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Operationalizing Deterrence: Claims Management (In Hospitals, a Large Retailer, and Jails and Prisons)

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Operationalizing Deterrence: Claims Management (In Hospitals, a Large Retailer, and Jails and Prisons)*

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Abstract

The theory that the prospect of liability for damages deters risky behavior has been developed in countless articles and books. The literature is far sparser, however, on how deterrence is operationalized. And prior work slights an equally important effect of damage actions, to incentivize claims management in addition to harm-reduction responses that are cost- rather than liability-minimizing. This article works in the intersection of these two understudied areas, focusing on claims management steps taken by frequently sued organizations, and opening a window into the black box of deterrence to see how those steps may end up serving harm-reduction purposes as well. To summarize, I observe that damage actions regulate risky enterprise by inducing organizations to develop claims management capabilities—that is, the capacity to process any resulting disputes. I then argue that these claims management practices and personnel are sometimes used, secondarily but importantly, to improve safety, reduce risk, and increase compliance with external legal requirements. Organizations’ internal claims management operations can, though they need not, facilitate care-taking in four important ways: (a) promoting the gathering and analysis of claims information; (b) requiring the hiring of specialized personnel with a mission to reduce claim payouts; (c) encouraging bureaucratized procedures that may be harm-reducing, and (d) increasing the salience of claims to various actors within the organization. I discuss the theory underlying these four points, drawing on organizational economics and sociology, as well as on psychology and behavioral law and economics. Then I discuss these four channels of influence in particular factual settings which serve as case studies, looking at a single large retailer, and then more generally at hospitals and hospital doctors, and jails and prisons. Because organizational theory tells us that this kind of transformation or repurposing is quite ordinary, the preliminary evidence I canvass suggests that claims management should be included in any study of how damage action deterrence is operationalized within large risk-creating organizations.

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This article thus makes two chief scholarly contributions. It proposes and theorizes concrete operational paths by which damage actions may elicit organizational compliance with external norms. And it describes in-house claims management, a heretofore underobserved arena in which law influences organizational activity. In the conclusion, I propose that who performs claims management functions may matter, as well, and suggest that in future research, claims management should be considered along with liability and loss prevention as the trio of liability-related operational areas in which firms must implement a “make-or-buy” decision.

INTRODUCTION

For several decades, scholars and policymakers have emphasized the regulatory function served by claims and lawsuits seeking damages, focusing on the incentive effects these damage actions create. The foundational insight is that our ex post damages system translates into ex ante care because the prospect of civil liability encourages organizations engaging in risky activities to minimize the justiciable harm they cause.¹ This deterrence theory, offered in support of both negligence and strict liability regimes, has been developed in countless articles and books. The literature is far sparser, however, on how deterrence is operationalized. And prior work slights an equally important effect of damage actions, to incentivize claims management in addition to harm-reduction responses to litigation—that is, responses that are *cost-* rather than *liability-*minimizing. This article works in the intersection of these two understudied areas, focusing on claims management steps taken by frequently sued organizations, and opening a window into the black box of deterrence to see how those steps may end up serving harm-reduction purposes as well.

To summarize, I observe that damage actions regulate risky enterprise by inducing organizations to develop claims management capabilities—that is, the capacity to process any resulting disputes. I then argue that these claims management practices and personnel are sometimes used, secondarily but importantly, to improve safety, reduce risk, and increase compliance with external legal requirements. Organizations' internal claims management operations can, though they need not, facilitate care-taking in four important ways: (a) promoting the gathering and analysis of claims information; (b) requiring the hiring of specialized personnel with a mission to reduce claim payouts; (c) encouraging bureaucratized procedures that may be harm-reducing, and (d) increasing the salience of claims to various actors within the organization. I first discuss the theory underlying these four points, drawing on organizational economics and

¹ Liability minimization is, of course, weighted against accident-prevention costs. For canonical statements of this now commonplace approach, *see, e.g.*, GUIDO CALABRESI, *THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS* 26 (1970) (“I take it as axiomatic that the principal function of accident law is to reduce the sum of the costs of accidents and the costs of avoiding accidents.”); Richard Posner, *A Theory of Negligence*, 1 *J. LEGAL STUD.* 29, 33 (1972) (“If . . . the benefits in accident avoidance exceed the costs of prevention, society is better off if those costs are incurred and the accident averted, and so in this case the enterprise is made liable, in the expectation that self-interest will lead it to adopt the precautions in order to avoid a greater cost in tort judgments.”). For much older theorizing along these lines, *see, e.g.*, *Powell v. Fall*, 5 Q.B. 597 (1880) (Bramwell, L.J.) (“It is just and reasonable that if a person uses a dangerous machine, he should pay for the damage which it occasions; if the reward which he gains for the use of the machine will not pay for the damage, it is mischievous to the public and ought to be suppressed.”); *United States v. Carroll Towing Co.*, 159 F.2d 169, 171-73 (2d Cir. 1947).

sociology, as well as on psychology and behavioral law and economics. Then I discuss these four channels of influence in three particular factual settings which serve as case studies, looking at a single large retailer, and then more generally at hospitals and hospital doctors, and jails and prisons. Because organizational theory tells us that this kind of transformation or repurposing is quite ordinary, the preliminary evidence I canvass suggests that claims management should be included in any study of how damage action deterrence is operationalized within large risk-creating organizations.

This article thus makes two chief scholarly contributions. It proposes and theorizes concrete operational paths by which damage actions may elicit organizational compliance with external norms. And it describes in-house claims management, a heretofore underobserved arena in which law influences organizational activity. In the conclusion, I propose that *who* performs claims management functions may matter, as well, and suggest that in future research, claims management should be considered along with liability and loss prevention as the trio of liability-related operational areas in which firms must implement a “make-or-buy” decision.²

I. PRIOR LITERATURE

Deterrence and regulatory insurance. A great deal of the abundant scholarship on deterrence assumes that the translation from law to action is fairly straightforward, at least for individuals and profit-maximizing organizations. Even government actors, long thought to maximize something other than profits,³ have been found to respond to damage action incentives.⁴ Of course, transactions costs, agency costs, and information costs interfere with perfect implementation of the incentivized conduct,⁵ and both individual, firm, and governmental

² See R.H. Coase, *The Nature of the Firm*, 4 *ECONOMICA* (n.s.) 386, 393-94 (1937), reprinted in R.H. COASE, *THE FIRM, THE MARKET, AND THE LAW* 33 (1988); OLIVER E. WILLIAMSON, *THE ECONOMIC INSTITUTIONS OF CAPITALISM: FIRMS, MARKETS, RELATIONAL CONTRACTING* (1985).

³ See, e.g., WILLIAM A. NISKANEN, JR., *BUREAUCRACY AND REPRESENTATIVE GOVERNMENT* 36-42 (1971) (arguing that government bureaucrats are most interested in maximizing budgets).

⁴ On government response to suits for damages, see, e.g., PETER H. SCHUCK, *SUING GOVERNMENT: CITIZEN REMEDIES FOR OFFICIAL WRONGS* (1983); Charles Epp, *Exploring the Costs of Administrative Legalization: City Expenditures on Legal Services, 1960-1995*, 34 *LAW & SOC'Y REV.* 407 (2000); Daryl Levinson, *Making Government Pay: Markets, Politics, and the Allocation of Constitutional Costs*, 67 *U. CHI. L. REV.* 345 (2000); Margo Schlanger, *Inmate Litigation*, 116 *HARV. L. REV.* 1555, 1664-90 (2003).

⁵ For foundational work on transactions costs, see Oliver E. Williamson, *Transaction-Cost Economics: The Governance of Contractual Relations*, 22 *J.L. & ECON.* 233 (1979); see also *THE ECONOMICS OF TRANSACTION COSTS* (Oliver E. Williamson & Scott E. Masten eds., 1999). On agency costs, see Michael C. Jensen & William H. Meckling, *Theory of the Firm: Managerial Behavior, Agency Costs and Ownership Structure*, 3 *J. FINAN. ECON.* 305 (1976); MICHAEL C.

compliance with external regulation are subject to error and distraction. Various social norms may undermine or augment the deterrent signal.⁶ Moreover, the litigation setting, with its complex procedures and rules of proof and justiciability, may warp the deterrent message sent by the liability and damages rules.⁷ And finally, liability insurance may pose a threat to deterrence by dampening damage actions' regulatory signal; this is the familiar story of moral hazard.⁸ (Other analysts agree that liability insurance is problematic for deterrence, but focus on the way in which liability insurance blurs, if not softens, the deterrent message, because insurers are forced to predict risk using actuarial groupings⁹ rather than

JENSEN, FOUNDATIONS OF ORGANIZATIONAL STRATEGY (1998). On information costs, see George J. Stigler, *The Economics of Information*, 69 J. POL. ECON. 213 (1961); Armen A. Alchian & Harold Demsetz, *Production, Information Costs, and Economic Organization*, 62 AM. ECON. REV. 777 (1972); KENNETH J. ARROW, THE LIMITS OF ORGANIZATION 33-59 (1974); Joseph E. Stiglitz, *The Contributions of the Economics of Information to Twentieth Century Economics*, 115 Q.J. ECON. 1441 (2000). More generally, on the limits on organizational capacity to optimize complex choices, see JAMES G. MARCH & HERBERT A. SIMON, ORGANIZATIONS (1958), and on the relationship these various factors have with the choice to conduct a particular activity within or without the firm's boundaries, see Coase, *Nature of the Firm*, *supra* note 2.

