Transparent and Open Discussion of Errors Does Not Increase Malpractice Risk in Trauma Patients

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Objective: We set out to determine if there is an increased medical malpractice lawsuit rate when trauma patient cases are presented at an open, multidisciplinary morbidity and mortality conference (M&M).

Introduction: Patient safety proponents emphasize the importance of transparency with respect to medical errors. In contrast, the tort system focuses on blame and punishment, which encourages secrecy. Our question: Can the goals of the patient safety movement be met without placing care providers and healthcare institutions at unacceptably high malpractice risk?

Methods: The trauma registry, a risk management database, along with the written minutes of the trauma morbidity and mortality conference (M&M) were used to determine the number and incidence of malpractice suits filed following full discussion at an open M&M conference at an academic level I trauma center.

Results: A total of 20,749 trauma patients were admitted. A total of 412 patients were discussed at M&M conference and a total of seven lawsuits were filed. Six of the patients were not discussed at M&M prior to the lawsuit being filed. One patient was discussed at M&M prior to the lawsuit being filed. The incidence of lawsuit was calculated in three groups: all trauma patients, all trauma patients with complications, and all patients presented at trauma M&M conference. The ratio of lawsuits filed to patients admitted and incidence in the three groups is as follows: All Patients, 7 lawsuits/20,479 patients (4.25 lawsuits/100,000 patients/year); M&M Presentation, 1 lawsuit/421 patients (29.6 lawsuits/100,000 patients/year); All Trauma Complications, 7 lawsuits/6,225 patients (14 lawsuits/100,000 patients/year). Patients with a complication were more likely to sue (P < 0.01); otherwise, there were no statistical differences between groups.

Conclusions: A transparent discussion of errors, complications, and deaths does not appear to lead to an increased risk of lawsuit.

Methods

The study was performed in a single, self-insured academic medical center consisting of 3 major components: The University of Texas Health Science Center at San Antonio (UTHSCSA), a state medical school; the University Hospital, San Antonio, Texas, the major teaching hospital for the medical school; and the Audie L. Murphy Veterans Administration Hospital. Texas passed significant tort-reform, which set specific limits on noneconomic damages. This tort reform was in effect over the last 3 months of the study period. The setting for this study includes the medical school and the University Hospital. The medical school faculty and resident physicians were the sole physician care providers for the University Hospital during the study period.

The UTHSCSA is governed by the University of Texas System. As a part of this system, the University participates in a self-insured malpractice plan and maintains its own risk management office, which includes legal counsel, a full-time director, and administrative support. UTHSCSA employs a full range of clinical faculty who provide comprehensive patient care at the University Hospital.
The University Hospital is a 604-bed, county tax-supported hospital, with governance separate from that of the medical school. The hospital functions as a tertiary referral center for a wide range of medical conditions. It is also the primary indigent care facility for Bexar County. As a part of its tertiary care role, University Hospital, an American College of Surgeons verified level I trauma center, serves as the lead trauma center for 22 counties in South Central Texas. The primary catchment area for University Hospital (Trauma Service Area P) encompasses a 26,904 square mile region with 2.1 million residents. The secondary catchment area includes Trauma Service Areas S, T, U, V, and W, extending from Laredo to Brownsville. This secondary catchment area includes an additional 26,102 square miles and an additional 2 million residents.

Medical Records Data Source

The UTHSCSA risk management office maintains records on all reported medical adverse events, medical malpractice claims, and medical malpractice lawsuits. A record is considered closed when the case is settled, a judgment is rendered, or the statute of limitations expires. The office maintains pertinent medical records and/or medical record summaries, transcripts of depositions, expert witness testimony/consultation, court records, and minutes of the UTHSCSA risk management committee. In addition to these hard files, the office maintains an electronic database of pertinent aspects of each file. A record of all defense costs (attorney and expert witness fees), and payment to plaintiffs is maintained in these files. These records are prospectively maintained and were retrospectively reviewed for this study.

The University Hospital has maintained a trauma registry since 1995. This registry was maintained using the Trauma Registry of the American College of Surgeons. In 2003, it was converted to Digital Innovations Collector software. Total trauma admissions, trauma intensive care admissions, and complications from 1996 until 2004 were gathered from the trauma registry. Since 1999, serious complications and adverse events have been prospectively entered into this database. These complications are identified by the trauma case managers, surgery faculty, and residents. Although prospectively collected, this registry does not include all complications and adverse events, particularly those involving patients in the intensive care unit, and those who have complications following discharge.

