph W. Doherty et al eds., 2012).

202 Furrow, *supra* note 93, at 77.

203 Meisen-Vehrs, *supra* note 96, at 680-81.

204 Lothes, *supra* note 90, at 433.

1) Adopting a presumption all court records are open to the public;

2) Limiting use of protective orders in discovery;

3) Requiring a party to show good cause before sealing court files;

4) Requiring a public hearing before sealing a court file;

5) Forbidding secret settlements in court; and

6) Making confidentiality agreements void as against public policy if the agreement conceals a public hazard.[205]

Several states and one court in particular have instituted sunshine rules that merit consideration in a discussion of how to increase access to medical injury data.[206]

Texas Rule 76a. Texas Rule of Civil Procedure 76a, adopted in 1990, presumes all court records including settlements are open to the public and may only be sealed upon specific showing.[207] Rule 76a lays out a test a party seeking to seal a record must satisfy.

First, the party seeking sealing must identify "a specific, serious, and substantial interest which clearly outweighs (1) this presumption of openness, and (2) any probably adverse effect that sealing will have upon the general public health or safety."[208] Additionally, the party must show that "no less restrictive means than sealing records will adequately and effectively protect the specific interest asserted."[209] A court must balance the interest of the party seeking secrecy against the public interest.[210]

Florida's Sunshine in Litigation Act. The Florida Sunshine in Litigation Act was adopted in 1990 and goes farther than the Texas rule by "preemptively prohibiting, without any balancing of private and public interests, the sealing of any information that has the purpose of concealing a public hazard or contains information that

---

205 Drahozal, *supra* note 98, at 1476.

206 Goldstein, *supra* note 72, at 380.

207 Smith, *supra* note 27, at 244-45.

208 Tex. R. Civ. P. 76a(1)(a).

209 *Id.* at 76a(1)(b).

210 Sanson, *supra* note 23, at 819.

would be useful in protecting oneself from a public hazard."[211] The law defines a public hazard broadly as "any . . . instrumentality that has caused and is likely to cause injury."[212] Thus, this broad statute may encroach on personal privacy.[213]

South Carolina District Court's secrecy ban. The nation's strictest secrecy ban is the South Carolina District Court's Local Civil Rule 5.03(e) that prohibits any settlement agreement filed with the court to be sealed.[214] South Carolina's federal trial judges voted unanimously to ban secret settlements because such agreements "made the courts complicit in hiding the truth about hazardous products, inept doctors, and sexually abusive priests."[215] However, private agreements made out of court can still freely suppress information about dangers to public safety.[216]

New Jersey's medical malpractice law. New Jersey adopted an anti-secrecy rule that applies specifically to medical malpractice information, whether generated through judicial action or private settlement.[217] The 2003 law requires any information about a malpractice award to be posted on the defendant's internet profile—but without any balancing of interests including privacy.[218]

Recommendations. While the concept of greater transparency in tort actions is simple, making it happen is complicated.[219] The public's interest in information must be balanced by privacy protections and ensuring that courts remain efficient forums in which to resolve disputes.[220] Though this Note argues enhanced transparency is desirable in providing access to medical injury data, matters of private

---

211 *Id.*

212 *Id.*; FLA. STAT. ANN. § 69.081(2) (opening the door to construing medical errors as a public hazard).

213 Drahozal, *supra* note 98, at 1478.

214 Goldstein, *supra* note 72, at 391.

215 Adam Liptak, *Judges Seek to Ban Secret Settlements in South Carolina*, N.Y. TIMES, Sept. 2, 2002, at A13, http://www.nytimes.com/2002/09/02/us/judges-seek-to-ban-secret-settlements-in-south-carolina.html [http://perma.cc/5AEY-X2G2].

216 Lothes, *supra* note 90, at 445.

217 Goldstein, *supra* note 72, at 434.

218 *Id.*

219 Ross E. Cheit, *Tort Litigation, Transparency, and the Public Interest*, 13 ROGER WILLIAMS U. L. REV. 232, 233 (2008).

220 Goldstein, *supra* note 72, at 406.

interest that do not threaten public health or safety, or conceal a public hazard, should always be exempt from disclosure.[221]

For cases resolved via the courts, there are viable public policy options that could increase transparency. Senator Herbert Kohl introduced a "Sunshine in Litigation" bill multiple times during the course of his 24 years in the U.S. Senate.[222] The legislation, if it had passed, would have applied to protective orders and sealing of cases and settlements.[223] The bill's language required judges to use a balancing test to weigh the need for secrecy against the potential for harm to the public, and to make specific factual findings before entering a confidentiality order.[224] A challenge in enacting a fair anti-secrecy law is that confidentiality determinations would require painstaking case-by-case analysis.[225] However, "weighing competing interests is what judges do on a daily basis."[226] Federal action though seems unlikely, thus states could follow in Texas's balancing test regulation to increase transparency.

Greater access to privately-negotiated out-of-court settlements that are protected with nondisclosure agreements is not likely. However, payment in these settlements must be reported by the insurer to the National Practitioner Databank. If the data elements were expanded there would be additional information available to patient safety researchers.