⁶ For a summary of the law and economics work on social norms, see Richard H. McAdams & Eric B. Rasmusen, *Norms and the Law*, in 2 HANDBOOK OF LAW AND ECONOMICS 1573 (A. Mitchell Polinsky & Steven Shavell eds., 2007); for a summary of the psychological literature relating to norms and compliance and its resistance to rational actor expectations, see Robert B. Cialdini & Melanie R. Trost, *Social Influence, Social Norms, Conformity, and Compliance*, in 2 HANDBOOK OF SOCIAL PSYCHOLOGY 151 (Daniel T. Gilbert, Susan T. Fiske & Gardner Lindzey eds., 4th ed. 1998).

⁷ See, e.g., Margo Schlanger, *Second Best Damage Action Deterrence*, 55 DEPAUL L. REV. 517 (2006) (arguing that damage actions can induce potential defendants to favor more cognizable or demonstrable care, and less cognizable or demonstrable harm—behavioral changes in the type rather than amount of care defendants take, or the type rather than amount of harm they inflict that do nothing to shift the probability or severity of accidents but rather limit expected liability by lowering the probability of claims or the expected amount of damages).

⁸ A long list of sources making this argument is cited by Gary T. Schwartz, *The Ethics and the Economics of Tort Liability Insurance*, 75 CORN. L. REV. 312, 312. For discussions of the moral hazard argument and the sociology of insurance, see, e.g., CAROL A. HEIMER, REACTIVE RISK AND RATIONAL ACTION: MANAGING MORAL HAZARD IN INSURANCE CONTRACTS (1985); Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237 (1996). On the economics of insurance and accident prevention, see, e.g., Steven Shavell, *On Liability and Insurance*, 13 BELL J. ECON. 120 (1982) (setting out parameters for interaction between insurance and efficient accident prevention); WILLIAM M. LANDES & RICHARD A. POSNER, THE ECONOMIC STRUCTURE OF TORT LAW 13 (1987) (conceding that liability insurance “does reduce deterrence,” though not inefficiently); Schwartz, *supra*, at 336-59.

⁹ See, e.g., CALABRESI, COSTS OF ACCIDENTS, *supra* note 1, at 241 (“Since individuals are allowed to insure against responsibility, however, the deterrence pressure resulting from the allocation of costs affects the actuarial groups to which the party held responsible belongs. . . . This characteristic gives rise to some of the most significant criticisms of the system.”); see also *id.* at 248-49.

experience rating or feature rating.¹⁰) But all these caveats operate only at the edges of the main point, which is that to some degree at least, damage actions function to price and internalize to risk-creating organizations many harms—caused by negligence, statutory noncompliance, or constitutional violations—that would otherwise remain externalities.

In most of the work on deterrence, however, the precise ways in which the liability signal is processed and its incentives made salient or even relevant to actors within the affected organizations is undertheorized. There are, of course, exceptions. The social norms scholarship already referenced illuminates the social psychology of communities of risk-takers and risk-imposers. More sociologically, a growing “self-governance” literature looks at the ways in which organizations adapt to law’s requirements—some scholars focusing on the ways in which organizations domesticate or even subvert those requirements,¹¹ others highlighting self-regulation’s positive potential for more effective and efficient care-taking.¹² I draw on some of this work below. Most relevant here, given the comprehensive interdependence of damage actions and insurance,¹³ a number of scholars examine how liability insurance, far from undermining risk reduction, instead augments it.¹⁴ This “regulatory insurance” literature identifies three ways in which this augmentation takes place, each facing moral hazard as a constraint and a challenge. First, where insurance is compulsory, it tends to price very risky (or broke and therefore less deterable¹⁵) actors out of the activity in question.¹⁶ In

¹⁰ See KENNETH S. ABRAHAM, *DISTRIBUTING RISK: INSURANCE, LEGAL THEORY, AND PUBLIC POLICY* 46 (1986) (discussing experience rating and feature rating as necessary for optimal deterrence of insured entities).

¹¹ See, e.g., the work of Lauren Edelman and coauthors, discussed *infra* at text accompanying notes 62-74.

¹² For a discussion of this body of work, see, e.g., Orly Lobel, *The Renew Deal: The Fall of Regulation and the Rise of Governance in Contemporary Legal Thought*, 89 MINN. L. REV. 342 (2004).

¹³ See, e.g., Kent D. Syverud, *On the Demand for Liability Insurance*, 72 TEX. L. REV. 1629, 1640 (1994) (“[Some observers] place liability insurance at the periphery of tort litigation—they view insurance as distinct, incidental, and largely reactive to developments in the courts. This view is wrong.”).

¹⁴ See, e.g., Deborah Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, in *EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY* 52 (Tom Baker & Jonathan Simon eds., 2002); Richard Ericson, Dean Barry, & Aaron Doyle, *The Moral Hazards of Neo-Liberalism: Lessons from the Private Insurance Industry*, 29 J. ECON. & SOC’Y 532, 532-58 (2000). Tom Baker, *Insuring Morality*, 29 J. ECON. & SOC’Y 559, 559-77 (2000). Of course, this effect is in addition to what is usually considered the most important function of insurance, spreading risk over time and over population.

¹⁵ See, e.g., Steven Shavell, *The Judgment Proof Problem*, 6 INT’L REV. L. & ECON. 45 (1986); Stephen G. Gilles, *The Judgment-Proof Society*, 63 WASH. & LEE L. REV. 603 (2006).

¹⁶ See Steven Shavell, *Minimum Asset Requirements and Compulsory Liability Insurance as Solutions to the Judgment-Proof Problem*, 36 RAND J. ECON. 63 (2005) (arguing that this effect

addition, insurers can use experience rating to reimpose accident costs on insureds, at least in settings in which policyholders need insurance after as well as before they incur a loss.¹⁷ And finally, having gained insight into accident prevention by sustained research¹⁸ and by analysis of claims,¹⁹ insurers can use various substantive contract terms related to prerequisites, pricing, and monitoring, as well as other less formal methods, to induce policyholders to engage in more effective harm reduction.²⁰ “Fire insurers might, for example, refuse to give coverage to businesses without sprinkler systems and fire drills,”²¹ or “[i]nsurance experts teach insureds the habits of prevention, for example, providing them with regimes of preventive health care and of preventive security for their property.”²²

As Ken Abraham has summarized this last point, “[w]hen insurers are in fact strategically positioned to be the cheapest cost avoiders, they will have to emphasize preinsurance inspections, periodic regulatory compliance audits, subjective evaluation of the applicant’s operations, and continuing involvement in risk management.”²³ Essentially, Abraham is describing insurance as a system by which firms outsource harm prevention information gathering—when, for example, insurers, with their larger risk bases, are better suited than policyholders

occurs, though it may sometimes be undesirable). Some observers suggest that compulsory car insurance tends to make the uninsured drive *less*, rather than not at all. See Alma Cohen & Rajeev Dehejia, *The Effect of Automobile Insurance and Accident Liability Laws on Traffic Fatalities*, 47 J.L. & ECON. 357 (2004).

¹⁷ See, e.g., HEIMER, REACTIVE RISK, *supra* note 8, at 42.

¹⁸ See, e.g., ABRAHAM, DISTRIBUTING RISK, *supra* note 10, at 16; Schwartz, *Ethics and Economics of Insurance*, *supra* note 8, at 356; NATIONAL BOARD OF FIRE UNDERWRITERS, PIONEERS OF PROGRESS: 1866-1941 (1941); JOHN BAINBRIDGE, BIOGRAPHY OF AN IDEA: THE STORY OF MUTUAL FIRE AND CASUALTY INSURANCE (1952).

¹⁹ See, e.g., George M. Cohen, *Legal Malpractice Insurance and Loss Prevention: A Comparative Analysis of Economic Institutions*, 4 CONN. INS. L.J. 305, 325 (1997); Schwartz, *Ethics and Economics of Insurance*, *supra* note 8, at 356.

²⁰ Accounts of this harm-reduction component of insurance operations include: ABRAHAM, DISTRIBUTING RISK, *supra* note 10, at 59-60; Cohen, *Legal Malpractice Insurance and Loss Prevention*, *supra* note 19; RICHARD V. ERICSON, AARON DOYLE, & DEAN BARRY, INSURANCE AS GOVERNANCE (2003); HEIMER, REACTIVE RISK, *supra* note 8; Carol Heimer, *Insuring More, Ensuring Less: The Costs and Benefits of Private Regulation Through Insurance*, in EMBRACING RISK, *supra* note 14, at 116; Harris Schlesinger & Emilio Venezian, *Insurance Markets with Loss-Prevention Activity: Profits, Market Structure, and Consumer Welfare*, 17 RAND J. ECON. 227 (1986). Schlesinger and Venezian make the important point that different insurance lines tend to be more or less focused on loss prevention. See *id.* at 228-29. For an account of safety-regulation and selection in the earliest days of the American insurance industry, see BAINBRIDGE, BIOGRAPHY OF AN IDEA, *supra* note 18.

