CASE STUDIES

A typology for legal risk management in patient care in Australian hospitals

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Abstract

The author reviewed the literature on legal risk management in patient care, and carried out research in two acute care hospitals. The hospital research involved auditing policies and procedures, interviewing key people in the hospital, reviewing external legal and policy trends, and examining selected complaints files and legal cases. The results were used to develop a 'typology' of legal risk management to provide guidelines and assistance to hospital management in improving their hospital's strategic response to legal vulnerability. The model sets out four levels of legal risk management programs, and identifies specific components classified as promoting loss prevention, or loss minimisation.

Introduction – Research objectives

In 1993, the author carried out research in two Australian hospitals to examine programs and methods in hospitals directed at, or contributing to, minimisation of *legal vulnerability and exposure to risk of litigation* in relation to patient care. The research was designed as a pilot project to develop a typology for auditing policies, procedures and practices, based on the legal risk management literature, and field work in the participating hospitals.

The objectives were:

1. to develop a typology as a tool for assessing the level of effort and resources required in a hospital to manage their legal risk

2. to identify components of a good legal risk management program based on assessment of that hospital's needs using the typology.

The research was carried out in a 360-bed tertiary level private hospital in Perth, Western Australia, and a major regional public teaching hospital, with 530 beds, located in New South Wales. The researcher was given complete cooperation and access in both hospitals.

Background context

In recent years Australian health services, particularly hospitals, have devoted an increasing level of resources and attention to improving the standards and quality of care to patients. Emphasis has been placed on achieving this through the adoption of a variety of structured approaches which fall generally within the generic term *quality management*. They include such activities as quality assurance, clinical peer review, utilisation review, clinical guidelines, incident monitoring, and risk prevention programs. More recently, quality management in hospitals has focused on the more positive, proactive approaches exemplified in such models as total quality management and continuous quality improvement.

During the same period health services have seen increasing legal claims against them from patients seeking compensation for the ill-effects of adverse outcomes to their health care (Tito 1994, 1995).

However, these parallel developments have not generally been accompanied by formal recognition of the connections between them. The primary objective of *quality improvement* programs is continued monitoring and enhancement of the quality and standards of patient care. In contrast, the focus of the legal system is to determine who will *compensate* patients who have been harmed by the health care they have received. The main purpose of hospital legal risk management is to *minimise exposure to liability* for compensation.

There are significant overlaps between the two objectives. While the principal concern of hospitals will always be to provide high quality care to patients, and quality improvement programs should remain primarily directed to this end, an important secondary benefit of effective, comprehensive quality improvement programs should be a reduction in exposure to legal risk, especially where there is a planned focus on this aspect as part of the overall policy commitment.

Conversely, effective analysis of individual incidents where harm has occurred to the patient for which the hospital may be legally liable – which Little (1992) termed 'sentinel events' – will contribute to the quality improvement process.

In Australia, programs with the primary objective of improvements in standards of care have not routinely been interlinked with those (if any) which focus on reduction of legal risk. More typically, management approaches have been based on the untested assumption that a continuous process of improvement in quality of care will *automatically* lead to decreased legal vulnerability. Nor has it been common practice for health care services to *systematically* examine their policies and procedures *with a view* to minimising their legal vulnerability. This assumption is a misconception. All relevant research indicates that the proportion of patients who are potentially compensable as a result of harm experienced during hospital care, who actually take legal action, is very small. Therefore, improved standards of care which reduce the number of potentially compensable incidents will not necessarily reduce legal exposure, if it is counteracted by an increase in the proportion of harmed patients who actually sue.

This may be contrasted with North America where, in the 1980s, the combined effect of a more privatised health system and a notable rise in medical litigation produced a structured risk management 'industry' targeted at legal risk. From this has developed, as a subset of the commitment to quality assurance, *risk management* programs specifically aimed at reduction of legal vulnerability in hospitals. (In the United States, the term 'hospital risk management' implies a systematic targeted program designed to reduce legal risk through reduction in preventable injuries and accidents as well as minimisation of financial loss to the institution as a result of complaints and claims following incidents.)

The participating hospitals

Hospital 1

At the time of the study, this hospital was the biggest hospital in the national health care service group, St John of God Health Care System, and one of the largest private hospitals in Australia. The hospital is part of an organisation which is financially independent, and 'not for profit', in that profits are reinvested into providing health care.