Morbidity and Mortality Conference

A weekly trauma morbidity and mortality (M&M) conference has been conducted since 1993. Attendance at this conference is open to any healthcare provider including students, paramedics, nurses, allied health professionals, midlevel providers, resident physicians, and faculty physicians. The conference is advertised in the institutional newsletter. All deaths and selected major complications and adverse events are discussed at this conference. The performance improvement program of University Hospital and the UTHSCSA trauma program are modeled on the American College of Surgeons Committee on Trauma’s performance improvement model. Consistent with an interpretation of this model, the surgery faculty, residents, and nurses openly discuss errors and deaths. Honest, open discussions and full participation are encouraged. A culture of transparency in all matters related to errors, adverse events, and complications has been fostered. Detailed attendance and case records have been kept since 1998 (Table 1).

Methods

The study period was defined from January 1, 1996 until January 1, 2004. The risk management database was queried for all malpractice claims and lawsuits filed during this period. All claims involving trauma patients were reviewed. The record review included the date of occurrence, date of the lawsuit, physicians involved, patient age, gender, employment status, education level, occupation, diagnosis, outcome, presence of disability, procedures performed, the plaintiff’s claim of malpractice, internal review classification, root cause leading to the claim, total paid liability, and legal expenses.

Patients presented at trauma M&M conference were tallied, reviewed, and categorized. Patients who filed a lawsuit were cross-referenced to the malpractice database. Attendance at this conference was analyzed.

Prospective death reviews were performed on all patients who died. Deaths were classified into 1 of 3 groups: preventable with a change in treatment, potentially preventable with a change in treatment, or not preventable with a change in treatment. This classification was prospectively assessed and recorded by the trauma faculty and trauma medical director.

While significant complications were prospectively maintained in the trauma registry, many less severe complications and adverse events were unrecorded. An underestimate of these complications and adverse events falsely increases the incidence of malpractice lawsuit in patients who had complications, which would lead to bias supporting our hypothesis; so for the purposes of this study, we estimated complications using the following formula: all prospectively recorded complications in the registry + all deaths + all ICU patients. By including all ICU patients as having a complication or adverse event, we overestimate the complications in this group; however, this serves to compensate for the under-reporting of minor complications and adverse events in the registry.

Malpractice suit incidence was calculated by dividing the total number of filed lawsuits by the total number of patients over an 8-year period for each of the 3 risk groups: patients presented at trauma morbidity and mortality confer-

| TABLE 1. Summary of Trauma Morbidity and Mortality Conference Attendance by Care Provider |
|----------------------------------|-------------------|
| Attendees                        | % of Attendance   |
| Resident physicians              | 41                |
| Nurses                           | 22                |
| Faculty physicians               | 19                |
| Students                         | 12                |
| Mid-level providers              | 7                 |
ence (M&M Presentations), all trauma patients (All Trauma Patients), and all trauma patients with complications (All Trauma Complications). The malpractice suit risk was calculated by dividing the total number of filed suits by the total number of patients over the study period. Relative risk for these 3 groups was calculated by dividing the incidence of the group exposed to the risk factor by the incidence of the group not exposed to the risk factor. Confidence intervals, analysis of variance, $\chi^2$, and Fisher exact test were calculated using MedCalc for Windows, version 7.5 (MedCalc Software, Mariakerke, Belgium) and Microsoft Excel for Windows XP.

**RESULTS**

Over the study period, 20,479 trauma patients were admitted to University Hospital. A total of 7 lawsuits were served (Table 2). One was dismissed and one was granted summary judgment. Three were settled with payments to the plaintiffs. Two suits are not closed and no malpractice data nor PI data are available for these patients. No cases went to trial. Total paid liability was $2.1 million, averaging $269,375/year. Total legal defense costs were $703,972, averaging $87,996/year (Table 2).

