Harmful clinical outcomes, medical malpractice litigation and the Michigan Model

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Conflict of Interest Disclosure

I have a financial interest in the subject of this talk.

Boothman Consulting Group, LLC is under contract with hospital systems interested in new approaches to clinical risk, peer review, patient safety, leadership training, claims management, crisis management, large scale patient safety challenges.

Richard C. Boothman

October 6, 2025

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The profound act of trust

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Medicine is inherently dangerous.

Nearly every decision, every treatment carries risk.

Even with the best of care, risks cannot be eliminated.

Unintended clinical outcomes are inescapable.
How Medicine responds to them really matters.

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Baby Maria
“Deny and defend” – best option?

Litigation Focused Response:
"Deny and Defend"

Medicine historically has looked to insurance, legal and risk management for a response to injured patients

Financial exposure as a concern has been THE priority

Totally divorced from the context of the health care mission *(and largely without attention to the harmful consequences)*

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Legal, insurance advice has been predictable:

- Don’t say anything to the patient
- Don’t talk about it outside counsel’s presence
- Don’t apologize for anything
- Don’t put anything damning in the clinical record
- Don’t change anything clinically
- Hold the patient’s billing
- Call risk/legal/insurance if the patient asks questions
- Keep your (collective) heads down

And in baby Maria’s case, it is not unimaginable that some would see the advantage of delay to limit future exposure and even cynically, contacting authorities for possible deportation.

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How well have deny and defend strategies served patients, healthcare professionals or healthcare organizations?

A sober look at the impact of these practices raises questions about their efficacy and worse, the harm they cause.

Who thought "deny and defend" was a good idea?

Not patients

- The greater the trust, the greater the betrayal
- A need to "be seen"
- Patients feel abandoned
- Many patient questions go unanswered
- Intense responsibility to prevent what happened to them from happening to someone else
- Family personal guilt, sense of responsibility
- A profound need for compassion, reassurance, validation
- Gaps in USA social safety net create financial pressures

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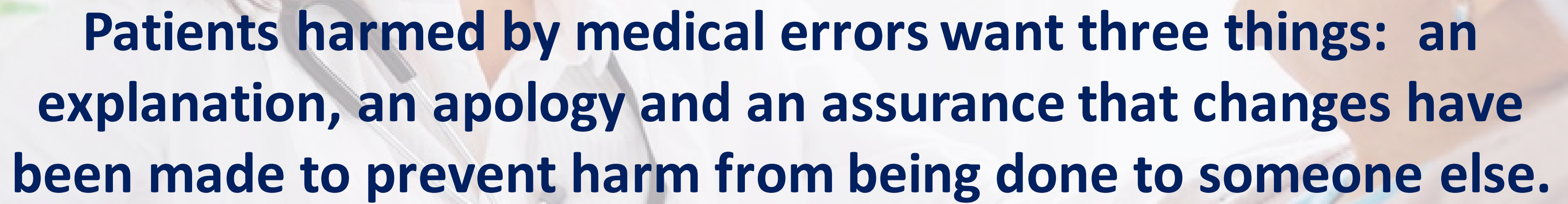

Leonard J. Marcus
Director of the Program for Health Care Negotiations
and Conflict Resolution, Harvard School of Public Health
(analysis of malpractice mediation sessions 1997)

When asked if anything could have been done to avert legal action, 37% said an explanation and apology would have made a difference.

Vincent, C, Young, M, Phillips, A
Why do people sue doctors? A study of patients and relatives taking legal action.
Lancet 1994; 343:1609-13

In another study, 24% said they filed when "they realized the physician had failed to be completely honest with them about what happened, allowed them to believe things that were not true, or intentionally misled them."

Hickson, G, Clayton, EW, Githens, P, Sloan, F
Factors That Prompted Families to File Medical Malpractice Claims Following Prenatal Injuries
267 JAMA 1359, 1361 (1992)

What drives patients to sue their care givers?

Four common themes:

1) the need for an explanation;

2) a desire to ensure the safety of others;

3) sense of accountability;

4) compensation.

Vincent, C, Young, M, Phillips, A
Why do people sue doctors?
A study of patients and relatives taking legal action.
Lancet 1994; 343:1609-13

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Deny and defend is harmful to healthcare professionals . . .