²¹ HEIMER, REACTIVE RISK, *supra* note 8, at 13; see also BAINBRIDGE, BIOGRAPHY OF AN IDEA, *supra* note 18.

²² ERICSON ET AL., INSURANCE AS GOVERNANCE, *supra* note 20, at 54.

²³ ABRAHAM, DISTRIBUTING RISK, *supra* note 10, at 59.

to research cost-effective methods of reducing harm.²⁴ Others put the point more sociologically, emphasizing that policyholding firms' attitudes about risk and its reduction are far from rigid, as insurance companies work to refashion their customers' culture and priorities. For example, Carol Heimer acknowledges that "the insurer will engage in strategic interaction to alter the incentive structure of the policyholder to make it resemble that of the insurer (or of the 'prudent uninsured owner'),"²⁵ but she emphasizes, as well, that "[i]nsurers recognize that if one is to exert control over agents this is usually not so much a matter of providing incentives for individual action as it is a matter of developing organizational routines and standard operating procedures."²⁶

Whether regulatory insurance scholarship describes firms that have outsourced to their insurers the task of risk and care analysis, or insurers who work to transform both the capabilities and attitudes of policyholders, the point is that it has traced one important way in which damage action incentives are operationalized. When insurers are the bearers of liability risk, they often institute practices to induce care-taking and corresponding harm reduction, managing moral hazard and reducing harm by compelling (by contract), incentivizing, advising, or persuading their customers to undertake various harm-reduction methods.

Claims management. For deterrence scholars, how firms manage claims against themselves, working to respond efficiently and effectively, is an afterthought. Even for regulatory insurance theorists, claims processing is far from central; the harm-reducing impact of claims management practices has not previously received sustained analysis. That is not to say that claims management itself is unknown to observers as a necessary function for organizations whose activities provoke claims. Some (though not many) scholars have looked at claims management for its own sake, not as a part of the deterrent system. Most

²⁴ Gary Schwartz approached the issue similarly, describing "loss control services that liability insurers might be able to provide their insureds." Schwartz, *supra* note 8, at 356.

²⁵ HEIMER, REACTIVE RISK, *supra* note 8, at 9; *see also id.* at 42 ("[S]ometimes insurers collect a great deal of information about how to prevent losses, then agree to reclassify policyholders into new categories with lower rates if they will make the appropriate modifications; sometimes, when a factor makes a big difference in loss experience, the renewal of the insurance policy at the current rate is made contingent on the policyholder making appropriate changes; sometimes insurers charge policyholders a rate appropriate to their rate classification but agree to return part of the premium if policyholders avoid losses (by whatever means)."); ERICSON ET AL., INSURANCE AS GOVERNANCE, *supra* note 20, at 88.

²⁶ HEIMER, REACTIVE RISK, *supra* note 8, at 24; *see also, e.g.*, ERICSON ET AL., INSURANCE AS GOVERNANCE, *supra* note 20, at 88 ("A key aspect of surveillance systems for governing moral risk at a distance is to make the insured self-governing. The ideal is to make each policyholder a watcher as well as watched and a bearer of her own control. Self-governance is accomplished through a number of interconnected mechanisms of creating individual responsibility for risk control.").

famously, H. Laurence Ross's classic book, *Settled Out of Court*,²⁷ published in 1970, investigated insurance "claims men" and claims processes, and argued that insurance claims management practices worked more to encourage speedy claims resolution than low payouts. (In this book, at least, Ross was thoroughly uninterested in deterrence, which he suggested was something of a fool's hope, because, he believed, car accidents were typically caused by momentary and unavoidable lapses in attention.²⁸) Other studies of insurers and their social practices might also be included in this same category.²⁹ Likewise, there is a limited amount of work on the costs, risks, and benefits of outsourcing claims management, either with³⁰ or without³¹ bundled liability coverage. All this prior work on claims management is concerned with what are, indeed, its two major goals, from the perspective of damage action defendants—to minimize processing costs by making responding to claims more efficient; and to minimize payouts, chiefly by detecting and deterring fraud, defending against claims, and negotiating resolutions.³²

The interaction between claims management and deterrence has received much less attention. One point that prior work *has* noticed is that claims management costs money, and therefore contributes to the felt deterrent impact of claims made. Scholars interested in deterrence have accordingly included claims

²⁷ H. LAURENCE ROSS, *SETTLED OUT OF COURT: THE SOCIAL PROCESS OF INSURANCE CLAIMS ADJUSTMENT* (1970).

²⁸ Ross endorsed research that suggested that "run-of-the-mill accidents nearly all involve failure to see an approaching hazard and to predict its course accurately. However, in the context of these accidents such failure can rarely be considered faulty," *id.* at 251, and concluded, more generally, that "accidents are most likely not the result of deficient driving," *id.* at 253. In fact, at the time Ross was writing, between 10% and 20% of injurious traffic accidents and about half of traffic fatalities had alcohol as a factor. R.K. JONES & J.H. LACEY, *ALCOHOL AND HIGHWAY SAFETY 2001: A REVIEW OF THE STATE OF KNOWLEDGE* ch. 2 (U.S. Department of Transp. 2001), available at <http://www.nhtsa.dot.gov/people/injury/research/AlcoholHighway>. But Ross's book was written before the emergence of drunk driving as a salient social problem, in the early 1980s. (Ross himself did important work in this area, later. See H. LAURENCE ROSS, *DETECTING THE DRINKING DRIVER: LEGAL POLICY AND SOCIAL CONTROL* (1982); H. LAURENCE ROSS, *CONFRONTING DRUNK DRIVING: SOCIAL POLICY FOR SAVING LIVES* (1992).)

²⁹ See, e.g., sources cited *supra* note 20.

³⁰ Efficiency in claims handling has long been thought to be an impetus for corporate insurance purchases. David Mayers & Clifford W. Smith, Jr., *On the Corporate Demand for Insurance*, 55 J. BUSINESS 281 (1982).

³¹ On public outsourcing of claims administration, without insurance, see Peter C. Young & John Hood, *Risk and the Outsourcing of Risk Management Services: The Case of Claims Management*, PUB. BUDGETING & FIN., Fall 2003, at 109; John Hood & Peter C. Young, *The Risk Management Implications of Outsourcing Claims Management Services in Local Government*, RISK MGMT., July 2003, at 7.

³² See Mayers & Smith, *Corporate Demand for Insurance*, *supra* note 30, at 285; sources cited *supra* note 31.

management costs—for example, defendants’ own attorneys’ fees—as a component of the damage action deterrence apparatus.³³ In addition, observers have occasionally pointed out that claims management expenditures may function as a *substitute* for harm-reducing investment; a profit-maximizing organization is likely to spend money on aggressive defense or anti-fraud measures, for example, until the marginal return on such expenditures is less than the return on accident-prevention measures.³⁴

This article analyzes a different dynamic relationship between claims management and accident prevention. I suggest that claims management practices, at least in some organizations under some circumstances, produce an important secondary effect of enabling and encouraging a variety of harm-prevention or accident-avoidance measures. By secondary, I mean to describe these effects as non-motivating—not the *reason* for the activity, but rather its predictable and desirable byproducts. Nonetheless, I argue, to understand damage actions’ regulation of care or risk requires understanding this aspect of litigation response. In Part II, I discuss the theory—economic, sociological, and psychological—bolstering my observations regarding claims management. In Part III, I describe in more detail the ways in which claims management induces care-taking in three factual settings which serve as case studies—a large “big box” retailer, hospitals and hospital doctors, and jails and prisons. The case studies vary somewhat in method—the first looks at a single example and is based mostly on one in-depth interview; the second is more grounded in secondary sources along with interviews; the third is based on interviews, secondary sources, and my own observations. I do not offer the case studies to provide rigorous proof of the theory; they function rather as its source, having helped to generate the hypotheses whose theoretical plausibility is sketched out in Part II.³⁵ Part IV concludes the customary promise of/plea for future research that will test these hypotheses and will expand the analysis from the *what* of claim management to *who*, considering together all of the litigation-related “make-or-buy” decisions—liability, loss-prevention, and claims management.

³³ See, e.g., A. Mitchell Polinsky & Yeon-Koo Che, *Decoupling Liability: Optimal Incentives for Care and Litigation*, 22 RAND J. ECON. 562, 564 (1991).

³⁴ See Cohen, *Legal Malpractice Insurance and Loss Prevention*, *supra* note 19, at 315-17 (1997); Terry Thomason & Silvana Pozzebon, *Determinants of Firm Workplace Health and Safety and Claims Management Practices*, 55 INDUS. & LAB. REL. REV. 286 (2002).

³⁵ On the use of qualitative case studies, see, e.g., ALEXANDER L. GEORGE & ANDREW BENNETT, *CASE STUDIES AND THEORY DEVELOPMENT IN THE SOCIAL SCIENCES* (2005).