A total of 412 patients were presented at Trauma M&M. Of the 7 patients who filed lawsuits, 3 patients were presented at M&M conference after their lawsuits were filed and 3 were not discussed at M&M conference. One patient died and was presented at M&M conference prior to the family filing a lawsuit; however, full disclosure of the events leading to the patient’s death occurred prior to the conference, and the records reflect the patient’s family’s decision to proceed with a malpractice claim before the time of the conference.

There were 858 deaths, 1530 complications prospectively recorded in the registry, and 4301 ICU admissions. A total of 464 patients died in the ICU. A total of 6225 patients (30.3%) either died or were estimated to have had a complication. Eleven deaths were classified as preventable with a change in treatment. Forty-four deaths were classified as preventable with a change in treatment. Forty-four deaths were classified as preventable with a change in treatment.

The ratio of lawsuits filed/admitted patient and incidence in the 3 groups is as follows: All Patients, 7 lawsuits/100,000 patients/year; M&M Presentation, 1 lawsuit/421 patients, (29.6 lawsuits/100,000 patients/year); and All Trauma Complications, 7 lawsuits/6225 patients (14 lawsuits/100,000 patients/year) (Table 3). There were no statistically significant differences between groups. Considering presentation of patients with complications at M&M as a risk factor for increased malpractice lawsuit, the relative risk for trauma was 2.3 (95% confidence interval = 0.278 to 19.06).

**DISCUSSION**

These data demonstrate no increased risk of litigation following presentation at an open multidisciplinary M&M conference. This is the first report of which we are aware that specifically examines the actual risk of litigation when patients are presented at such a forum, and over this 8-year period, we could identify no “tattletale” lawsuits. These data also demonstrate a relatively low incidence of lawsuit in a high risk cohort of patients.

Why are these simple conclusions important? After all, almost every surgical residency program has a formal M&M conference, and the American College of Surgeons Committee on Trauma has laid out a model performance improvement program that is based first on identifying system problems and errors, and second, implementing a corrective plan of action. It is true that surgeons have led the way with respect to a candid appraisal of errors and complications; however, many surgeons still resist open discussion of errors.

### TABLE 2. Summary of the Clinical and Legal Information Relevant to the Closed Malpractice Suits in Trauma Patients

<table>
<thead>
<tr>
<th>Group</th>
<th>Diagnosis</th>
<th>Plaintiff’s Claim</th>
<th>Error Classification</th>
<th>System or Provider Related</th>
<th>Clinical Outcome</th>
<th>Legal Outcome</th>
<th>Liability ($)</th>
<th>Legal Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients</td>
<td>Cardiac arrest</td>
<td>Medication error</td>
<td>Medication error</td>
<td>Both</td>
<td>Death</td>
<td>Settled</td>
<td>910,000</td>
<td>206,496</td>
</tr>
<tr>
<td></td>
<td>Clavicle fracture</td>
<td>Missed Diagnosis</td>
<td>Miscommunication</td>
<td>Both</td>
<td>Recovered</td>
<td>Dismissed</td>
<td>0.00</td>
<td>27,324</td>
</tr>
<tr>
<td>Complications</td>
<td>Facial fractures</td>
<td>Failure to treat</td>
<td>Supervision</td>
<td>Provider</td>
<td>Death</td>
<td>Settled</td>
<td>1.2 million</td>
<td>163,887</td>
</tr>
<tr>
<td>Complications</td>
<td>Femur fracture</td>
<td>Technical error</td>
<td>Poor communication</td>
<td>Provider</td>
<td>Recovered</td>
<td>Settled</td>
<td>45,000</td>
<td>63,527</td>
</tr>
<tr>
<td>Complications</td>
<td>Spinal cord injury</td>
<td>Delay in surgery</td>
<td>Inappropriate D/C</td>
<td>None</td>
<td>Paraplegia</td>
<td>Summary judgment</td>
<td>0.00</td>
<td>242,737</td>
</tr>
</tbody>
</table>

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Errors in Trauma Patients

647

TABLE 3. Comparison of the Incidence of Malpractice Lawsuit Between Groups

<table>
<thead>
<tr>
<th>Patient Group</th>
<th>Malpractice Incidence (Suits/100,000 Patients/Yr)</th>
<th>$P$</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients (n = 20,479)</td>
<td>4.25</td>
<td></td>
</tr>
<tr>
<td>Patients with complication (n = 6225)</td>
<td>14</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>Patients presented at M&amp;M (n = 421)</td>
<td>29.6</td>
<td>0.39†</td>
</tr>
</tbody>
</table>

Patients with a complication were more likely to file a lawsuit than those with no complication. There were no differences in malpractice incidence between patients presented at M&M, all trauma patients, or patients with a complication.