IT'S NOT NATURAL

- To abandon someone in need
- To view patients as adversaries
- To treat people without compassion
- To be less-than-honest
- To not feel responsible when a patient has been injured by unreasonable care
- To avoid doing everything possible to improve

Good idea for healthcare professionals?

- Patient harm triggers complex emotions
- Caregivers feel isolated
- Knee jerk defense encourages victimization
- Accountability disappears: It's just a "lawyers' game", patients labeled
- Yet, none of it erases the guilt, the shame, the fear which they bear mostly privately
- Suicide, depression, burn-out is significant
- They practice (and teach) defensive medicine

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Is this case defensible?

Is not the same as . . .

Did this care meet our own expectations?
Is this the care we want to teach our trainees?
Is this the care we want for our family?
Are we proud of this care?

Consequence of litigation-driven thinking on accountability?

"Physicians revile malpractice claims as random events that visit unwarranted expense and emotional pain on competent, hardworking practitioners . . ."

Studdert, DM, Mello, MM and Brennan, TA,
Health Policy Report: Medical Malpractice N Engl J Med 2004; 350; 283

"For over a century, American physicians have regarded malpractice suits as unjustified affronts to medical professionalism and have directed their ire at plaintiffs' lawyers . . . and the legal system in which they operate."

Sage, William, Medical Malpractice: Insurance and the Emperor's Clothes
54 DePaul Law Review 463, 464 (24 March 2005)

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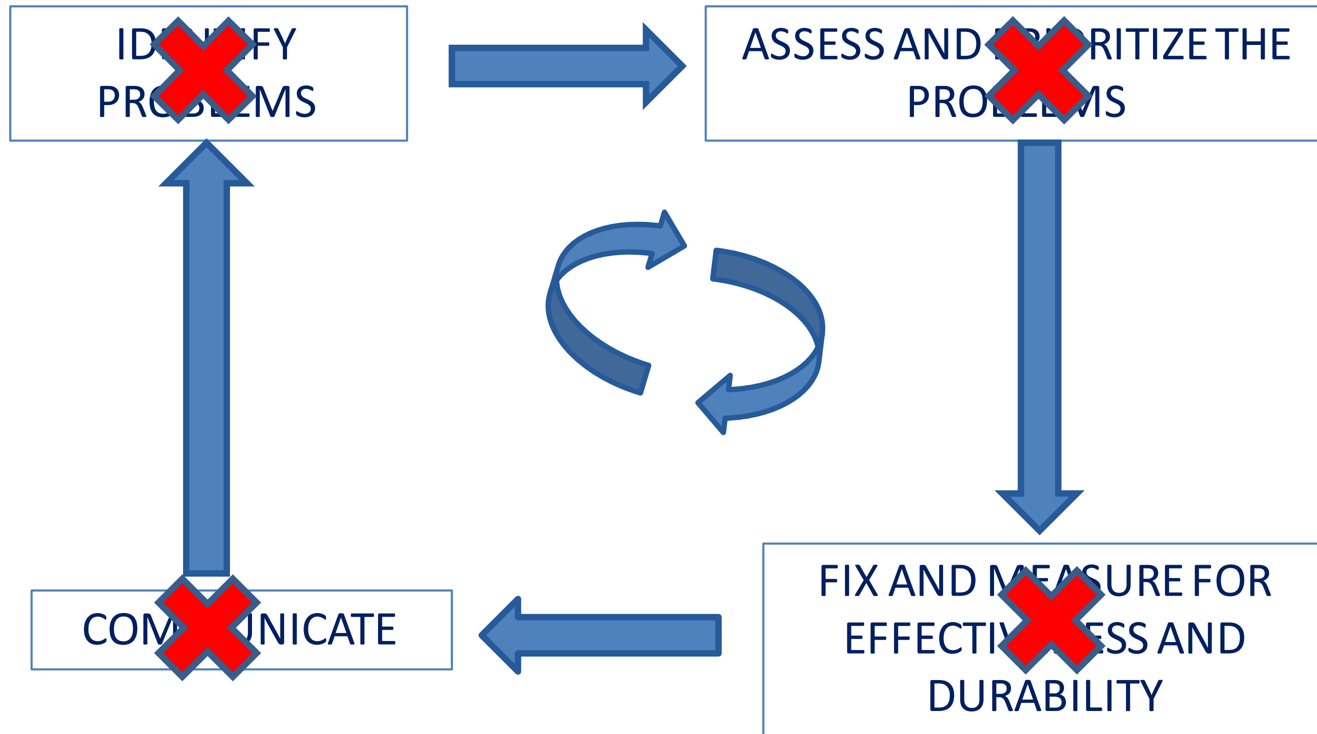
Functional Flow for Organizational Clinical Improvement