II. CLAIMS MANAGEMENT AND OPERATIONALIZING DETERRENCE

Damage action filings induce organizations to develop claims management abilities—that is, the capacity to process any resulting disputes, *ex post*. This capacity imposes both processing costs, including paying for whatever personnel is involved (accountants, lawyers, paralegals, investigators, customer service staff, operational staff as needed, etc.), and payout costs (for both settlements and litigated judgments, and including fraudulent as well as legitimately owed payments).³⁶ The goal of claims management activity is to minimize the sum of the costs of processing and payout. But a possible, though not necessary, byproduct can be harm-reduction measures. In particular, organizations' internal claims management operations can, though they need not, promote care-taking in four important ways: (a) by promoting the gathering and analysis of claims information; (b) by requiring the hiring of specialized personnel with a mission to reduce claim payouts; (c) by encouraging bureaucratized procedures that are harm-reducing, and (d) by increasing the salience of claims to various actors within the organization. In this Part, I discuss the organizational theory—economic, sociological, and psychological—underlying each of the four channels of influence just listed.

If organizations were perfectly informed and perfectly rational, this project would be very different. Under perfect information and rationality, no operative difference could exist between “primary” and “secondary” effects, between goals and desirable byproducts. All predictable effects would be anticipated, and included in any decisional calculus. Organizations could choose their goals and calibrate precisely how much to invest towards them based on full information not only about primary but also secondary costs and benefits. But of course even for individuals, perfect information is impossible, both cognitively³⁷ and economically.³⁸ And organizations, while they can improve on individual decisionmaking in many respects,³⁹ also face large obstacles in harnessing

³⁶ This is all fairly straightforward, except for the complexities created by the prevalence of fraud in some claims situations. See, e.g., Keith J. Crocker & Sharon Tennyson, *Insurance Fraud and Optimal Claims Settlement Strategies*, 45 J. L. & ECON. 469 (2002); Sharon Tennyson & Pau Salsas-Forn, *Claims Auditing in Automobile Insurance: Fraud Detection and Deterrence Objectives*, 69 J. RISK & INS. 289 (2002); David S. Loughran, *Deterring Fraud: The Role of General Damage Awards in Automobile Insurance Settlements*, 72 J. RISK & INS. 551 (2005).

³⁷ For a summary of work on the limited cognitive capacity of human decisionmakers, and how that limited capacity affects the rational choice model of human behavior, see Russell B. Korobkin & Thomas S. Ulen, *Law and Behavioral Science: Removing the Rationality Assumption from Law and Economics*, 88 CAL. L. REV. 1051, 1075-1126 (2000).

³⁸ See sources cited on information costs, *supra* note 5.

³⁹ See MAX WEBER, *THE THEORY OF SOCIAL AND ECONOMIC ORGANIZATION* (1947); ARROW, *LIMITS OF ORGANIZATION*, *supra* note 5; PAUL MILGROM & JOHN ROBERTS, *ECONOMICS, ORGANIZATION AND MANAGEMENT* (1992). For a summary of additional literature that

individual initiative and activity towards the collective goals, even if those goals are properly chosen.⁴⁰ There is, moreover, substantial evidence that organizational decisionmaking frequently does not follow such an anthropomorphic path—that more useful than analyzing the organization’s “goals” may be examination of its structures, including personnel, capacities, routines, and standard operating procedures.⁴¹ The four channels of influence whose description follows operate in those areas of organizational structure.

A. Information

The case studies in Part III suggest that firms collect a great deal of information in order to manage claims made against them. The case studies include more specifics, but to cite one example, organizations collect statements of employee witnesses to harmful incidents, in order to use those statements to assess and contest liability. It is my contention that this information, once collected, may end up being used, as well, to design interventions for harm prevention or reduction.

If information or its processing and use were cost-free for organizations, this suggestion would be insupportable. Any information useful for harm prevention would of course be collected—without cost—for that very purpose. But of course information and its use are far from free⁴²; as with other factors of production and management, accumulating and using information requires capital and non-capital investment, in technology, personnel, training, and materials. The result is bounded rather than perfect rationality in decisionmaking. (As economist Roy

demonstrates ways in which “[c]oordinating tasks through formally rational structures permits firms to augment, rather than just aggregate, the capacities of the individual,” see Kenneth A. Bamberger, *Regulation as Delegation: Private Firms, Decisionmaking, and Accountability in The Administrative State*, 56 DUKE L.J. 377, 409-13 (2006).

⁴⁰ See Bamberger, *Regulation as Delegation*, *supra* note 39, at 417-34 and sources cited; see also sources cited *supra* note 5.

⁴¹ Cf. *supra* text accompanying note 26. There is, of course, a very large literature on organizational behavior; I have benefited from discussions of that literature and its relation to legal compliance in Jeb Barnes & Thomas F. Burke, *The Diffusion of Rights: From Law on the Books to Organizational Rights Practices*, 40 LAW & SOC’Y REV. 493 (2006), and Bamberger, *Regulation as Delegation*, *supra* note 39, at 414-16. For some key contributions and reviews, see PHILIP SELZNICK, *LEADERSHIP IN ADMINISTRATION* (1957); MARCH & SIMON, *ORGANIZATIONS*, *supra* note 5; RICHARD M. CYERT & JAMES G. MARCH, *A BEHAVIORAL THEORY OF THE FIRM* (1992) (1963) (especially relevant here is *id.* at 120-34 (on standard operating procedures)); Paul J. DiMaggio & Walter W. Powell, *The Iron Cage Revisited: Institutional Isomorphism and Collective Rationality in Organizational Fields*, 48 AM. SOC. REV. 147 (1983) (examining structures within organizations); Markus C. Becker, *Organizational Routines: A Review of the Literature*, 13 INDUS & CORP. CHANGE 643 (2004).

⁴² See sources cited *supra* note 5.

Radner has written, “[t]o study seriously the economics of managing, one must face squarely the boundedness of rationality of economic decision makers. This phenomenon has long been recognized by theorists, if rarely acted upon.”⁴³) Given high information costs, it may be that claims information is insufficiently useful in harm prevention to justify its costly collection for that purpose alone. Or perhaps this informational investment does not occur because the potential uses of claims information for harm prevention are non-obvious to organizational decisionmakers, or because those uses are too uncertain. Once claims management needs for information are added into the mix, however, the case studies suggest that the economic or sociological calculus sometimes changes.

JoAnne Yates has written a fascinating account that highlights, in the context of American manufacturing firms between 1850 and 1920, the ways in which intra-firm supply of and demand for information may shift.⁴⁴ She points out that investments in information gathering, processing, and dissemination “are shaped by many organizational and technological factors, as are their consequences.” These “[i]nvestment decisions interact with issues of information needs, ideology, and organizational power. As each element of an organization’s information system is established, it becomes entrenched locally by virtue of the human and nonhuman capital invested in it.” Both information investments and their abandonment are, accordingly, lumpy and sticky; firms cannot or at least do not “buy information in increments of any size . . . at the moment when its value exceeds its theoretical cost,”⁴⁵ and they likewise do not abandon prior information investments without hesitation.

Foundational work by economist Kenneth Arrow⁴⁶ on organizational information acquisition similarly emphasized that information comes into

⁴³ Roy Radner, *Hierarchy: The Economics of Managing*, 30 J. ECON. LIT. 1382, 1389 (1992).

⁴⁴ Joanne Yates, *Investing in Information: Supply and Demand Forces in the Use of Information in American Firms, 1850-1920*, in *INSIDE THE BUSINESS ENTERPRISE: HISTORICAL PERSPECTIVES ON THE USE OF INFORMATION* (Peter Temin ed., 1991); see also JOANNE YATES, *CONTROL THROUGH COMMUNICATION: THE RISE OF SYSTEM IN AMERICAN MANAGEMENT* (1989). For other economic historical accounts of the ways in which information within firms affects operations, see, e.g., *INSIDE THE BUSINESS ENTERPRISE*, *supra*.

⁴⁵ YATES, *Investing in Information*, *supra* note 44, at 152.