*Patients with complication compared with all patients.
†Patients with complication compared with patients presented at M&M.
‡Patients presented at M&M compared with all patients.
because of a fear of increased malpractice risk. This is exacerbated by a modern malpractice crisis. Some surgeons accept the need for a review of complications and deaths but think that this should be limited to a closed discussion among peers. This approach fails on 3 fronts. It usually fails to address system problems. Most serious errors and complications are failures of systems, rather than isolated provider failures. It may be more emotionally rewarding to blame a person rather than a system, but most serious errors require fixing a system of care to prevent the same mistake from repetitively occurring. Second, the closed peer-review process also fails to involve other disciplines who have a stake in the problem. Modern surgery is a complicated endeavor that requires involving everyone in solving problems. Third, the closed peer review process tends to create a culture of secrecy and suspicion among those excluded from the process. When errors or complications occur, those excluded from the closed process still have concerns, but they have no venue in which to participate in solving the problem. An untoward consequence of the closed process may lead to more anonymous incident reports, anonymous complaints to external bodies, patients’ families, and possibly even the local plaintiff attorney. These are the avenues available to those not empowered to participate in the formal process.

These data clearly have limitations that should be considered when interpreting the results of this work. Although the risk of lawsuit was not significantly greater in the M&M group, both the number of suits and the overall number of patients presented at M&M were relatively small, so the possibility of a type II error exists. A longer study time duration with more patients in the M&M group may have led to a significant difference.

In addition, complications were estimated and not actually measured. An underestimation of complications falsely elevates the incidence of malpractice suits in the comparison group; however, the percentage of estimated complications (30.3%) is consistent with a prospective complication study by Healey et al in which they demonstrated a 32.3% complication rate in trauma patients, and there is no significant increase in lawsuit risk even when the M&M group is compared with all patients, not just those with complications.

Another limitation of this study is that it is localized to a single hospital with a single group of physicians and patients. There are clearly regional differences with respect to the malpractice climate, numerous regional differences in the local conduct of M&M conferences, and differences in the attitudes of those who attend. The trauma M&M conference is open to any and all care providers, and we proceed in good faith that those attending are also acting in good faith. Our data support the validity of this assumption, but perhaps in a different local environment this may not be the case. It is conceivable that our data, for some reason, may not generalize to the rest of the surgical world. Since there are no published reports, it is difficult to compare the risk of lawsuits in this report to other regions or localities. Comparison data from other institutions would be useful.

Finally, these data may miss 2 additional classes of litigation: lawsuits that have not yet been filed and lawsuits that do not involve physicians covered under the University of Texas malpractice plan. In the first instance, the statute of limitations may extend for many years. For the second, the University Hospital’s malpractice database was queried, and we identified 2 additional lawsuits that did not involve University of Texas faculty or residents. The hospital was named as the sole defendant in one lawsuit, and a rotating orthopedic resident was named as the defendant in the second. We did not have access to the legal records, but neither of these suits appeared to be the result of a tattle-tale event.

Studdert et al cited a “deep seated tension between the malpractice system and the goals and initiatives of the patient-safety movement.” In matters of disclosure and reporting, transparency is a key initiative of the patient safety movement. To correct errors, one must be free to discuss them frankly and openly with all care providers in the system. Our data, in this and a previous study, lend direct support to the notion that internal transparency with respect to discussion of errors does not lead to increased risk of lawsuit.