The majority of its admissions are in orthopaedics, general surgery, internal medicine and obstetrics. It provides acute care and a range of other tertiary and secondary level services. It also has a medical teaching role. There are 360 beds (300 general and 60 obstetric) and the hospital admits approximately 23 400

patients per year. There are approximately 1000 employees, of which just over 500 are nursing staff. It does not employ any medical staff, except the director of medical services. Clinical care is provided entirely by the 630 independent general practitioners and specialists who have admitting privileges with the hospital (although only approximately 150 use these regularly). In addition, a small number of residents from a public teaching hospital are assigned to the hospital for short rotations.

When the researcher visited the hospital, it was undergoing major corporate redefinition of its mission, values and commitment to provision of quality health care to its patients. This process was producing a profound shift in the corporate culture to a proactive, structured and institution-wide focus on continuous improvement to the quality and standards of patient services. However, this process was largely limited to internal management and to support services (clinical and non-clinical) provided by employees of the hospital. As medical services are provided by independent doctors external to the hospital, these changes have less of an impact on medical treatment of patients (although the hospital was embarking on a program to upgrade its requirements for accreditation of medical practitioners). In addition, the hospital was preparing for ACHS accreditation.

Hospital 2

Hospital 2 is a new hospital (it accepted its first patients in January 1991) and is the largest hospital in its area health service. It is a public teaching hospital and the major referral centre for its (non-metropolitan) region. It provides acute care, a full range of tertiary and secondary level services, and is one of four level 3 trauma centres in New South Wales. It has 530 beds, and admits 44 000 patients annually (of which 19 000 are day-only patients). At the time of the study it was still in the early stages of developing a sense of corporate culture and identity, following the dislocation of the move from an older hospital (which had been partially closed). The organisation of the hospital was largely concentrated into distinct and relatively autonomous clinical departments, which made the development of hospital-wide policies and systems by hospital management a complex and difficult task.

Definitions and research objectives

For the purposes of this research, 'legal risk management' was defined as:

> *A program designed to reduce the incidence of preventable injuries and accidents and to minimise the...loss to the institution should an accident or injury occur.*

The focus of a legal risk management program is on monetary losses, and meeting *legal* standards of health care. It operates through identifying and monitoring *individual incidents* where a patient is harmed, and using these as a basis for *identifying preventive strategies*, and review of *loss minimisation follow-up*. The primary beneficiary is the *hospital*. Secondary beneficiaries are patients, internal health care providers, funders and insurers.

It is worth contrasting this with the emphasis of *quality management*, where the objective is to monitor and enhance quality and standards of patient care, and describe a variety of hospital and clinical activities with improved quality as a primary objective. The primary beneficiary of the quality program is *future patient care.*

A perfect record in eliminating all preventable incidents which harm patients and are potentially compensable is, of course, impossible. In every large and complex institution, a one hundred per cent score is an unattainable goal. Yet the philosophy of effective quality improvement models is to aim for continuous improvement in a positive way, as if it *were* attainable. In a hospital setting, both from the point of view of patient care and of legal risk management, this approach is significant. In every hospital, preventable incidents which harm patients will occur, because of incompetence, system failure, or the inevitable human mistakes which competent and conscientious people will occasionally make. Effective hospitals will aim to reduce these as much as possible through a range of quality improvement approaches directed at each type of incident (*loss prevention*). An ancillary benefit of this is also a reduction in exposure to legal risk. Secondly, as reduction of compensable incidents is not automatically linked to reduced numbers of patients seeking compensation, when adverse incidents do occur, the well-managed hospital will act strategically to minimise their effect as much as possible (*loss minimisation*).

Smith and Wheeler (1992, pp 9–17) define this process as:

> *A program designed to accomplish at least two objectives; (1) to reduce the incidence of preventable injuries and accidents and (2) to minimise the...loss to the institution should an accident or injury occur.*

This research was designed to, in a preliminary way:

- examine and evaluate the extent to which two major hospitals, one private and one public, incorporate and focus on, directly or indirectly, reduction in legal vulnerability in their quality improvement and patient care policies and general management strategies
- determine the need for or value of targeted legal risk management in the context of the views of senior hospital managers and clinicians, the role of insurance companies and other external agencies, the environment (current and anticipated) affecting exposure to legal risk, and other relevant factors.

Methodology

The research method involved the following.

(a) An 'environment scan' to identify external legal, policy and administrative factors affecting the hospital's strategic approach to this issue (through, for example, statutory, common law, consumer, government or insurer requirements). Attention was paid to the role of medical defence organisations and hospital insurers, and the impact of their strategic responses to legal risk exposure of their members.