Boothman, Richard C., Imhoff, Sarah J., Campbell, Jr., Darrell A., *Nurturing a Culture of Patient Safety and Achieving Lower Malpractice Risk Through Disclosure: Lessons Learned and Future Directions. Frontiers of Health Services Management 28:3 (2012)*

Compartmentalizing responses to patient harm is a myth

Traditional responses to patient harm has negated peer review, clinical culture change

- **Peer review:** Once a hospital defends care, no medical staff can effectively question it for disciplinary purposes, privileging
- **Culture of safety:** High reliability, patient safety depends heavily on openness and transparency – defensiveness and stonewalling sends inconsistent signals to clinical staff about organizational priorities

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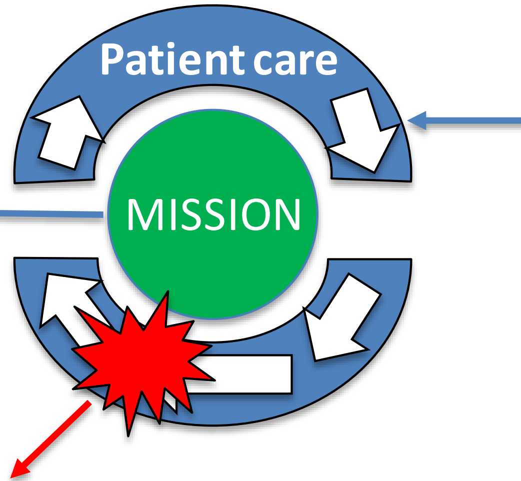
What if the focus wasn't financial? What if the response to patient harm was aligned with the healthcare mission and clinical goals?

Though the language varies, mission statements share common themes: COMPASSION, EXCELLENCE, CARING, QUALITY, SAFETY, HEALING



Ideally, the Patient-caregiver relationship should also be characterized by TRUST, HONESTY, COMPASSION, PATIENT-CENTRICITY, SHARED PURPOSE

Deny and Defend: completely inconsistent with healthcare system's missions and effectively interrupts the positive cycle to patient centricity, high reliability, staff wellbeing, and continuous clinical improvement

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The genesis of the Michigan Model (2001)

What if there was an alternative?

That took the clinical mission seriously?

That prioritized patient safety over short term financial exposure?

That honored the profound trust on which the patient-provider relationship was built?

That prized continual clinical improvement over HR discipline?

All while managing claims in a proactive and cost-effective way?

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THE MICHIGAN MODEL

RESPONSE TO THE PATIENT HARMED IS GUIDED BY PRINCIPLED CLINICAL ASSESSMENTS, NOT RISK OF FINANCIAL LOSS

The most important patient after an adverse event has occurred is not the patient harmed,
it's the patient we haven't harmed yet.

PREVENTING MEDICAL ERRORS

U-M hospital's goal: Safest in the nation

Improving labeling, records is part of effort

By PATRICIA ANSTETT
FREE PRESS MEDICAL WRITER

TAKING CONTROL

- VA health system a leader in patient safety. **3A**
- **In Body & Mind:** Patients must fight hard to be heard. **6H**
- See **www.freep.com/specials** for the full series.

ANN ARBOR — Kati Bauer was concerned. The incision on her husband's neck "looked yucky."