This may seem paradoxical; but when one questions what actually happens in a hospital, these data pose less of a paradox. When an adverse event or complication occurs, many, if not most of the people, providing care discuss the event. If it is a major problem, this quickly spreads to those with no direct knowledge of what actually occurred. Anecdotally, we recently had a major adverse event in a patient in the emergency department. Within 48 hours, an informal survey of 10 residents, nurses, and faculty outside the emergency department who were not involved revealed that 8 of the 10 had some knowledge of the adverse event. Some of the knowledge was accurate, some was not. Often there are exaggerations, misperceptions, and distortions. So, almost unavoidably, physicians, nurses, and students discuss errors and complications. An inclusive, multidisciplinary M&M conference provides an accepted forum to accurately and openly discuss errors and complications. In a properly conducted conference, the truth is discussed and often the complexity (system problems) surrounding the adverse event is transmitted to those in the audience. Rumor, distortion, and innuendo are swept away; system problems are addressed; and patient care is improved. Honest discussion of errors and adverse events is good for patient care. Rather than increasing risk of litigation, we think that such discussions foster a cultural attitude that may minimize malpractice risk.

We think that heavy-handed attempts at secrecy spawn mistrust between care providers, and ultimately, between care providers and patients. Soil tilled with secrecy and mistrust is fertile ground for the malpractice attorney.

Polk, in his address to the American Surgical Association, defined transparency as “a ‘nothing to hide’ approach established through an honest and open assessment within an organization to gain trust, collaboration, and a higher level of credibility.” He went on to encourage surgeons to embrace the concept of transparency in health care. The most determined voice for transparency and adverse event reporting has been Leape. Both Polk and Leape advocate for transparency in reporting surgical adverse events. Leape et al cite the importance of reporting adverse events so that data may
be obtained for system improvements.\textsuperscript{11} Without these data, there can be no understanding of what needs to be improved. Leape cites 3 reasons why physicians are not inclined to report errors and adverse events: fear, lack of belief that reporting leads to improvement, and the time required to report. The fear of reporting is multidimensional. It relates to a fear of malpractice litigation, and fear of embarrassment, shame, or punishment.\textsuperscript{11,12} Our data lend support to the notion that transparency does not lead to increased risk of malpractice, although our data exclusively relate to internal transparency, being transparent within the walls of the institution. Both Leape and Polk were primarily advocating for external transparency, reporting to an entity outside of the walls of one’s own hospital or practice, although obviously the first step to external transparency begins within one’s own institution and internal transparency is a requirement for effective performance improvement.

Consistent with other reports, our data demonstrate a low rate of malpractice lawsuit filing in a very complex group of patients.\textsuperscript{15,16} There were 20,479 patients. Of these patients, 858 died. There were 4301 ICU admissions and an estimated 5367 complications. Seven patients filed a lawsuit.

CONCLUSION

Openly discussing errors, complications, and deaths does not appear to lead to an increased risk of lawsuit. There is no medical-legal risk justification for a secret and closed performance improvement process.

REFERENCES


Discussions

DR. J. DAVID RICHARDSON (LOUISVILLE, KENTUCKY): Dr. Stewart has rightly reminded us of the conundrum of trying to have open and transparent patient safety discussions in the adversarial “blame the doctor” medical-legal climate that I believe the tort system fosters? I have no comparative data to present so I will be forced to rely on some anecdotal experiences that might be germane to this issue.

First, I would note that many surgeons and many hospitals find almost any type of critical review of potential errors abhorrent either because of ego, competitive pressures, or alleged malpractice fears. Having had the onerous duty for many of the early years of my career of conducting M&M conferences in a private hospital that was a very good hospital, I know critical care review was not looked upon with favor by any of the surgeons in that institution. So I do think that the problem that Dr. Stewart tries to address is a real one in many places.

I do not know if these data that Dr. Stewart is now trying to present will convince surgeons that openness is the best policy or not, but I am persuaded that many surgeons particularly in non-teaching settings do not accept the fact that open and frank discussions of adverse events are necessary or certainly good for them, even if patient care might be improved.

The second anecdotal point I would make is that such open and frank discussions should be conducted in an appropriate setting in an atmosphere of quality improvement rather than assignation of blame. Too often, our M&M conferences—and I have sure seen a lot of them around the country—seem to focus on personal accountability and assigning blame even for clear-cut fatal problems that probably nobody could prevent or for widespread system problems. This really does need to change in many of our M&M formats.

Likewise, I believe discussions outside the formal process should be limited and very circumspect. Open and frank discussion should not, in my opinion, occur on elevators, in the hallways or cafeterias, or in physician lounges, where patient confidentiality almost always is going to be breached and true potential for quality improvement is lost. While I am not aware of any tattletale lawsuits initiated by an M&M discussion at our institution, I am aware of three cases that likely originated from inappropriate hospital gossip or banter.