⁴⁶ ARROW, *LIMITS OF ORGANIZATION*, *supra* note 5. For more recent theoretical work on information flow within organizations, see, e.g., Patrick Bolton & Mathias Dewatripont, *The Firm as a Communication Network*, 109 Q. J. ECON. 809 (1994) (explaining how organizations can minimize costs of processing and communicating information by specialization, collaboration, and centralization); Wouter Dessein, *Authority and Communication in Organizations*, 69 REV. ECON. STUD. 811 (2002) (modeling delegation as an alternative to communication); Steven D. Levitt & Christopher M. Snyder, *Is No News Bad News? Information Transmission and the Role of “Early Warning” in the Principal-Agent Model*, 28 RAND J. ECON. 641 (1997) (analyzing optimal incentive contracts when an agent has information about the likelihood of the project’s success not available to the principal, except by the agent’s disclosure); Roy Radner, *The Organization of*

organizations by way of specific “structures” or “channels.”⁴⁷ In a discussion of information and its relation to pricing and risk-bearing, Arrow noted:

It follows that the information structure of individual economic agents powerfully conditions the possibilities of allocating risk-bearing through the market. . . . Thus the possibility of using the price system to allocate uncertainty, to insure against risks, is limited by the structure of the information channels in existence. Put the other way, the value of nonmarket decision-making, the desirability of creating organizations of a scope more limited than the market as a whole, is partially determined by the characteristics of the network of information flows.⁴⁸

The point, which Arrow did not limit to pricing and risk but rather made generally for any organizational use of information, is that information structures may well predate a firm’s calls upon those structures, and determine whether and how well those calls will be answered. As he said some pages later, “history matters.”⁴⁹ Yet, Arrow continued:

[T]he presence or absence of information channels is not prescribed exogenously to the economic system. Channels can be created or abandoned, and their capacities and the types of signals to be transmitted over them are subject to choice, a choice based on a comparison of benefits and costs.⁵⁰

Arrow proceeded to elaborate the costs of information gathering and decoding, and then made three different points relevant here. First, he noted, “the demand for investment in information is less than it would be if the value of the information were more certain.”⁵¹ Second and, Arrow surmised, likely most important, information investments are path-dependent. Or, as he put it, “random accidents of history will play a bigger role in the final equilibrium.”⁵² The reason is that “[o]nce the investment has been made and an information channel acquired, it will be cheaper to keep on using it than to invest in new channels.”⁵³ Third, the price or effort needed to develop new information structures or

Decentralized Information Processing, 61 *ECONOMETRICA* 1109 (1993); Timothy Van Zandt, *Real-Time Decentralized Information Processing as a Model of Organizations with Boundedly Rational Agents*, 66 *REV. ECON. STUD.* 633 (1999).

⁴⁷ ARROW, *LIMITS OF ORGANIZATION*, *supra* note 5, at 37.

⁴⁸ *Id.*

⁴⁹ *Id.* at 56.

⁵⁰ *Id.* at 37.

⁵¹ *Id.* at 41.

⁵² *Id.*

⁵³ *Id.* For more general discussions of the path-dependent results of firm activities, see Kenneth J. Arrow, *The Economic Implications of Learning by Doing*, 29 *REV. ECON. STUD.* 155 (1962); Alwyn Young, *Invention and Bounded Learning by Doing*, 101 *J. POL. ECON.* 443 (1993).

channels varies based on the organization's prior activities, both related to information and to production. In particular, Arrow suggested, expertise transfers better across small conceptual gaps than large ones: "Learning generalizes naturally and cheaply in some directions, with much greater difficulty in others."⁵⁴ Likewise, often information can be relatively cheap because of ongoing related productive activities: "There is a complementary between a productive activity and some kinds of information. An individual cannot help making observations while working at some task."⁵⁵

My suggestion that claims management can aid in care-taking by promoting the gathering and analysis of claims information, which information may then be used to monitor and improve harm prevention, harvests insights from both Yates' and Arrow's work. Organizations make investments in information gathering and processing for the purpose of efficient and effective processing of claims. That investment, once made, will tend to become somewhat entrenched. And it may well encompass personnel who have sufficient extra capacity to shift or expand their mission, if that is useful to them (a point I develop in the next section). Moreover, "an information channel used primarily for one purpose"—here, claims management—"may turn up a signal with implications for taking action in a hitherto passive area"⁵⁶—here, harm prevention. As Gary Schwartz put the point in the context of insurance, it makes sense that insurers sell loss prevention services bundled with claims management services; the result economizes on information costs, because "the insurer acquires its [loss-prevention] information in a natural low-cost way, as an incident to its normal activities of underwriting and claims evaluation."⁵⁷

B. Professional Personnel

The case studies below suggest that personnel assigned to claims management tasks sometimes take on the additional job of preventing harm or promoting legal compliance. This shift is not unexpected, in light of sociological findings about how professionals function within organizations.

Organizational sociologists suggest that law's impact on organizational practice is mediated by the content of the structures chosen by organizational participants. The relevant choices are in part rationally and instrumentally made. As Philip Selznick described in his early work, organizations are designed as

⁵⁴ ARROW, LIMITS OF ORGANIZATION, *supra* note 5, at 41-42; *see also* H.B. Malmgren, *Information, Expectations and the Theory of the Firm*, 75 Q. J. ECON. 399 (1961) (noting ways in which the costs of information acquisition may vary based on prior firm investments or activities).

⁵⁵ ARROW, LIMITS OF ORGANIZATION, *supra* note 5, at 42.

⁵⁶ *Id.* at 58.

⁵⁷ Schwartz, *Ethics and Economics of Insurance*, *supra* note 8, at 356.

“technical instrument[s] for mobilizing human energies and directing them toward set aims,” and “conceived as an exercise in engineering, . . . governed by the related ideals of rationality and discipline.”⁵⁸ But, Selznick continued, over time organizations become “institutionalized,” a process “reflecting the organization’s own distinctive history, the people who have been in it, the groups it embodies and the vested interests they have created, and the way it has adapted to its environment.”⁵⁹ As he defined it, “‘to institutionalize’ is to *infuse with value* beyond the technical requirements of the task at hand.”⁶⁰ The interaction of professionals of different stripes and their organizations, and the development of the relevant professional orientations towards claims and risk management, are a key site for inquiry into the what Selznick would call institutionalization. DiMaggio and Powell, for example, point to the role of professional training, career paths, and networks in molding organizational structures and routines, which they argue tend to evolve “isomorphically,” to resemble those in other similar firms.⁶¹ As described by Edelman, Fuller, and Mara-Drita: “Professionals carry ideas as they move among organizations, and through participation in professional networks: conferences, workshops, and the professional personnel literature all offer forums for the exposition and diffusion of new ideas within professions. . . . [C]ertain ideas, practices, routines, and scripts become institutionalized as the professions offer normative solutions to perceived managerial problem[s].”⁶²

The work of Lauren Edelman and her many coauthors is particularly enlightening on the topic of professional personnel and legal compliance.⁶³ As Edelman et al. summarize the findings of a long series of investigations into the

⁵⁸ SELZNICK, LEADERSHIP IN ADMINISTRATION, *supra* note 41, at 5.

⁵⁹ *Id.* at 16.

⁶⁰ *Id.* at 17 (emphasis in original); *see also, e.g.*, Stewart Macaulay, *Private Government*, in *LAW AND THE SOCIAL SCIENCES* 445 (Leon Lipson & Stanton Wheeler eds., 1986).

⁶¹ *See* DiMaggio & Powell, *The Iron Cage Revisited*, *supra* note 41, at 152-54.

⁶² *See* Lauren B. Edelman, Sally Riggs Fuller, & Iona Mara-Drita, *Diversity Rhetoric and the Managerialization of Law*, 106 AM. J. SOC. 1589, 1596 (2001).

⁶³ *Id.*; Lauren Edelman, *Legal Environments and Organizational Governance: The Expansion of Due Process in the American Workplace*, 95 AM. J. SOC’Y 1401 (1990); Lauren B. Edelman, Stephen Petterson, Elizabeth Chambliss & Howard S. Erlanger, *Legal Ambiguity and the Politics of Compliance: Affirmative Action Officers’ Dilemma*, 13 LAW & POL’Y 73 (1991); Lauren Edelman, *Legal Ambiguity and Symbolic Structures: Organizational Mediation of Civil Rights Law*, 97 AM. J. SOC’Y 1531 (1992); Lauren B. Edelman, Stephen E. Abraham & Howard S. Erlanger, *Professional Construction of Law: The Inflated Threat of Wrongful Discharge*, 26 LAW & SOC’Y REV. 47, 48-49 (1992); Lauren Edelman & Mark C. Suchman, *The Legal Environments of Organizations*, 23 ANNUAL REV. SOC’Y 479 (1997); Lauren B. Edelman & Mark C. Suchman, *When the “Haves” Hold Court: Speculations on the Organizational Internalization of Law*, 33 LAW & SOC’Y REV. 941, 963 (1999); Lauren Edelman et al., *The Endogeneity of Legal Regulation: Grievance Procedures as Rationalized Myth*, 105 AM. J. SOC’Y 406 (1999).

law governing and large organization personnel offices, those investigations support three important theoretical points. First, “legal ambiguity amplifies the opportunities for professionals to identify management problems and to propose new ideas to remedy those problems.”⁶⁴ Second, this mediation of law by professionals is consequential: “[I]deas about law and compliance that originate with the professions tend to become institutionalized in organizational fields and, over time, generate a diffusion of new organizational practices.”⁶⁵ And third, “[a]s law is communicated by and among professions, it is filtered through a variety of lenses, and colored by different professional backgrounds, training, and interests.”⁶⁶

Edelman’s work, and that of others, demonstrates several of the different results of professional filtering of the law’s message. For example, in some circumstances, “to inflate their own status within organizations and to expand the markets for their services, the professional [may] create[] the impression of a much greater threat than . . . doctrine actually pose[s],”⁶⁷ thus “amplify[ing] the threat of law.”⁶⁸ Alternatively (though it may look much the same), personnel assigned or hired to ensure compliance with legal norms may “tend to become internal advocates for the values that the practices symbolize.”⁶⁹ In still other circumstances, professionals within firms may “transform[] legal threats into nonlegal problems”⁷⁰ when “complaint handlers tend[] to recast discrimination complaints as managerial or interpersonal problems, thus deemphasizing the legal aspects of these claims.”⁷¹ In yet other settings, professionals may “construct[] the nature of the response rather than the legal threat itself,” promulgating the notion that “grievance procedures offer[] organizations substantial protection

⁶⁴ Edelman et al., *Diversity Rhetoric*, *supra* note 62, at 1596.