D. Increase Access to Medical Malpractice Insurance Claims Data

The anesthesia closed claims study demonstrated the value of using insurance data to influence the health system. But most researchers have been unable to gain access to closed claims records except limited information provided to state insurance departments in Florida, Texas, and Missouri.[227] As long as access to liability

---

221 Smith, *supra* note 27, at 266.

222 SUNSHINE IN LITIGATION ACT OF 2011, S. Rep. No. 112-045 (2015), http://thomas.loc.gov/cgibin/cpquery/?&sid=cp112SUHud&r_n=sr045.112&dbname=cp112&&sel=TOC_46858& [http://perma.cc/SGU4-M6YT].

223 Joseph F. Anderson, *Secrecy in the Courts: At the Tipping Point*, 53 VILL. L. REV. 811, 827 (2008).

224 *Id.*

225 Cheit, *supra* note 219, at 269.

226 Anderson, *supra* note 223, at 827-28.

227 Baker, *supra* note 29, at 194.

insurance data relies on the insurer's discretion, the information provided will likely be incomplete, and may be biased to favor the public policy agenda of the insurance carrier.[228]

The presently private nature of malpractice claims could be brought more fully into public view, though that is unlikely without government action.[229] The Insurance Research Council (IRC) collects extensive data on motor vehicle claims from insurers and publishes large data-sets every three to five years.[230] Each participating automobile insurer provides individual claims-level data creating a pool of about 80,000 claims.[231] Mandatory reporting of de-identified medical malpractice claims data to the Insurance Research Council or other appropriate agency could significantly enhance the quantity and quality of medical injury claims data now available. Congressional action would be required to enact this policy but would garner data far beyond what is now accessible.

---

228 *Id.* at 184.

229 *Id.* at 197 (explaining that insurance is a highly competitive endeavor; it is not in an insurer's interest to share claims information with competitors thus they can't be expected to do so voluntarily).

230 *About the IRC and its Mission*, INS. RES. COUNCIL, http://www.insurance-research.org/about [http://perma.cc/6TB7-Z7FB] (last visited Dec. 18, 2015); Baker, *supra* note 29, at 188.

231 Baker, *supra* note 29, at 188.

VI. CONCLUSION

> *We decided long ago that the dangers of excessive and unwarranted concealment of pertinent facts far outweighs the dangers which are cited to justify it.*[232]
>
> –John. F. Kennedy

The extent of medical errors, injuries, and negligence in the United States health system should shock the conscience of anyone made aware. While tribute must be paid to those who have contributed to patient safety improvements, the intractability of the problem demands new strategies be added to tools currently used. Solutions will not be effective unless they are firmly rooted in valid and reliable data. Thus, this Note has argued that it's time for the health system to look to rich sources of data within the legal system.

The anesthesia closed claims studies transformed a risky medical specialty into a safe one, demonstrating the powerful influence research using closed medical malpractice insurance claims can have on a problem-riddled system. Mandating that medical malpractice insurers report detailed, de-identified data to a third party collection agency is likely the most achievable of the recommendations proposed in this Note. However, even if access were provided to data from every closed malpractice claim, the sample size would be only three percent of the entire universe of patients who experience some type of medical harm.

Secrecy in litigation can hide harm from the public. Although court records documented the dangers associated with the fatal marriage of Firestone tires and Ford Explorers, 271 deaths and over 800 serious injuries occurred before unsealed court documents revealed the danger.[233] The Florida and New Jersey approaches to medical malpractice that demand full "sunshine" are a step too far though. Patients must have the option to preserve their privacy if they so choose. But Texas Rule of Civil Procedure 76a provides an exemplar for other jurisdictions to consider. The rule presumes openness in

---

[232] *John F. Kennedy Speeches*, JOHN F. KENNEDY PRESIDENTIAL LIBRARY AND MUSEUM, http://www.jfklibrary.org/Research/Research-Aids/JFK-Speeches/American-Newspaper-Publishers-Association_19610427.aspx [http://perma.cc/6TY5-ZBZN] (last visited Dec. 18, 2015).

[233] Sanson, *supra* note 23, at 815.

judicial records but permits sealing if a party can show that sealing will have no adverse effect on public health and safety.

A bigger malpractice litigation pipeline could foster real change in the health system (and provide compensation to many who are harmed but have no access to justice in the current system). Effective pressure for safer hospital culture is most likely to develop from an increased risk of liability – stimulated by an increase in patient safety lawsuits.[234]

Medical malpractice tort reform has been legislated on behalf of special interest groups – not on behalf of patients who have experienced medical injury. Patient-centered tort reform could erode barriers to bringing claims that now exist. Notwithstanding the need for better access the medical injury data, patients who experience harm deserve better access to justice than exists now. But to handle a larger volume of cases, more resources would be essential.

Policy change is unlikely to address any patient-centered medical malpractice issue until the "malpractice myth" is exposed and discarded. The entrenched myth, resting on such misconceptions as patients winning undeserved "jackpot justice," is widely accepted despite resting on a wobbly factual foundation.

Public access to litigation-generated information permits citizens to observe and participate in the judicial system and gain confidence that courts serve public, as well as private, interests.[235] Enhancing access to medical malpractice data is a logical role for the tort system because of the intractability of the medical injury problem. The tort system's social utility function requires that it work toward the good of society, and the medical negligence problem infesting the health system demands action.

---

[234] Annas, *supra* note 18, at 2066.

[235] Goldstein, *supra* note 72, at 435.