(b) *Review of policies, procedures and (where appropriate) practices in the hospital, with a specific focus on identification of those which potentially contribute to the level of vulnerability to legal risk in the institution*. This was done through *interview* of key clinical and non-clinical personnel, *examination* of written policies and procedures, and *audit* of selected files where complaints and/or legal action have occurred. Data collected were *analysed* using parameters of *loss prevention* (strategies which potentially reduce the number of compensable events) and *loss minimisation* (effective management of incidents, complaints and legal actions to reduce negative effects). Policies, procedures and practices were identified and examined with *preventive* potential – patient care policies such as informed consent, confidentiality, privacy; review by the hospital of patient satisfaction; quality improvement programs (clinical guidelines, quality assurance, peer review etc); staff and clinician training and education; management accountability and so on. Analysis also focused on *minimisation* activities such as incident reporting; complaints procedures; patient access to medical records; handling of medical records; management of potential or actual claims. (These factors have been identified in United States research as having a significant relationship to effective legal risk management.)

The results were used to develop a model typology as a tool for hospitals in conducting their own legal risk management needs analysis.

The external environment

Trends in hospital liability for 'common law negligence' in patient care

The following general principles summarise the present law in relation to hospital legal liability.

- A hospital is *vicariously* liable for *all* 'negligent' care by its *employees*, including clinical care by doctors employed as consultants on a sessional basis.
- The hospital owes a *direct duty of care* to all patients for *all clinical and non-clinical support services (nursing, pathology, pharmacy etc.)* it provides to patients who are admitted to receive medical treatment.
- The hospital is liable under its direct duty of care for *all patient care (including clinical care/medical treatment)* to *any patient who admits him/herself to the hospital* or *who is referred to the hospital for the purposes of obtaining medical treatment* provided or organised by the hospital.
- The hospital owes *no* duty of care and is *not liable* for medical treatment/clinical care provided to patients by *independent doctors* with admitting rights who provide medical services/clinical care to their own patients whom they arrange to be admitted to the hospital and use hospital facilities.

These general principles were applied to participating hospitals in the study.

Hospital 1, as a private hospital which employs virtually no medical staff involved directly in patient care, is not generally liable for the medical treatment provided to patients by the doctors with clinical privileges to their own patients using hospital facilities. It is liable, both vicariously and through its direct duty of care, for non-clinical support services (equipment, diet, laundry etc.), non-medical clinical support services provided by health professional employees (nursing, pharmacy etc.), and for medical support services (pathology, radiology, and nuclear medicine) provided by professionals employed by the hospital.

Hospital 2, as a public teaching hospital, is generally liable for all aspects of health care, including medical care by visiting consultants, to its public patients. In relation to private patients, the situation is as for Hospital 1, expect that a private patient in a public hospital is far more likely to receive medical care from an employed or sessional clinician for which the hospital is vicariously liable.

Legal trends are emerging in common law through court decisions which could potentially raise this present level of hospital legal exposure to liability for patient care:

- *Damages awards* by courts are increasing, particularly in high-risk areas such as obstetrics, where results of preventable adverse events can be catastrophic, and irreversible. Hospital exposure to even one case of this type is a major risk, both financially, in terms of insurability, and in terms of reputation.
- The *direct duty of care* owed to patients could expand into clinical care by independent doctors, following trends in North America. Within the context of a private hospital, or a public hospital treating private patients, these trends recognise the direct *benefit* to a private hospital of attracting clinicians to use the hospital (patient referrals and 'marketing' of reputable clinicians 'create' the hospital's customer stream), and therefore impose a corresponding duty of care to the patient as to the quality of medical care provided within the hospital. This trend is already evident in some judgments in Australian court cases (see, for example, Mr Justice Kirby's minority judgement in *Ellis v Wallsend District Hospital* (1989) NSWLR 17; Geis 1993). This direct duty of care could include:
  - the *duty to see that reasonable care is taken* by clinicians using the hospital, which would encompass selection of clinicians with admitting privileges, enforcement of clinical standards, training of clinicians using the hospital in hospital policies and procedures in critical legal risk management areas
  - a shift from holding doctors solely responsible for misadventure in clinical procedures to a recognition that clinical care is provided on a *team* basis, and it is the hospital, not the independent doctor, who has direct authority over this support team
  - courts eventually rejecting the concept that determination of liability turns on fine technical distinctions as to the contractual relationship that the hospital has with the patient in favour of *extending the direct duty of care to all medical services provided within the hospital.* This has happened in the United States, and in other areas of tort law in Australia.
- Developments in *contributory negligence* concepts may see more hospitals held jointly liable with independent doctors for clinical care provided by doctors using hospital facilities.

