Editorial

Building a National Surveillance System for Malpractice Claims

Surveillance is a fundamental tool of public health. The systematic tracking and analysis of patterns of disease have facilitated innumerable interventions to improve population health, and health officials have worked hard to create systems to enable them to access and use such information while appropriately protecting people's privacy. Unfortunately, this commitment to surveillance has not yet permeated another important area of health policy: medical malpractice. The lack of a comprehensive, nationwide surveillance system for malpractice claims is a missed opportunity to improve patient safety and better understand the performance of the medical liability system.

Malpractice claims are, in a sense, the oldest reporting system for adverse events in the United States. For more than a century and a half, patients have filed these claims in pursuit of compensation, information about why the harm occurred, and corrective action to address the causes of the injury (Mohr 2000). Health care facilities and professional liability insurers receive, investigate, and act on these reports, but they do not generally coordinate their work. Reporting is spread over an estimated 150 medical liability insurers nationwide. With a few notable exceptions (Cheney 1999; CRICO Strategies 2016; Physician Insurers Association of America 2016), insurers have not pooled their data. Moreover, reporting is neither systematic nor comprehensive—most instances of injury never surface as malpractice claims, particularly minor injuries (Brennan et al. 1991; Studdert et al. 2000).

This underreporting is one reason that quality-improvement analysts have undervalued malpractice claims as a useful source of information about patient safety problems. Another reason is the widespread misperception that most malpractice claims do not actually involve negligence. But both objections are overstated. Although there is considerable underreporting, every adverse event reporting system faces that problem. Malpractice claims at least

have the advantage of emanating from outside the health care delivery system, making them less susceptible to pressures that health care providers face that may chill reporting.

With respect to the second objection, whereas research on malpractice claims brought in the 1980s found that a substantial proportion of claims lacked evidence of clear medical injury or error (Localio et al. 1991), more recent findings from a study of a large sample of closed claims indicate that 80 percent of malpractice claims involve a serious physical injury and 61 percent involve an injury caused by a medical error (Studdert et al. 2006).

Malpractice claims data provide important insights into the patterns, causes, and consequences of medical injuries (Bismark and Studdert 2010). Though not a representative sample of all adverse events, claims tend to capture information about the most serious ones (Studdert et al. 2006). Thus, claims can focus safety improvement efforts on areas where they can avert the greatest harm. They can also generate evidence about areas in which investing in safety improvements yields financial returns in the form of lower liability costs, which helps to make the business case for safety improvement (Riley et al. 2016).

Malpractice claims data—either alone or linked with other data about health care utilization and cost—also provide information about how well the medical liability system performs its key functions: compensation, deterrence of medical negligence, and corrective justice for injured persons. To know whether the system is worth what it costs us—an estimated \$55.6 billion per year, including \$45.6 million in defensive medicine costs (Mello et al. 2010)—we need reliable data on who receives money from the system, how much they receive, how consistently they receive it, how equitable payments are across similarly situated claimants, how much we spend in administrative costs, and how these payments affect the cost of liability insurance, the supply of health care providers and services, and providers' clinical behavior. For these reasons, the question is not whether we can learn anything useful from malpractice claims data, but how we can collect these data more systematically and use them to better effect.

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Currently, the most comprehensive surveillance system for malpractice claims in the United States is the National Practitioner Data Bank (NPDB), which is administered by the Health Resources and Services Administration (HRSA). Federal law requires that liability insurers and certain other entities report all amounts paid in the name of a health care practitioner in response to a written demand for payment to the NPDB (United States Department of Health and Human Services 2015). Certain adverse actions taken against physicians' licensure, certification, or clinical privileges must also be reported. Most of the reported information is publicly available in de-identified form. The dataset contains a host of useful claim-level information, including the amount of indemnity payments, whether they resulted from a court judgment or a settlement, the nature of the adverse event, and the number of other payments associated with the same practitioner.