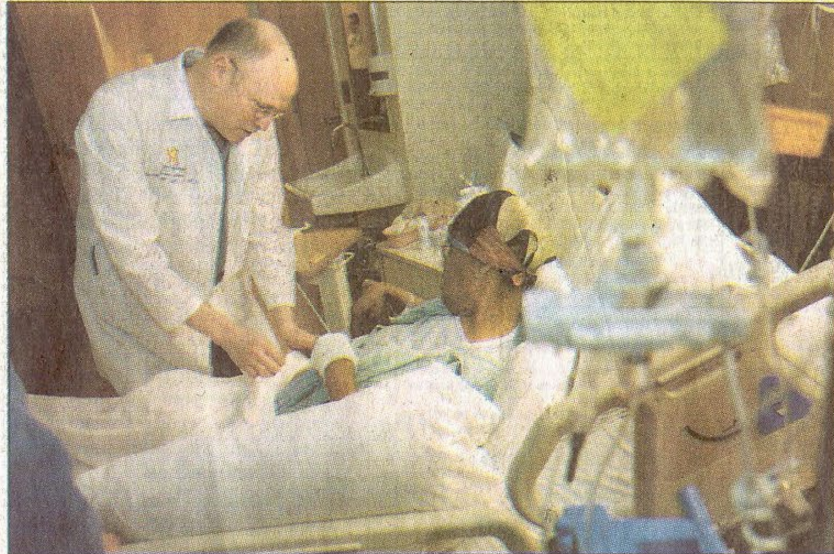
But when she told several young physicians caring for him in June 2002 at the University of Michigan Medical Center, they dismissed her concerns, she says. The medicine they had prescribed would protect him, she says they told her.

Jim Bauer, a builder hospitalized with serious injuries from a fall at work, then developed an infection that added weeks to his hospital stay and threatened his life.

After her husband was discharged in August 2002, Bauer saw a story in a U-M employee newsletter about efforts at the university to improve patient safety. It invited employees to contact Dr. Darrell Campbell Jr., chief of staff for clinical affairs at U-M. Bauer is an assistant to U-M's associate provost and a 27-year U-M employee from a family with a long U-M employment record.

She e-mailed him. Campbell

Please see U-M, Page 3A



ROB WIDDIS/Special to the Free Press

Dr. Darrell Campbell Jr., chief medical officer at the University of Michigan Hospital in Ann Arbor, examines the incision from Elizabeth Wilson's recent liver transplant.

Detroit News and Free Press
February 24, 2004

THE MICHIGAN MODEL

SHOULDN'T OUR RESPONSE TO PATIENTS HARMED ALIGN WITH OUR ORGANIZATION'S CLINICAL MISSION, VISION AND VALUES?

Compensate quickly and fairly
when inappropriate medical care causes injury

Support/defend staff when
the healthcare involved was reasonable

Reduce patient injuries (and claims)
by learning from our patients' experiences

Generic claims management roadmap

Unplanned outcome

Report to 1st Responders

ASAP

Stabilize the clinical environment

Engage patient

Support Staff

Notify leaders, essential authorities

Manage patient/staff communication/expectations

Focused investigation w/ interviews of involved staff

Internal and if nec external reviews

CCRC review Claims worthiness assessment

If insured, partner w insurer and collaborate w involved private medical staff insurers

Share w pt/staff/leaders

Reasonable?

Explain, listen, reassess if warranted

If no agreement, support & defend staff

Grey?

Explore compromise mindful of audience

Unreasonable?