- The *informed consent/'duty to warn'* decision by the High Court in *Rogers v Whittaker* (ALR 1992) authoritatively defines legal obligations of health care providers in ensuring that patients understand and agree to the treatment they receive.

Legal relationship of hospital to independent doctors with admitting rights

Traditionally, hospitals have been seen to have no liability for negligent medical care by doctors who have patient admitting rights, but are paid by the patient, not the hospital, for clinical care. However, as the boundaries between hospital and doctor responsibility for quality of clinical care become more blurred, the hospital is in a potentially vulnerable position, unless compliance by doctors with hospital policy and clinical standards requirements when they treat admitted patients are spelled out, for example, in the accreditation contract or through hospital by-laws.

Statutory obligations and trends in Australian legislative policy in hospital care

All hospitals, particularly private hospitals which require a licence to operate, must meet a range of statutory standards and comply with legislative requirements. All such hospitals should periodically *audit* their compliance levels as part of legal risk management. There was no evidence of this having been done in either of the participating hospitals. All hospitals should receive regular advice on current State and national trends which may alter or add to existing legal responsibility under statutes and regulations in relation to patients and give rise to specific legal risk factors. For example, many States in Australia now have *'right to refuse treatment/die'* laws; and the Commonwealth *Professional Indemnity Review in Health Care* reported in November 1995 and made recommendations in relation to common law liability for medical negligence, and the structure and financing of medical defence organisations. Other examples are that the reform of *private hospital regulatory laws* is shifting the emphasis of regulation from meeting technical standards in equipment, buildings and facilities etc., towards setting standards in quality of patient care; and reforms to private health insurance linked to 'managed care' plans have significant implications for private hospitals financially, and in terms of the way they offer clinical services.

Unexpected deaths

Hospitals are frequently involved in coronial inquiries following unexpected deaths. Policies and procedures should specify standardised responses to unexpected death to maximise the hospital position in any inquiry, and be periodically monitored, and reviewed.

Insurance

The role of hospital insurers in legal risk management is pivotal. They critically influence a hospital's approach to legal risk in a number of ways – through premium levels; follow-up procedures for potentially litigious incidents; litigation case management; and, generally by establishment of requirements for legal risk management programs. However, despite their significance in medico-legal issues in relation to patient care, most insurers in Australia have been curiously silent on requiring proactive legal risk management by hospitals at the patient care level, particularly in relation to prevention. This is in contrast to the United States, where detailed insurer requirements as to hospital strategies on quality and legal risk etc, 'at the coal face' of patient care, have been a driving force behind hospital action in this area.

Insurers of participating hospitals interviewed as part of this research (both of whom are large insurers in the field) commented that the reasons for this are largely historical. Most insurance is underwritten by multinational companies and consortiums. These assess actuarial risk industry-by-industry on a global, regional or country-wide basis, with risk management policies for insurance clients developed at this level, rather than within an individual hospital/insurer contract. Nevertheless, this laissez faire approach is changing rapidly. Over the last five years in Australia there has been a steady rise in the number of claims, but more significant has been the substantial increase in the average cost per successful claim, whether settled or litigated.

In the participating hospitals, insurers did not appear to actively manage their relationship with their hospital customers in a way that demonstrated an in-depth knowledge of the health industry and its particular risks and requirements, or a proactive 'partnership' with the hospitals to minimises their own exposure as well as meeting the interests of their client. Two issues were of particular significance: the *assessment of actuarial risk and setting of premium and excess levels* and the potential for linking this to *legal risk management*; and the contribution of the insurer to *loss minimisation* through incident reporting and legal case management requirements.

Neither insurer required any legal risk management or quality standards from the hospitals, or linked introduction of such strategies to premium levels. In one hospital, over the last four years increases in premiums have been in the order of 33 per cent, and the excess amount increased by 500 per cent. These changes were not linked to hospital performance. In both hospitals there was a basic incident reporting requirement, but its parameters were not clearly spelt out so a huge range of relatively unimportant information was collected, and minimal use made of it either by the hospital or the insurer. Once a legal claim was lodged, the insurer determined the case management almost entirely. Both of these practices pose difficulties for effective legal risk management by the hospital.