However, the NPDB has several significant limitations (United States General Accounting Office 2000; Chandra, Nundy, and Seabury 2005). First, to ensure that practitioners cannot be identified, HRSA redacts important information, including geographic identifiers below the county level and the exact amounts of indemnity payments. Because physician identifiers are not available, the dataset cannot be linked to other datasets, such as physician quality ratings or state adverse event reporting systems. The NPDB does not collect information about claims that did not result in a payment, estimated to constitute about a third of all filed claims (Mello et al. 2010). It does not ask insurers to estimate how payments break down into the constituent components of economic damages, noneconomic damages, and punitive damages. Minimal clinical information is collected and the taxonomy used to classify the alleged error is muddled and does not produce high-quality data. Finally, with a few exceptions, the NPDB does not collect information about payments made in the name of health care facilities.

Several state governments maintain malpractice claims databases that, while limited to claims or providers in that state, collect a wider range of data fields than the NPDB (Cohen and Hughes 2007). New York State's Department of Insurance, for example, requires insurers to report extensive information about all closed claims to a database that can be linked to the state's mandatory reporting system for adverse events.

These data-collection efforts are impressive in scope. Nevertheless, these databases tend to have a number of shortcomings. First, they are not always publicly accessible (at least with identifying information). Second, they typically exclude certain types of defendants, reporters, or claims. For example, Texas only requires a report if a payment of

\$25,000 or more was made on the claim. Third, despite statutory reporting requirements, the data reported may be incomplete and of varying quality. In New York, for example, fields designated as optional are rarely completed, and there are gaps even for required fields. The collecting agencies are technologically sophisticated but lack resources to audit the reports, check them against other databases (such as the NPDB), and follow up about missing or unclear information. Finally, the state reporting systems have not been designed to interact with one another. Reporting requirements vary from state to state, as do coding conventions and the structure and format of the databases. The databases thus are not easy to combine in multistate analyses.

We can do better, and pursuing the vision of a true national surveillance system for malpractice information is worth the investment. What principles should undergird such an initiative? First, we should recognize that hospitals and liability insurers already struggle under the burden of multiple reporting requirements for adverse events and adverse actions against health care practitioners. Thus, a unified surveillance system should minimize duplicative reporting requirements and include resources to analyze the data collected, perhaps through partnerships with external researchers.

Second, the reporting system should reside at the federal level. It is unrealistic to expect most states to marshal the resources to carefully maintain sophisticated claims databases of their own. Consideration should be given to whether the NPDB might be restructured to serve as a more robust malpractice claims surveillance system, offering researchers a wider range of variables and data linkage opportunities. The NPDB was founded for a different purpose—preventing “problem providers” from being able to hide their malpractice records by moving across state lines—and its current access rules, set by federal statute, may not serve the purposes of a reconceived surveillance system. But HRSA is well suited to administer a new system, because it has experience gathering claims data, a strong information technology infrastructure, and skilled personnel.

Third, the reporting system should reflect thoughtful deliberation about which data fields are most important to collect in order to answer key questions and how those fields should be structured. Academic researchers, insurance industry representatives, regulatory agencies, and major interest groups in debates about the malpractice system all have useful insights to contribute. If the data are not likely to be useful and used, they should not be collected. Data collection should also reflect current thinking about taxonomy and format and facilitate linkages to other datasets.

Fourth, a public conversation should occur about the confidentiality of identifying information in malpractice claims. Allowing unfettered access to individually identifying information about health care providers may not be justifiable, but neither is a policy of denying access to provider identifiers regardless of the purpose for which they are sought. For patient health information, we have evolved workable ways of balancing individuals' privacy interests with the scientific and other public benefits to be gained from analysis of the information. So too should we here.

Nearly all participants in the contentious political debate over medical liability reform share a common interest in bringing reliable information to bear on the problem. A national surveillance system for malpractice claims would seed this common ground with invaluable information that could help resolve empirical disagreements among stakeholders, facilitate further learning about why medical injuries occur, and make progress in advancing evidence-based policy. The Institute of Medicine's landmark report (Kohn, Corrigan, and Donaldson 2000) firmly established medical error as a public health problem requiring population-level analysis. A national surveillance system is an essential step toward achieving this vision.

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of this article:

Appendix SA1: Author Matrix.