The third anecdotal point I would make relates to possible mechanisms of quality improvement in hospitals which don’t have some mechanism for open and frank discussion. I serve as a surgical consultant to our state licensure board and have noted that many of the issues that come to me, and I think to the board, come from hotline processes or anonymous letters, most of which appear to emanate from healthcare providers within the hospital. While one could
argue about the motives of some of these in certain cases, I am persuaded that in many instances these arise simply because there is no formal mechanism to really discuss problems that result in quality improvement and that healthcare providers are really concerned about that. This observation may offer some credence to Dr. Stewart’s hypothesis about transparent processes.

The only question I have, Dr. Stewart, relates to your small sample size, particularly in the lawsuit group. Even though your numbers are not statistically significant, your M&M discussed group, if I read it right, had a six-fold difference in lawsuits over the overall trauma patient lawsuit rate and a two-fold incidence of suits compared to your overall complication group. The question I have is, just how confident are you that you haven’t made a type 2 statistical error just based on small sample size in that lawsuit or M&M discussed group?

**DR. RONALD M. STEWART (SAN ANTONIO, TEXAS):** I do think the data does leave open the possibility of a type 2 error. If we were enrolling patients, I think you would conclude that the study was underpowered.

I did do some calculations, though, particularly comparing the M&M group to the complication patients, which I think is a reasonable comparison, and if the incidence remained constant and unchanged and we continued to get patients at the same rate, we would need 40,000 complicated patients to show a statistically significant difference. And that would take 56 years.

Another point, too, I have tried to be conservative with respect to the interpretations, partly because the more I try to understand malpractice, the less I understand it. And we did attribute that one patient into the M&M group out of 412 patients. In reality, though, that patient had already decided to sue. I sat in on the discussions immediately after the event. Our discussions were recorded. They didn’t tell us, but our discussions were recorded. And they had already contacted the plaintiff’s attorney. So in reality, the incidence of tattle-tale lawsuits was zero out of 412, basically zero. So I think that minimizes the chance of the type 2 error problem.

I strongly agree with your comments that M&M conferences should shift to more identifying system problems, and that requires a less punitive approach at most institutions.

Concerning the issues of anonymous reporting, I think anonymous reporting is oftentimes a failure of a closed PI process. It really backfires. My own personal belief is that trying to tightly control that information is like trying to squeeze Jello in your hands. You squeeze it and it squishes out and the information comes out mangled.

A transparent and open M&M allows a forum where if you are really searching for the truth, I think that comes across, rumor is swept away, and non-physicians are given a voice. And quite frankly, the non-physicians who attend our conference don’t choose to use that voice very often, but they feel a part of the process. So they don’t feel they have to go do anonymous reporting, they know they can do non-anonymous reporting right in the middle of the conference, which tends to be more effective.

**DR. EDWARD E. CORNWELL, III (BALTIMORE, MARYLAND):** The description of the tension between the medical malpractice system and the performance improvement/patient safety system is insightful, and the discussion section is a frank and thorough analysis of factors that may drive reluctance to adapt an M&M conference in the way the authors describe.

This study describes 7 malpractice claims over an 8-year period covering over 20,000 patients and 412 M&M cases discussed. Since 6 of the 7 cases weren’t even discussed in M&M before the lawsuit was filed, and in the seventh case it was clear that the family decided to file a lawsuit before the M&M conference; we can, in the parlance of our legal colleagues, stipulate as to the conclusion that transparent and open discussion does not appear to produce a malpractice claim risk.

I do have a couple of questions.

The first would be—compared to what? The malpractice climate in Texas is such that tort reform had taken place, and, was in effect during the last few months of your study. Your institution is the primary provider for indigent care in your county and the lead Level 1 trauma center for 22 counties. You may have difficulty comparing yourself to the malpractice claim incidence in a similar institution that doesn’t share your institutional philosophy regarding the conduct of your M&M conference. Are you anecdotally aware of cases or providers where the M&M discussion led to a “tattletale” lawsuit? Or was there some other premise for pursuing this study other than that described in your well-written introduction?