In relation to *incident reporting*, the absence of negotiated guidelines or a clear understanding of what is required by either insurer or customer has produced confusion, a certain level of 'ad hocery' in what gets reported to the insurer, and difficulties within the hospital in using the information for incident prevention.

There were also difficulties when the insurer determined legal case management without sufficient attention to the broader interests of the hospital and its customer focus. In one hospital where legal case files were examined, in several cases problems were caused for the hospital in following insurer instructions because the insurer appeared to require actions which were not sensitive to the particular needs of its health care client. In one example a patient suffered a minor injury and sought compensation. The insurer advised denial of liability and limited communication. Two years later, after the patient had engaged lawyers and lodged legal action, defence lawyers advised settlement 'because there was no legal defence!' The sum involved was $3500, the loss to the hospital's reputation incalculable, and the cost to the hospital of the two years negotiation well over the final settlement figure. Another example was an insurer requirement that a patient who has refused to pay their bill because of an unsatisfied grievance, nevertheless be pursued for the amount irrespective of the validity of their complaint. This will often not be in the best interests of the hospital's reputation.

As part of developing a legal risk management strategy, hospitals, or a group of hospitals, could consider a range of issues in terms of their relationship with their insurers:

- Proactive introduction of legal risk management policies on a hospital or group-wide basis could provide a basis for *negotiation with insurers on premium levels and discounts*.
- The hospital could consider negotiating a more proactive approach to *management of incidents, complaints and legal cases* (at least at their initial stages).

These issues could be discussed with the insurer. Insurance is a competitive industry and this should provide the opportunity for constructive negotiations. Because of the pivotal role of insurance, it will not be possible to effectively upgrade the level of legal risk management within any hospital unless this is done in consultation with the insurer. Where a health care group is self-insured, these issues are not relevant and there is more flexibility to determine case management; however, the financial incentive in developing effective legal risk management is even more acute.

This topic should not be left without a mention of the role of medical indemnity organisations in relation to clinical care by doctors with clinical privileges treating private patients within a hospital, but who are not employed by the hospital. Traditionally, hospital liability, and liability of the medical practitioner for adverse patient outcomes in the hospital, have been treated, both by the law and practically, as entirely separate. Because of the increasing potential for legal claims against both hospital and medical practitioners as co-defendants, and the blurring of legal demarcations between hospital and independent practitioner liability, it will be increasingly important for hospitals to work closely with medical insurers in legal case management (carefully negotiated to manage the potential for later legal conflict of interest).

In addition, in private hospitals where all of the medical services are provided by independent practitioners, the best potential for effective legal risk management training, and monitoring of doctor performance, will occur through close cooperation between the hospital and medical defence organisations. For example, a hospital/medical defence joint policy on legal risk management for medical treatment performed within the hospital by doctors, covering all aspects of legal risk management relevant to the interests of the hospital and of the defence organisations as well as those of the doctors, could provide a benchmark for the whole industry.

Evaluating hospitals for legal risk

Although American research into this area is extremely valuable in identifying the most effective targets and strategies for legal risk management activity, one of the difficulties that the researcher had in reviewing the considerable United States literature on the topic was the presupposition by all commentators as to the desirability of all hospitals (large acute care hospitals, anyway) adopting a complete package of comprehensive, structured and costly legal risk management programs. While in the United States legal context this is no doubt justified in

terms of cost benefits, and indeed is often an insurer, or even a statutory, requirement, for Australian hospitals, the situation is not at all the same.

In the first place, although assertion of their legal rights by patients and the perceived increase in levels and costs of litigation are a growing concern for institutions providing health care, at least in the hospitals participating in this research (both of which had insurers), it did not presently appear to be a major management issue. Managers were looking, not at resolving an immediate and present issue for the hospital, but rather, at identifying a potential problem and preparing their institution to meet it effectively. One could perhaps assume that hospitals which are *self-insured* would be quicker to move towards proper legal risk management, but anecdotal evidence indicates that, even in this sector, issues of managing for legal vulnerability are in their infancy, with hospitals (or the governments/companies which own them) traditionally relying on their large revenue base to absorb any costs.