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ *Id.* at 1597.

⁶⁹ Edelman & Suchman, *When the “Haves” Hold Court*, *supra* note 63, at 941, 963. Serge Taylor points to a similar situation when environmental analysts are hired by government agencies, because they have the technical skills to produce environmental impact statements. He observes:

Environmental analysts . . . tend to have distinctive personal values. Being strongly committed to professional standards of “truth,” they want their agency to study and reveal all potentially significant environmental problems. Being strongly committed to environmental policy values, they often disagree with their organization’s decisions. For both reasons, they are potentially disloyal to their organization. And disloyalty can have can have significant political and legal consequences, by providing environmentalists on the outside with potent ammunition against their agency’s projects.

SERGE TAYLOR, MAKING BUREAUCRACIES THINK: THE ENVIRONMENTAL IMPACT STATEMENT STRATEGY OF ADMINISTRATIVE REFORM 6 (1984).

⁷⁰ Edelman et al., *Diversity Rhetoric*, *supra* note 62, at 1597.

⁷¹ *Id.* at 1596-97.

from discrimination lawsuits,” despite the dearth of evidence to support that claim.⁷² The organizational environments themselves may further mold the effect of professional orientation; my own prior work has pointed to the ways a context can influence professional conceptualization of legal compliance. I pointed out that in the oppositional milieu of jail and prison management, compliance personnel may need to “ensure that they are not too deeply identified with the inmates by their colleagues,” and may therefore “develop[] a finely honed derision for inmate complaints.”⁷³

What all these factually specific discussions have in common is that they support the theoretical point that while “[t]he precise impact of the professions varies,” “professionals tend to interject their own interests and training into how they understand law.”⁷⁴ Scholars in other disciplines and traditions agree: They, too, point out that different actors within organizations bring to bear different mind-sets.⁷⁵ The case studies below develop the ways in which professionals assigned to claims management tasks sometimes expand their mission to encompass, as well, harm prevention or legal compliance.

C. Bureaucracy: Written Records and Standard Operating Procedures

Two of the case studies (hospitals and prisons/jails) suggest that claims management needs promote the use of contemporaneous written records. Such records are useful for claim defense because compared to oral testimony they can be produced more easily and earlier in litigation, and are often more persuasive. In addition, the prison and jail case study in particular suggests that claims management priorities can push organizations to use standard operating procedures; these can help reduce liability because they can be characterized in court as rational and even expert and therefore worthy of deference, and because they provide circumstantial evidence of due care or compliance even when no defense witness has a specific recollection relating to the harm-causing event. Both of these organizational strategies, geared towards claims management, turn out to have potential for harm reduction, as well.

⁷² *Id.* at 1597.

⁷³ Schlanger, *Inmate Litigation*, *supra* note 4, at 1671.

⁷⁴ Edelman et al., *Diversity Rhetoric*, *supra* note 62, at 1597.

⁷⁵ See, e.g., W. Bernard Carlson, *The Coordination of Business Organization and Technological Innovation within the Firm: A Case Study of the Thomson-Houston Electric Company in the 1880s*, in COORDINATION AND INFORMATION: HISTORICAL PERSPECTIVES ON THE ORGANIZATION OF ENTERPRISE 55, 59 (Naomi R. Lamoreaux & Daniel M.G. Raff eds., 1995) (“I find it useful to think of the firm as a collection of interest groups, each with its own mind-set.”); *id.* at 60 (citing as a precursor SAMUEL B. BACHARACH & EDWARD J. LAWLER, *POWER AND POLITICS IN ORGANIZATIONS: THE SOCIAL PSYCHOLOGY OF CONFLICT, COALITIONS, AND BARGAINING* (1980)).

Note first that use of standard operating procedures and of written records are both core components of bureaucratization. Indeed, the core elements of bureaucracies, according to Weber, bureaucracy's great expositor, are: their dependence on rules and officially designated duties; their hierarchical organization, under which higher bureaus supervise lower ones; their adherence to principles of expertise and training, and, therefore, standardization of tasks along the lines developed by experts; and their use of written records.⁷⁶ It should be expected, then, that claims management should, in turn, at least sometimes drive bureaucratization.

How might standardization and written records prevent harm and encourage legal compliance? Standardization of operations, in particular, has familiar costs and benefits. Standard operating procedures tend to reduce line-level discretion, which can be extremely beneficial (to the task, if not the autonomy of the affected workers⁷⁷) if the task in question is one that can be done in what Frederic Winslow Taylor labeled the "one best way."⁷⁸ Thoughtful and informed standardization can promote decisionmaking and conduct that is more expert, more effective, less harmful.⁷⁹ Of course, in other, more complex or ambiguous, circumstances, line-level discretion can be more beneficial than standardization to the ultimate values sought to be implemented. It is well beyond the scope of this article to develop the circumstances in which discretion is better promoted or

⁷⁶ See, e.g., MAX WEBER, *THE THEORY OF SOCIAL AND ECONOMIC ORGANIZATION* 329-36 (A.M. Henderson & Talcott Parsons trans., The Free Press 1947) (1925). Weber thought these features key to the effectiveness of bureaucracy, which he famously described as "superior to any other form in precision, in stability, in the stringency of its discipline, and in its reliability. It thus makes possible a particularly high degree of calculability of results for the heads of the organization and for those acting in relation to it. It is finally superior both in intensive efficiency and in the scope of its operations." *Id.* See also GARY J. MILLER, *MANAGERIAL DILEMMAS: THE POLITICAL ECONOMY OF HIERARCHY* (1992). Miller agrees that hierarchical organizations can be extremely effective, but he argues that hierarchies succeed not because of their advantages with respect to incentives and supervision, but because hierarchy "can be a means for creating common knowledge and cooperative work norms." *Id.* at 217.

⁷⁷ For accounts sympathetic to the complaint of lost autonomy, see, e.g., Karl E. Klare, *The Labor-Management Cooperation Debate: A Workplace Democracy Perspective*, 23 HARV. C.R.-C.L. L. REV. 39 (1988); Marion Crain, *The Transformation of the Professional Workforce*, 79 CHI.-KENT L. REV. 543 (2004). For a discussion of autonomy as an obstacle to appropriate care-taking, because it interferes with more rational, standardized operations, see David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORN. L. REV. 893, 921, 952-56 (2005).

⁷⁸ See ROBERT KANIGEL, *THE ONE BEST WAY: FREDERICK WINSLOW TAYLOR AND THE ENIGMA OF EFFICIENCY* (1997); FREDERICK WINSLOW TAYLOR, *PRINCIPLES OF SCIENTIFIC MANAGEMENT* (1911).

⁷⁹ See, e.g., KENNETH CULP DAVIS, *POLICE DISCRETION* (1975); Brigitte M. Hales & Peter J. Pronovost, *The Checklist—A Tool for Error Management and Performance Improvement*, 21 J. CRITICAL CARE 231 (2006).

restrained,⁸⁰ suffice it to say that if claims management encourages organizations to develop and implement standard operating procedures—as the hospital and prison/jail case studies suggest that it does—there will be occasions in which that rein on discretion is helpful for harm prevention.

Likewise, when claims management imperatives support contemporaneous recordkeeping because of the usefulness of contemporaneous records in court, those records are sometimes also useful for harm prevention; contemporaneous records, first, enable closer review of line-level staff decisions by their hierarchical superiors, and second, themselves assist in beneficial standardization. The first point—that written records are more efficient than other methods in transferring information within large organizations⁸¹—may be more intuitive than the second. But the second point is equally clear. Generation of written records such as logs, reports, charts, and the like is regulatory as well as communicative, because the form in which the record is kept can structure job performance and decisionmaking, as with a checklist⁸² or a log with a space for observations once each specified period. Moreover, substantive reporting requirements of various kinds are well known to foster the report-makers' consideration of issues that might otherwise receive less notice.⁸³

⁸⁰ The literature attempting to do just that is large and very interesting. In law, it often concerns the debate between judicially enunciated rules and standards. *See, e.g.*, Duncan Kennedy, *Form and Substance in Private Law Adjudication*, 89 HARV. L. REV. 1685 (1976); Pierre Schlag, *Rules and Standards*, 33 UCLA L. REV. 379 (1985); Carol M. Rose, *Crystals and Mud in Property Law*, 40 STAN. L. REV. 577 (1988); Antonin Scalia, *The Rule of Law as a Law of Rules*, 56 U. CHI. L. REV. 1175 (1989); FREDERICK SCHAUER, *PLAYING BY THE RULES: A PHILOSOPHICAL EXAMINATION OF RULE-BASED DECISION-MAKING IN LAW AND IN LIFE* (1991); Louis Kaplow, *Rules versus Standards: An Economic Analysis*, 42 DUKE L.J. 557 (1992); Kathleen Sullivan, Foreword: *The Justices of Rules and Standards*, 106 HARV. L. REV. 22 (1992); Cass R. Sunstein, *Problems with Rules*, 83 CAL. L. REV. 953 (1995); Russell B. Korobkin, *Behavioral Analysis and Legal Form: Rules vs. Standards Revisited*, 79 OR. L. REV. 23 (2000); Steven M. Shavell, *Optimal Discretion in the Application of Rules*, 9 AM. L. & ECON. REV. 175 (2007).