Secondly, share with us, if you would, details regarding those 3 patients in the manuscript where cases were discussed after a lawsuit was filed. That seems to be a long time interval between the case and discussion in M&M.

In short, the authors have initiated an open and honest discussion about open and honest discussions. They make the case that frank dialogue at M&M conferences in their setting is not a bad thing. I hope they will maintain their enthusiasm for this type of study as we all continue to search for those factors that are good things as relates to the medical malpractice crisis.

**DR. RONALD M. STEWART (SAN ANTONIO, TEXAS):** Concerning your first question and comment about “compared to what?” I think you are asking about comparing the single center to the rest of the surgical world. I do think it is a problem. And it may be the most serious problem of this study, because as I think most people appreciate, there is a wide variability of the malpractice climate and individual cultures in a given institution. So it may be somewhat—I suppose I could be accused of being somewhat Pollyanna-ish to say this although I don’t think that is true—I think it is a
problem that this is a report from a single institution and the results may not generalize through the rest of the surgical world.

And then the cases discussed after the lawsuit was filed, you are correct that 3 of those patients were patients that we would have liked to have discussed at a morbidity and mortality conference. In at least 1 of those, it was hard to figure out what exactly happened because the time interval was so long between the event happening, the trauma happening, and the lawsuit being filed. Quite frankly, we didn’t know about those cases until we were sued.

**Dr. John A. Morris, Jr. (Nashville, Tennessee):** Five years ago at this meeting we presented our analysis of malpractice risk and came to very similar conclusions: malpractice risk is a regional process. At that time we were having frank and open discussions at our M&M, but it failed to put us in a malpractice risk management environment that was fiscally responsible.

Consequently, we introduced a rounding technique where on a daily basis we have frank and open discussions at the bedside with the patient’s family present. We are doing malpractice damage control the day the complication asserts itself and continuing to manage that process in a structured environment at the bedside.

Now, it will take us a while to be able to analyze whether that helps our malpractice dollars, but it is the next step to potentially add on to what we were doing.

**Dr. Ronald M. Stewart (San Antonio, Texas):** Concerning the rounding technique, I think that is a very good idea. I think that a lot of malpractice risk management centers around managing expectations and I think oftentimes the patient or family are unhappy when their expectations are not met. Enhancing that communication can’t help, but I would expect enhancing communication reduces malpractice risk.

**Dr. Raleigh R. White, IV (Temple, Texas):** As a fellow Texan, I sat on the Department of Health Board during the time the trauma system in Texas was developed. If I understood your opening comments correctly, you are an examiner for Level 3 hospitals. As you know, the Level 1 hospitals that you and I represent are a relatively small component of the system in Texas, the Level 3 hospitals being sort of the smaller community hospital.

It seems to me that your perception of reluctance to discuss cases in the Level 3 hospital environment is probably a completely different mind-set than the environment that you and I have in the Level 1 hospital setting where there is a heavy commitment to teaching and education and open discussions of all kinds and probably less of a potential because of that open environment for an ambulance chaser to have a mole, you might say, that might be present in a smaller community hospital.

I wonder if that is really perhaps a conundrum for a discussion like this, that your observations probably are more pertinent for the small number of Level 1 hospitals in Texas. I am not sure it really applies to the Level 2s and Level 3s. They are just completely different environments. Would you comment on that because you have a personal experience in that?

**Dr. David W. Tuggle (Oklahoma City, Oklahoma):** An excellent study and I think a very important one, and we need to keep this mind as we continue our quality improvement efforts. I would ask a question. Did you include pediatric patients in this population? If you did, do you think you should adjust for that given that discovery for pediatric patients is 18 years plus 2 versus standard or across-the-country 2-year discovery for adult patients?

**Dr. Ronald M. Stewart (San Antonio, Texas):** We did include pediatric patients. Actually, the study has no adjustments for discovery. Suits that were filed during that period were included. I do think that is an important question and an important point, that we could underestimate the malpractice risk because of suits that come later on.

Also, another related weakness would be that we use the UT Risk Management Database for determining malpractice suits. So that misses cases that may not be in there, specifically the things that I can think about would be a suit against the hospital only would not be in there, or a suit against somebody who was covered under another provider, which is admittedly really rare. But all 3 of those issues could result in an underestimation of the malpractice risk in the data.