However, hospital management has a strongly perceived need to 'do something' about the issue both for economic reasons (in times of budget constraints every dollar saved in litigation pay-outs or reduced insurance premiums counts), and as part of maintaining their public image and reputation for providing high quality health care. This concern is fuelled by a perception of an increasingly litigious population, combined with steady increases in insurance premiums, and high pay-outs for the few major legal cases in the country which are successful. In relation to major legal cases, an analogy can be made with the air travel industry. While there are very few air crashes, the results of even one is catastrophic, and therefore the aim of safety programs and risk management should be to prevent even that one. Similarly, in hospital care, while the volume of major legal cases is not at all high (and relative to the total number of patients will remain very small), the damage caused financially to the hospital, and to its reputation, by a major malpractice claim against it could be very great. In addition, in relation to more minor complaints, hospitals paying out on small claims themselves because they have an excess amount on their insurance policies, or who are part of a self-insurance scheme, will not need many claims before there is an impact on their financial position. Hospital managements are looking for a *measure* of the level of attention that should be paid to the issue, given their *specific* hospital profile, and, then, some signposts and guidelines on strategies they may adopt to meet their particular needs, and the broad cost/benefits of these. As a result of this research, the researcher has developed a suggested model typology to assist hospitals in this area.

Obviously, for most hospitals, the full costs of a 'total' risk management program along the United States model would not be justified. However, it is possible to

build on existing management practices and quality improvement activities for little additional expenditure. This involves adopting an overall program focus on legal risk management as a secondary objective of commitment to quality patient care, and 'picking and choosing' among a range of strategies to improve the hospital's performance in this area.

Such an approach has significant potential for flow-on benefits. These include:

- improving patient care and patient relations (customer service)
- reducing the number and/or cost of actual legal cases taken against the hospital
- providing a basis for negotiating with insurers about the costs of premiums.

A typology for legal risk management for Australian hospitals

This typology sets out four levels of legal risk management program. Each stage is designed to meet a different level of need according to the risk profile and resources of the hospital. It involves, firstly, assessment of the particular health care facility's current position and, secondly, a strategic approach to legal risk management based on need as determined by the assessment. The key to the typology is *flexibility*. Hospitals may, using this typology, plan a *staged* process of adoption of legal risk management strategies and programs. Strategies in each stage constitute the building blocks for the next stage. Hospitals can upgrade their level of commitment as their need grows in terms of relative cost/benefit. They can structure flexible 'packages' of legal risk management to meet their perceived level of risk. They can adopt different levels of the program in different areas of the hospital, depending on the degree of high-risk activity there.

Level 1

Assessment of current position

A hospital at this level is characterised by a commitment to quality improvement, and has introduced programs to achieve this. As a relatively new concept in the hospital's corporate culture, effective adoption is patchy, but steadily improving, and beginning to show returns in improved patient care and satisfaction. There is no planned or structured focus on legal risk management. There is a perceived management issue in responding to complaints and legal action, but no proactive planned approach. The operational response is *reactive* on an ad hoc case-by-case basis, rather than proactive and policy-driven. The present level of adverse events giving rise to legal vulnerability is probably not known, and the actual number

of complaints and legal actions arising from them are not a major concern. Both hospitals in the research were assessed at level I.

Strategies for legal risk management

The hospital continues its planned focus on quality improvement in patient care and customer service without any specific attention to legal risk management, although it remains aware of this issue. It pays particular attention to aspects of the quality program which also have a legal vulnerability benefit, for example, informed consent, records handling and confidentiality, development and enforcement of clinical guidelines. It reviews its incident monitoring program, perhaps through an audit of high-risk areas or procedures, to evaluate any 'hidden' exposure to legal risk. It pays attention to strategies for quality improvement with proven benefit in legal risk management, in particular, staff training, clinician involvement in development and enforcement of clinical standards, and monitoring of patient satisfaction with service. It puts in place procedures for identifying and tracking complaints and legal actions.

There are *no additional resource implications*.

Level 2

Assessment of current position

The hospital is at level 1, and is concerned about rising levels of complaints; apparent increases in the volume or costs of legal cases; patient dissatisfaction; results of incident audit or staff concerns identifying higher than expected level of 'hidden' incidents; changes in the external environment – increasing insurer premiums, publicity given to high-profile claims, changes to law as to hospital liability etc.

Strategies for legal risk management

The hospital adopts a planned focus on *legal risk management*, building on its quality management program and incident monitoring system. Similar strategies are used as in level 1, but with *planned objectives*, and *monitoring and evaluation of their achievement*.

Quality improvement areas of benefit to legal risk management are prioritised in planning, and policies specifically identify this element as a secondary purpose. Incident monitoring identifies 'legal vulnerability cases' (where patient suffers some harm) and follow-up procedures are established. Staff and medical

practitioner training in applying relevant policies and procedures (informed consent, confidentiality, patient relations, standards of care, etc) is improved, and the legal risk management element emphasised. Proactive procedures are established to respond to complaints and to legal actions/approaches from lawyers. Costs and progress of complaints and cases are indexed and monitored. Management of legal actions is referred to insurers.