⁸¹ JoAnne Yates' historical account of information technology from 1850 to 1920, discussed above, demonstrates this point well in its description of the importance of document copying technology to hierarchical control within large firms such as Sears and the Scovill Manufacturing Company. YATES, *Investing in Information*, *supra* note 44.

⁸² *See* MICHAEL SCRIVEN, *THE LOGIC AND METHODOLOGY OF CHECKLISTS* (2000, revised Dec. 2007), available at http://www.wmich.edu/evalctr/checklists/papers/logic&methodology_dec07.pdf; Hales & Pronovost, *The Checklist*, *supra* note 79.

⁸³ *See, e.g.*, TAYLOR, *MAKING BUREAUCRACIES THINK*, *supra* note 69; Bradley C. Karkkainen, *Information as Environmental Regulation: TRI and Performance Benchmarking, Precursor to a New Paradigm?*, 89 GEO. L.J. 257 (2001); *cf.* Bengt Holmstrom & Paul Milgrom, *Multitask Principal-Agent Analyses: Incentive Contracts, Asset Ownership, and Job Design*, 7 J.L. ECON. & ORG. 24, 33-38 (1991) (suggesting that easily measured tasks are preferred by multi-tasking agents, at least if their incentives are tied to performance).

D. Salience

Finally, various claims management techniques may remind organizational actors of both the possibility of mishap and the threat of litigation that might result. This reminder makes those possibilities more “available” or cognitively salient. As Amos Tversky and Daniel Kahneman have explained, “people assess the frequency of a class or the probability of an event by the ease with which instances or occurrences can be brought to mind.”⁸⁴ Because people tend to be overconfident about the threat to them of bad outcomes,⁸⁵ deterrence may depend on such countervailing availability.⁸⁶ This point is analytically simple, so its theory does not need much elaboration—but the hospital and prison case studies suggest it is no less important for its simplicity.

In short, organizational theory, sociology, economics, and psychology all suggest that certain strategies that organizations use, *ex post*, to respond efficiently and effectively to tort claims may also generate the byproduct of harm reduction and legal compliance. The next part examines claims management in three specific organizational settings, to put some meat on the theoretical bones just described.

III. CASE STUDIES

I chose three settings in which to investigate claims management by looking for two common features—frequent claiming and a significant degree of in-house processing—along with enough variation to surface a range of possible responses to claims management imperatives. Thus I picked organizations of different sizes, facing different liability environments and threats, operated by governments and private entities, profit-seeking and not. The case studies are the factual source rather than the proof of this article’s theory; they help with hypothesis generating rather than hypothesis testing.

Table 1 summarizes some important characteristics of the case study organizations.

⁸⁴ Amos Tversky & Daniel Kahneman, *Judgment under Uncertainty: Heuristics and Biases*, 185 SCIENCE 1124, 1127 (1974); *see also* Korobkin & Ulen, *Law and Behavioral Science*, *supra* note 37, at 1085-90 (citing additional studies on availability bias).

⁸⁵ Christine Jolls, *Behavioral Economics Analysis of Redistributive Legal Rules*, 51 VAND. L. REV. 1653, 1659 & n.22 (1998) (noting the existence of nearly two hundred studies demonstrating optimism bias).

⁸⁶ Eric A. Posner, *Probability Errors: Some Positive and Normative Implications for Tort and Contract Law*, 11 SUP. CT. ECON. REV. 125 (2004) (describing how excess optimism might undermine tort deterrence). Posner emphasizes, as well, that potential defendants’ mistakes with respect to the change in the probability of harm caused by their care may induce them to take too much care, but this point seems to me not pertinent here.

Table 1: Case study comparisons

Type of organization	Size of enterprise	Annual claims (N)	Annual lawsuits (subset of claims) (N)	Annual payouts	Ratio—Payouts: budget
Retailer: “Acme” Private, for-profit (2004)	\$6 billion in sales; \$100 million in net income	500	15	\$3 million	1: 2000
Large academic hospital Private, non-profit (2006)	~1000 staffed beds; ~ \$1 billion gross revenues	100-150	50-100	\$14 million (insurance premiums + defense costs + payouts)	1:70
Corrections Public, non-profit					
Federal Bureau of Prisons (1992-1998)	\$2.6 billion annual budget	4000	400	\$150,000 (claims) \$2 million (suits)	1:1200
Cal. Dept. of Corr. (1999)	\$4.6 billion annual budget	?	585	\$6.2 million	1:750

Sources: Acme: 2004 Annual Report and interview with Acme director of risk management. See *infra* note 87.
 Hospital: Interviews with medical school director of risk management; academic hospital director of risk management.
 Federal BOP: Results of FOIA request, see *infra* note 174.
 Cal. Dep’t of Corrections: California documents on file with author, see *infra* notes 184-185.

A. Acme

I gathered information about the publicly held corporation I will call “Acme” in 2005. It is a large retailer⁸⁷—in 2004 it had over \$6 billion in annual sales and over \$100 million in annual net income, over 150 stores, and about 20,000 employees. Damages claims made against Acme are significant but not overwhelming; As of 2005, Acme’s stores saw about 500 potentially compensable accidents a year, mostly categorized by its risk management office as “slips, trips, and falls,” and “struck-by’s” (when customers are hit by merchandise falling from

⁸⁷ Information about “Acme” comes from its 2004 annual report, on file with the author, and from an extensive telephone interview (Feb. 15, 2005) of the head of its risk management department. I was given full information on the condition that I shield the identity of the corporation.

store shelves).⁸⁸ The company paid about \$3 million each year to its claimants. Most were settled without any lawsuit or even lawyer; only about 50 had attorneys involved, and only 15 got to actual litigation. This large base of claims and small point of litigated cases appears to create a fairly typical dispute pyramid.⁸⁹ The vast majority of the payout amount was due to just a few large claims. Acme self-insured for all claims below \$500,000.

To understand the impact of claiming costs, an intra-firm comparison may be useful. Acme's claims payouts in 2006 were lower than its losses to shop-lifting: "inventory shrinkage" accounted, Acme's annual report states, to less than 0.2% of net sales, which amounted to something under \$12 million, compared to about \$3 million in claims (.05% of net sales). Still, three million dollars is not an insignificant amount of money, and 500 claims annually was likewise a number large enough to require an infrastructure.

Because Acme needs to be able to process the claims its customers predictably bring, it has developed a procedure that store management follows whenever there is an accident. Each and every time a customer complains about an accident, store management is directed to assemble a file, complete with statements and pictures. The file is then forwarded to a central risk management office. Acme's head of risk management (I'll call him A., for ease of reference) explains that claims are then processed entirely in-house for all but the few in which claimants are represented by counsel. Small cases dominate Acme's claims docket. In fact, because Acme's average customer spends several thousand dollars annually at Acme, the loss of an average customer costs more, for Acme, than an average claim. Accordingly, A. considers the most important quality for a good claims manager to be strong orientation to customer service. Great customer service people ("people people," A. calls them) can typically settle claims by customers for store coupons, discounts, merchandise, or membership fee waivers. These are attractive settlement items for Acme because they have a higher value to customers than their cost to Acme, and because they assist in preserving the customer's connection to the firm.

Acme is just one firm, and I have no information on how typical its claims management features are. But its situation is at least suggestive. In any event, at Acme, claims management is linked to harm prevention in three of the four ways

⁸⁸ These categories are common in similar operations. One source reports that Wal-Mart, for example, had by 2001 recorded "about 30,000 falling-merchandise incidents resulting in injuries to customers." Jeffrey A. Hyman & Molly E. Homan, *Falling Merchandise*, TRIAL, January 2001, at 44. See also Lea S. VanderVelde, *Wal-Mart as a Phenomenon in the Legal World: Matters of Scale, Scale Matters*, in WAL-MART WORLD: THE WORLD'S BIGGEST CORPORATION IN THE GLOBAL ECONOMY 115, 130 (Stanley D. Brunn ed., 2006) ("Claims against Wal-Mart typically involve injuries resulting from slips and falls and from falling merchandise.").

⁸⁹ William Felstiner, Richard Abel & Austin Sarat, *The Emergence and Transformation of Disputes: Naming, Blaming, Claiming*, 15 LAW & SOC'Y REV. 631 (1981).

theorized above. Claims management imperatives have promoted information production and use, the hiring of risk management staff, and the salience of accident-related losses:

Information production. I have already mentioned the accident report and claims file that store managers, by policy, assemble for each customer claim. A. conceptualizes this policy as serving a core claims management purpose. He describes the policy as requiring store managers to do “everything that can be done early on after an event to solidify the file” so that it can be used to respond to subsequent litigation. Obviously, there is a large liability defense advantage in assembling such a file right away. Whatever conditions caused the accident are still present to be described or photographed; witnesses can be identified and their statements can be memorialized. The file can therefore be both more comprehensive and more accurate, less costly to assemble, and available both for immediate use in negotiations and eventual use in litigation. The rationale for assembling the files, then, is a claims management one.