Explain, apologize, intro poss compensate and damage eval

If no agreement, explore ADR, prepare to litigate if nec

Collaborative, cooperative w/other parties if poss

Consider capturing patient stories, share lessons learned

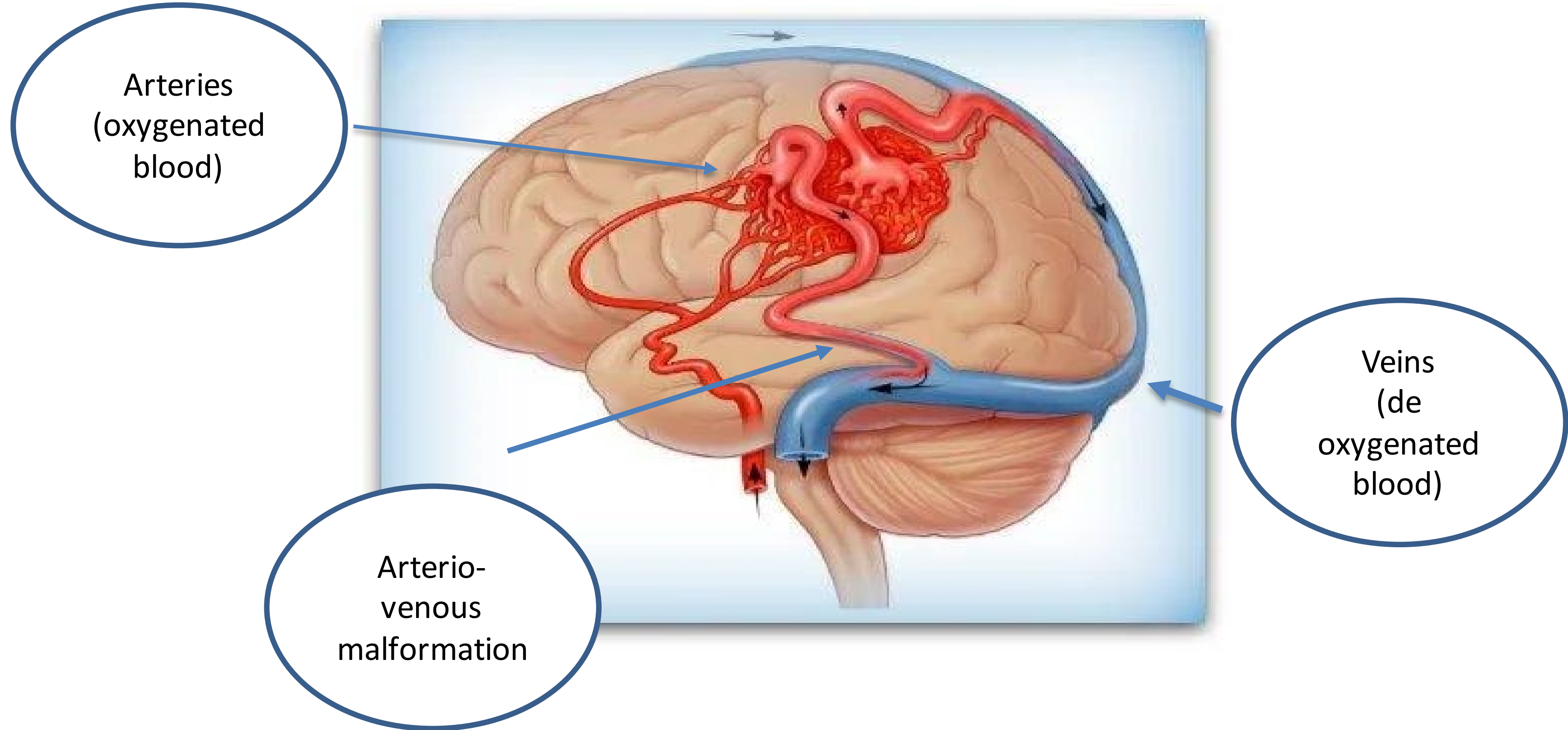
Baby Maria
In the Michigan Model

Baby Maria

- Physician was carefully peer reviewed in days. She was embraced but accountable: voluntarily surrendered obstetrical privileges, proctored in chronic pain and other clinical aspects of her practice, patients reassigned
- Lawyer recruited for the patient made two promises: 1) open a probate court conservatorship so we could support them until Maria plateaued neurologically and we could comfortably predict Maria's future needs and 2) we would settle the case based on her predicted needs, not potential jury verdicts
- Maternal-fetal, obstetrical and family medicine services collaborated to leverage strengths and reach confident uniformity with ongoing quality and safety surveillance in obstetrical training and clinical practice

Christine

AV malformation



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Documented Performance of the Michigan Model

- New claims per month dropped
- Total liability costs dropped
- UMHS closed potential claims and asserted claims faster
- UMHS increasingly avoided litigation in both, claims without merit and claims with merit
- Total claims dropped

Kachalia, Allen, Kaufman, Samuel, R, Boothman, Richard C., et al
Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program
Ann Intern Med. 2010; 153: 213 – 221 (2010)

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More importantly, the University of Michigan Health System:

- Achieved a clarity few other health systems have
- Weeded out most of the bogus claims
- Avoided litigation and its costs (financial, emotional, lost productivity)
- Can no longer blame greedy lawyers, opportunistic patients, or a broken court system
- Has a much clearer view of its clinical challenges, dangerous practices and practitioners with a clear view of its problems and a clear path to improvement

THE MICHIGAN MODEL, FORERUNNER OF THE COMMUNICATION AND RESOLUTION PROGRAM (CRP)