As this activity is integrated within existing structures, personnel and programs, there are *limited resource implications*, other than possibly initial 'seeding' money for review by consultants of existing systems, project planning, staff and clinician training, etc, in addition to planning and development time for existing managers.

Level 3

Assessment of current position

The hospital identifies a requirement for a more structured, planned and integrated approach to legal risk management, separate from general quality improvement policies and programs, in all or part of the hospital's activities. This could occur because of an unexpected rise in the level of complaints, and/or incidents leading to legal action, as a result of insurer pressure, or following introduction of new high-risk services, technology or clinical procedures. It could be that a single major claim places a heavy burden on the hospital in terms of costs, morale, reputation and (for private hospitals) admission rates. Or it could simply be that, in a large secondary or tertiary level hospital, the range and risk levels inherent in the health care services provided, combined with changes in the external environment (for example legal risk management programs become part of hospital accreditation requirements, as occurred in the United States in the mid-1980s) and/or in patient expectations, lead to a higher priority for this area.

Strategies for legal risk management

At this stage, implementation of legal risk management becomes a separate planned priority for the hospital. Although it remains interlinked with and a part of quality improvement in terms of most programs and of staff and clinician activity, it develops separate program objectives, evaluation criteria, and so on.

There will be additional management time and function, if not personnel, allocated to legal risk management, particularly in relation to *loss minimisation*

strategies, and utilising individual incidents, cases and complaints data to feed back into the quality improvement system.

There will be a defined senior management role in responding to complaints, proactive identification and follow-up to incidents involving harm to patients, and management of actual or threatened legal action, in liaison with the hospital insurer and any other potential co-parties (for example, medical defence organisations). These will follow well-established procedures and protocols. Managers will receive training in all aspects of legal risk management, as will all staff working in areas affected by legal risk management.

At this point the question of *cost benefit* arises. As a legal risk management program at this level involves some commitment of resources additional to existing functions, a hospital manager and/or the insurer will need to be convinced that there is some benefit (financial or other) to the organisation. This can be quite difficult to do. Attempts in the United States by researchers to quantitatively demonstrate the dollar benefit of effective legal risk management to a hospital, in terms of reduced compensable incidents or a decreased proportion of such incidents leading to successful legal action, have been crude and inconclusive – although they have been successful in isolating which elements of a comprehensive program are the most effective (Russell et al. 1989; Moorlock & Murray 1992). On a case-by-case basis, there are too many independent variables affecting the outcome. In any event, within a specific hospital there will be too few cases to draw any valid statistical conclusions.

However, in considering the question of commitment of resources to legal risk management, managers should weigh the following points.

- Introduction of a planned legal risk management program should be in consultation with the insurer. It could form the basis of negotiation for a layered approach to premium-setting.
- Other indirect benefits will flow on to the hospital. These may be improved quality of care through integration of legal risk management with quality assurance activities, better customer relations as patients respond to the more proactive and conciliatory approach to incidents which harm them, as well as improved staff and clinician morale, and understanding of legal-related issues in patient care. (Currently, the general level of apprehension and lack of knowledge of some health care providers as to medico-legal issues can result in a climate of fear and counterproductive defensive practices, such as secrecy and non-reporting of incidents, poor documentation, refusal to communicate properly with patients, and so on.)

Level 4

Assessment of current position

The hospital has implemented up to level 3 of a legal risk management program, but determines that the amount of high-risk activity in the hospital (or a part of it) or the level of actual or anticipated legal action justifies introduction of a complete legal risk management program package, utilising models from the United States health industry (as described in the literature and, in many states, mandated by law). Examples of significant risk activity could include a large 'high-risk' obstetrics, neurology or orthopaedic surgery practice in the hospital; and use of cutting edge technology, procedures or drugs to treat severely ill patients.

Strategies for legal risk management

A level 4 legal risk management program will have all the elements and priorities of the previous levels, but be established separately from and parallel to the quality assurance program, with its own program and budget within the hospital. It will have dedicated management structures and staff, including legal risk management managers, legal risk management committees, sophisticated monitoring and 'tracking' systems for identification, classification and follow-up of incidents, 'defensive' clinical protocols for high-risk procedures with mandatory incident reporting to external agencies (for example, insurer), detailed accountability for legal risk management to and by the governing body, and so on.