2004: The first reporting on the Michigan Model and "apologies save money" stories begin to appear in local, then national press

2005: Senator Hillary Clinton takes notice and seeks to build components into national legislation – the MEDiC Act is introduced by Clinton and Obama

2008: President Obama instructs the Secretary of Health and Human Services to study wide application of the Michigan Model, ultimately described by academics as a "communication and resolution program" (CRP)

2015: The Agency for Healthcare Research and Quality (AHRQ) publishes the CANDOR toolkit
(See https://www.ahrq.gov/patient-safety/settings/hospital/candor/index.html)

The Michigan Model serves as the prototype to what the scholars call Communication and Resolution Programs (CRPs)*

Communication and Resolution Program (CRP) defined

A proactive, clinically-principled, highly disciplined and consistent response to unintended patient outcomes that prioritizes patient safety and aligns the post-injury engagement of the patient and family with the healthcare organization's mission, vision and values

*the label is unfortunate in my opinion because it implies the primary purpose is claims management and patients deeply resent it bec many never get true "resolution" after permanent harm

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"Well, to be honest after that night I left there like I was on a mountain top. I felt like I had finally been heard, they listened.

I mean I had all these very important people in that room listening to me, they were there because of my story and if that had been the end of the legal pursuit that would have been fine with me.

I was I was perfectly satisfied after that night. I felt like I finally had spoken up for myself."

Jennifer 2007

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... and How Massachusetts Can Lead the Way
on **Patient Safety**

The Betsy Lehman Center
June, 2019

Start healing after the harm

- FINDING: Medical errors are associated with long-lasting physical and emotional impacts
- FINDING: Medical errors are associated with long-lasting loss of trust and avoidance of health care
- FINDING: Patents and families rarely receive an apology or offer of support following a medical error
- FINDING: Most people are dissatisfied with the communication they receive from providers after an error
- FINDING: For people who receive it, open communication is associated with lower levels of adverse emotional health impacts and health care avoidance

The Financial and Human Cost of Medical Error,
The Betsy Lehman Center for Patient Safety June, 2019

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Plaintiffs' Bar's Survey Response
52 Michigan medical malpractice specialists, 2007

- 100% rated UMHS "the best", "among the best" for transparency
- 90% recognized a change in 2001
- 81% changed their approach to meet our change
- 81% experienced lower costs
- 71% settled cases for less than expected
- 86% said transparency allowed them to make better claims decisions
- 57% dropped cases they otherwise would have pursued

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CRP impact on trial lawyers

"Instead of adversarial, it was conversational. It was instead of trying to figure out what claims and defenses needed to be, I found myself trying to figure out some higher calling, what's the right thing to do here? What's the best thing to do here?

My role changed from advocate to warrior to counselor is the best way that I can describe it. We are attorneys and counselors and the counselor part got emphasized, in fact, became the dominant, the ascendant part just as soon as it became clear the University Hospital was gonna take a different approach to this case."

Thomas Blaske, Esq
2007

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CRP impact on trial lawyers

"In forty years handling mostly catastrophic injury cases, I've always known how to make damage arguments – pretty damned successfully, really.

This is the first time in my career I've learned how much it ***actually*** costs to take care of someone with these *(catastrophic)* injuries."

Prominent Michigan plaintiff's lawyer
September 2010

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Hi Rick,

I just returned from a week-long leadership course at the Harvard School of Public Health. One of the presentations was regarding the legal and ethical issue of medical error. He highlighted your medical error disclosure program as the exemplary model of how to reduce the litigations. There were some skeptics in the crowd, but I shared that this program has really facilitated the improvement of provider-patient relationship at Michigan, which ultimately is the what we want to preserve as the driver of improving quality and safety.

I felt so proud to hear of your work and just wanted to drop you a note!
Thanks!!

John Park, MD, PhD (Surgeon-in-Chief, CS Mott Children's Hospital)

Dear Mr. Boothman,

Wanted to let you know there is a great article in today's NY Times that paints your work here at Michigan in very favorable light. Also, I thought I'd mention that Michigan's medical error policy was a big part of my choosing to come to residency here.

I'm sure I'm not alone. Keep up the good work!

With deep appreciation,

Melissa ______________

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Hi Mr. Boothman,

I just wanted to tell you that your lecture yesterday was one of the best lectures I've ever heard. I talked my family's ears off last night because I was so excited about what you're doing at Michigan. The story that hit me the most was the one with the neurology resident and the massive heparin overdose. I want to be that sort of practitioner, who patients know really care about them. Your willingness to be honest and patient-focused made me proud to be part of Michigan, and I hope that I can practice medicine in an environment like you've created here.

Thank you for coming!
Christa __________

UMHS Medical Staff Survey Response
482 physicians, 2007

- Of more than 400 responses:
  - 87% said that the threat of litigation adversely impacted the satisfaction they derived from practice
  - 98% perceived a difference in approach post 2001
  - 98% approved of new approach
  - 55% said that the new approach was a “significant factor” in their decision to stay at UMHS
  - Only criticism was that they wanted more attention

The Michigan Model intentionally serves a healthcare organization’s path to high reliability, Just Culture, meaningful peer review and clinical accountability

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HIGH RELIABILITY?

"Performance as intended consistently over time"

"Collective mindfulness"

1. Preoccupation with failure, the continual looking for and reporting of hazards;
2. Reluctance to simplify, not accepting the obvious explanation for a failure;
3. Sensitivity to operations, paying attention to issues at the frontline;
4. Commitment to resilience, the ability to detect errors, react, and recover; and,
5. Deference to expertise, the flattening of the hierarchy in an emergency so that the most qualified person is in charge, regardless of seniority."

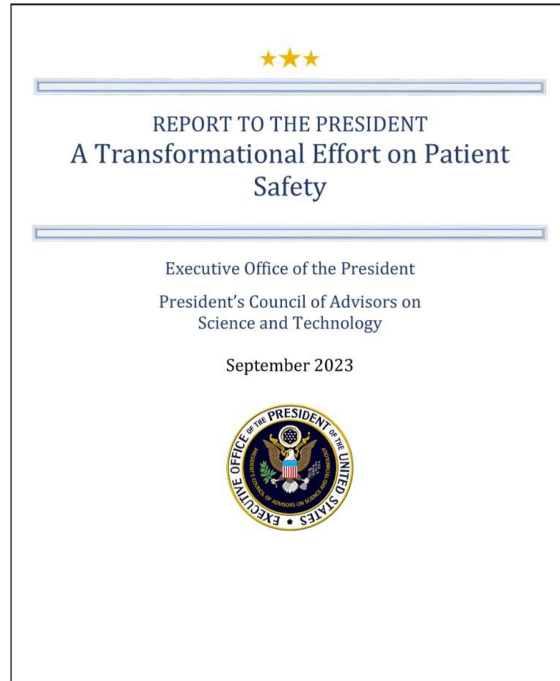
Weick, KE, Sutcliffe, KM, Obstfeld, D *Organizing for high reliability*. Res Organ Behav. 1999:21:81-123

Safer Together

A National Action Plan to Advance Patient Safety

The **Institute for Healthcare Improvement** convened the **National Steering Committee for Patient Safety** as a collaboration among 27 national organizations committed to advancing patient safety.

President's Council of Advisors on Science and Technology (PCAST Report, September 2023)


REPORT TO THE PRESIDENT
A Transformational Effort on Patient Safety
Executive Office of the President
President's Council of Advisors on Science and Technology
September 2023

Interest continues unabated, but too often health systems aren't really "all in"

- CRP is narrowly ***equated*** with selective, early claims resolution
- Often artificial restrictions are imposed:
  - Can't approach patients ***before*** they have asserted a claim
  - Won't offer compensation before suit
  - Refuse to engage unrepresented patients; refuse to talk with patients who hire a lawyer
  - Refusal to acknowledge injuries altogether
    - "We don't count cases if the complication was actually listed on the consent form the patient signed."

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Too often, health systems aren't in ***at all***

"Are you suggesting that we alleviate the mother's pain? It's the pain that will drive her to the negotiating table. It's her pain that will let us settle this case.

We would never do THAT!"

February, 2019, Director of Risk Management at a large, highly ranked Midwest academic medical center

* * *

When asked if she had suggested a CRP approach to the general counsel, the Chief Executive Officer replied,

"Yes. Once. I'm afraid my suggestion was unwelcomed."