At this stage it is probable that most hospitals in Australia are not at such a high level of exposure to legal risk to warrant such a commitment. The 'litigation crisis' in this country is not anywhere near the levels of its North American counterparts. However, a hospital may consider establishing a level 3 or level 4 program within specific areas of the hospital which it considers particularly at risk. This could be done for a limited period, as a monitoring and review exercise.

'Doing legal risk management' – priority areas for action

Having established a need for improved legal risk management, hospitals then have the task of identifying the particular priority areas and actions specific to their institutional profile. Review of relevant literature, combined with experience in the participating hospitals, suggests which aspects of patient care are most likely to pay dividends if they are the focus of legal risk management planning.

Both hospitals in this study were assessed at being at level 1 in the legal risk management typology. It was *recommended* that the hospitals consider moving to level 2. This involves a focus on legal risk management integrated into the hospital's strategic planning process, using the model set out in this paper, divided into actions to promote loss prevention and actions focusing on loss minimisation.

Specific *preventive* actions suggested include the following.

- Building the *quality management program* to meet the *a priori* conditions of a successful program (commitment of senior management, comprehensive integration with hospital core patient service activities, priority to involvement of clinicians in quality improvement and permeation through corporate culture through training etc) and giving priority to components of the quality program with proven benefits for legal vulnerability. In addition, legal risk management should specifically be identified as a secondary purpose of quality management, and effective feedback loops developed from incident reporting, complaints and legal case management to quality management processes.
- *Review of policies* identified as needing attention from a legal risk management perspective – particularly consent, record keeping and confidentiality, incident reporting – combined with personnel training in the upgraded policies, and monitoring of compliance.
- *Staff and medical practitioner training* emphasising the legal risk management element.
- Identification of *high-risk* activities and specific organisational vulnerability within them, for example, non-indicated use of hospital-supplied drugs, monitoring of the infection rate and compliance with infection control, intervention rates in obstetrics.
- Promotion of *effective record keeping and patient information* policies which will:
    - facilitate communication between doctor and the rest of the health care team
    - maintain confidentiality and privacy for the patient
    - record activities relevant to legal risk management – consent, incidents, complaints, etc
    - facilitate patient relations and complaints handling through sensible policies about patient access to their records.

- Appropriate policies and training on *patient communication and information, and consent* which integrate the responsibility of doctors and nursing staff in relation to obtaining consent, and adequately cover such issues as the role of the consent form, treatment of children, assessment of competence in relation to adult patients and the guardianship laws, and consent requirements in emergencies.

Minimisation activities will concentrate on the following.

- Review of the *incident monitoring program* – to evaluate any 'hidden' exposure to legal risk; review of the incident reporting system to identify 'legal vulnerability cases' (where patient suffers some harm) and establishment of follow-up procedures, and effective guidelines for insurer reporting and management.
- Consolidating existing *complaints response* to establish structured proactive procedures for managing and tracking complaints and legal actions/ approaches from lawyers, and indexing and monitoring costs and progress of complaints and legal cases. Effective complaints handling policies involve timely follow-up by senior management with the patient, devolution of initial responsibility to staff looking after the patient, and openness and willingness to meet patient needs.

  Poor handling of complaints can leave a dissatisfied customer, inclined to litigation. In one participating hospital several years ago, an elderly man in poor health fell off an X-ray table and was sufficiently injured to require a further two weeks in hospital. His subsequent failure to get minimal satisfaction, even in terms of a reasonable explanation and apology or waiver of his hospital expenses for the extra two weeks, let alone a compensation offer, led him to sue. It took several months to settle the claim, and he will never return to that hospital for his health care.

  Successful complaints handling depends, firstly, on effective procedures to ensure that such complaints are identified and, secondly, on insurer cooperation.
- Monitoring of *patient satisfaction* through surveys and so on. A satisfied patient, with a personal relationship with their health carer, is less likely to sue than an unsatisfied customer.
- Development of proactive policies for *legal case management and incident and complaint follow-up* with patients.

Conclusion

The development of legal risk management as a structured focus within hospital management is long overdue in Australia. As a result of this research, and based upon many years of experience in this field, the researcher is aware that progress is being made as health care grapples with rapidly changing consumer expectations and legal environments. However, there is still a long way to go. The industry as a whole is only just becoming aware of the need for specific attention to systemic proactive planning in legal risk management but, as yet, in the Australian context there are few signposts to follow. This paper sets out some models and approaches which will hopefully be of assistance in this regard.

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