January, 2023, Chief Executive Officer of a mid-sized community hospital in Illinois

Skepticism and misconceptions of the model

- "This man will singlehandedly bankrupt the University of Michigan Health System in 5 years." Acclaimed scholar, Troyen Brennan, MD, PhD, JD ***Leading Medical Reform***, University of Michigan, Nov. 24, 2004

- "This might work in the sleepy Midwest, but it will never work here." New York attorney at the Greater New York Hospital Association conference, May 13, 2005

- "You don't know what you're talking about. Just how many cases have YOU tried? I've tried more than 200 cases and you're an idiot." Defense attorney at Fallon Clinic presentation, Sept. 27, 2006 *(he was escorted out)*

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- "That severe injuries are prevalent and that most of them never trigger litigation are epidemiological facts that have long been evident. The affordability of the medical malpractice system rests on this fragile foundation, and routine disclosure threatens to shake it. Movement toward full disclosure should proceed with a realistic expectation of the financial implications and prudent planning to meet them." *Disclosure Of Medical Injury To Patients: An Improbable Risk Management Strategy*, Studdert, Mello, Gawande, Brennan, and Wang Health Affairs, January/February, 2007 HTTPS://DOI.ORG/10.1377/HLTHAFF.26.1.215

- "Why in hell would we do THIS? We're already paying out a king's ransom! You must be insane." Executive for a prominent TPA, New York, Sept. 16, 2009

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- “You should be ashamed of yourself, taking advantage of people like this.” Judge Douglas E. McKeon, NY State Supreme Court, Sept. 16, 2009

- “The most commonly referenced apology program is the University of Michigan Healthcare Services model. The architect of the program is Attorney Richard Boothman . . . Attorney Boothman has become one of the most prominent proponents of apology programs in the United States. UMHS’s philosophy is consistent with the concept of ‘cooling the mark out’.” Gabriel H. Teninbaum, How Medical Apology Programs Harm Patients 15 Chap. L. Rev. 307 (2011)

Questions?

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Michelle M. Mello, Richard C. Boothman, et al, *Communication-And-Resolution Programs: The Challenges And Lessons Learned From Six Early Adopters Health Affairs, 33, no.1 (2014):20-29 (2014)*

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CRP instead of traditional tort reforms: Sage, Wm, Boothman, R, Gallagher, TH *Another Medical Malpractice Crisis? Try Something Different* AMA. 2020;324(14):1395-1396. doi:10.1001/jama.2020.16557

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PRO: Clinton, H R, Obama, B, *Making Patient Safety the Centerpiece of Medical Liability Reform* N Engl J Med 2006; 354:2205-2208MAY 25, 2006 DOI: 10.1056/NEJMP068100

CON: Studdert, Mello, Gawande, Brennan, and Wang *Disclosure Of Medical Injury To Patients: An Improbable Risk Management Strategy,* Health Affairs, January/February 2007 HTTPS://DOI.ORG/10.1377/HLTHAFF.26.1.215

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Other relevant publications:

Report to the President; A Transformational Effort on Patient Safety President's Council of Advisors on Science and Technology (PCAST) Report to the President https://www.whitehouse.gov/wp-content/uploads/2023/09/PCAST_Patient-Safety-Report_Sept2023.pdf

https://npsb.org/resources/pcast-report/

Leape, Lucian L. ***Making Healthcare Safe, The Story of the Patient Safety Movement*** Springer (2021) (Open Access) https://link.springer.com/book/10.1007/978-3-030-71123-8

A World of Hurt: How Medical Malpractice Fails Everyone An examination of the devastating impact of medical malpractice (Video, Rhode Island PBS 26 min, 45 sec) June 1, 2024

https://www.pbs.org/video/a-world-of-hurt-how-medical-malpractice-fails-everyone-uklpuo/

Other relevant publications:

Leilani Schweitzer at TEDxUniversityofNevada **Transparency, Compassion, and Truth in Medical Errors:** https://www.youtube.com/watch?v=qmaY9DEzBzI

SHINING A LIGHT *Safer Health Care Through Transparency* A White Paper on Patient Safety by the Lucian Leape Institute at the National Patient Safety Foundation

https://www.ihi.org/sites/default/files/Shining_a_Light_Transparency_LLIReport.pdf

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