In addition to assembling individual files, Acme tracks claims statistically, in order to monitor costs. Here, Acme’s primary design seems split between claims management and harm reduction. The claims management purpose is that part of managing a claim is accounting for losses, which are paid centrally but attributed back to the store that occasioned them; when a claim occurs, the involved store’s profit and loss statement is “taxed” \$20,000. This is quite rough justice, of course—most of the losses are a great deal less costly to Acme. That approximation also serves a risk-reduction purpose, however. The accounting treatment of claims payouts is an important component of Acme’s loss-prevention program, because of its incentive effects. The \$20,000 tax on the profit and loss statement works out to about \$300-500 less for its manager’s annual bonus. In addition, a collective fund for employees at each store (for parties and the like) is credited with \$250 for each quarter that is accident free, and an extra \$1000 for each year that is accident free. The point is to give all of the relevant organizational actors some limited but real reason to notice and wish to reduce claims.

These basic statistics are not, however, the end of the analysis. Once the files and tracking information are assembled, they are used not only for claims management but for accident prevention as well. In particular, they are used to generate strategic information that central management analyzes in order to instruct store managers how to reduce accidents. For example, A. explains that files for claims coming out of Florida alerted Acme to the problem that stores were not changing floor mats quickly enough after rainstorms, so that customers were tracking in water, which caused falls. The problem has, he says, been corrected now, and subsequent tracking demonstrates that claims are down in the relevant categories. The information generated to satisfy Acme’s need to respond

and process litigation efficiently, and keep track of its costs in that arena of operations, is thus harnessed in service of safety improvements. This is not an isolated example; such interventions happen frequently, A. says.

Personnel. The strategic use of claims information described above is far from inevitable. Logically, it seems to depend most crucially on the second issue—the presence of claims personnel with time and inclination to take on a broader risk-management mission. Until a few years prior to my interview of Acme’s risk manager, A., Acme had contracted with a third-party administrator to process claims. A. explained that this approach turned out not to be a good one; “Their thought process was deny, deny, deny, fight, fight, fight.” The third-party combatants spent far more of Acme’s money than its in-house people. A. explains that because Acme’s own personnel come to the task with customer service rather than claims skills, they are interested in preserving customer satisfaction, and that works out cheaper. In other words, Acme’s current “make-or-buy” decision, choosing in-house over third-party claims administration, was reversed for claims management, not harm prevention, reasons.

Nonetheless, the decision to go in-house has clear harm prevention effects, as well. In-house claims managers like A. conceptualize their role as reducing the impact of claims on Acme’s bottom line. They can achieve that role by economizing on claims processing costs, or claims settlement costs, or by reducing the number of harmful incidents that cause claims altogether. And they often have a long-standing background with and commitment to the firm, with concomitant insight into its operations. At the time I interviewed him, A. had spent nearly 15 years working at Acme. Lacking similar inside information or access, third-party claims managers have much less ability than their internal counterparts to take on a harm-reduction role. Moreover, ordinarily they have much less incentive to do so, because they are paid based on claims processing, not claims reduction. (Here they are unlike insurers, which have an incentive to decrease payouts, and therefore take the kind of regulatory measures described in the introduction. But I am not aware of any literature describing situations in which insurers perform the kind of firm-specific risk analysis that is ordinary within Acme’s claims management operation.)

Saliency. At Acme, claims management techniques can and often do serve as reminders of safety imperatives. Because the file is assembled at a low level within the organization, the very act of putting it together—the interviews and other investigation—joins up with the accounting techniques used to bring home to Acme’s managers and lower level employees the lesson that accidents do happen. As explained in Part II, this makes the need for harm prevention more available, cognitively.

B. Hospital Medical Malpractice

In almost every way, risk and claims management look very different for hospitals than for retailers. The most important difference is that medical injuries are both more common and more serious than the injuries Acme processes. Iatrogenic injury—injury caused by medical treatment—is a leading cause of death in the United States; the much-publicized Institute of Medicine report, *To Err is Human*, estimated that preventable medical errors, which cause a bit over half the iatrogenic injuries experienced by patients, kill between 44,000 and 98,000 Americans each year—more than car accidents, breast cancer, or AIDS.⁹⁰ Another key difference is that causation is far more opaque for medical injuries than for Acme’s “slips, trips, and falls” and “struck-by’s.” After all, it is in the nature of hospital patients that they are, in large part, sick. It can be very difficult to figure out whether a patient’s bad outcome is attributable to treatment at all, much less to error or negligence rather than misfortune in that treatment.⁹¹ Also important is the extremely low rate of claiming.⁹² Only a very small percentage of those who suffer even serious avoidable harm in hospital settings actually make claims, whether because they do not know if they were the victims of malpractice or other breaches; because those same informational and proof difficulties (coupled with the expense of litigating) make their cases unenticing to lawyers; or because they like and trust their doctors.⁹³ To repeat, causation, by contrast, is

⁹⁰ INSTITUTE OF MEDICINE, *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* 26 (2000). For sources making a range of estimates on iatrogenic injury in American hospitals, see Hyman & Silver, *Problem or Solution*, *supra* note 77, at 901-04 & nn.23-41.

⁹¹ The most extensive study of adverse events was known as the Harvard Medical Practice Study; it used an elaborate protocol to identify first treatment-caused, and then more narrowly tortiously caused injuries. For a description of the protocol, and results, see HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK: THE REPORT OF THE HARVARD MEDICAL PRACTICE STUDY TO THE STATE OF NEW YORK ch. 5 (1990); Troyen Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*, 324 N. ENG. J. MED. 370 (1991); Lucian Leape et al., *The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study II*, 324 N. ENG. J. MED. 377 (1991).

⁹² For summaries of the evidence on claiming rates, see TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* 22-38 (2005), and sources there cited; David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It’s the Incentives, Stupid*, 59 VAND. L. REV. 1085, 1113-15 (2006). Interesting additional evidence, comparing claiming rates to observed clinical discussions of errors in patient care is presented in Lori Andrews, *Studying Medical Error in Situ: Implications for Malpractice Law and Policy*, 54 DEPAUL L. REV. 357 (2005), and Lori B. Andrews et al., *An Alternative Strategy for Studying Adverse Events in Medical Care*, 349 LANCET 309 (1997).

⁹³ See sources cited *supra* note 92; Marlynn L. May & Daniel B. Stengel, *Who Sues Their Doctors? How Patients Handle Medical Grievances*, 24 LAW & SOC’Y REV. 105 (1990).

typically cartoonishly obvious in Acme's cases, and presumably there is no similar bond that discourages claiming against retailers.

Organizationally, retailers and hospitals are also extremely different. Hospitals have the significant complication that often different risk management and claims management systems serve the hospital's attending physicians, who may be, technically, independent contractors (and for whose torts the hospital itself may therefore not be vicariously liable) and hospital employees like nurses, custodial staff, technicians of various kinds. Interns and resident physicians may be employed by the hospital itself or by some (related or affiliated) organization.⁹⁴ A medical school, might, for example, run risk management and claims management for non-resident physicians at its teaching hospitals. In addition, hospitals themselves do risk and claims management for the parts of operations for which they are legally responsible. (Some hospitals, however, merge these two offices. For example, risk management for the Harvard Medical School affiliated hospitals covers both the hospitals and their employees and also the independent contractor physicians.⁹⁵)

As with Acme, the components of hospitals that process claims are referred to as "risk management" rather than "claims management" offices. The risk referred to was, at least in hospital risk management's infancy, conceptualized as monetary rather than as health-care related. Thus the American Hospital Association, which "helped to foster the acceptance of risk management in health care," defined risk management as the "science for the identification, evaluation, and treatment of the risk of financial loss."⁹⁶ And claims have been the central preoccupation of hospital risk management, which was born in the medical malpractice insurance crisis of the mid-1970s.⁹⁷ As one observer has commented (with regret):

[T]he dollar impact of claims management and insurance purchasing activities is easily, if deceptively, measured upon

⁹⁴ See John D. Hodson, Annotation, *Liability of Hospital or Sanitarium for Negligence of Physician or Surgeon*, 51 A.L.R. 4TH 235 (1987).

⁹⁵ At the Harvard hospitals, risk management and claims management is run by a unit of Controlled Risk Insurance Company (CRICO), the "captive" insurance company owned by the medical institutions it insures. See <http://www.rmfi.harvard.edu/company/about-us.aspx>.

⁹⁶ Deborah Korleski, *The Emergence of a Profession*, in ESSENTIALS OF HOSPITAL RISK MANAGEMENT 1, 4 (Barbara J. Youngberg ed., 1990), citing Todd Dankmyer & James Groves, *Taking Steps for Safety's Sake*, HOSPITALS, May 16, 1977, at 60; Sally T. Holloway & Arline B. Sax, *AHA Urges, Aids Hospitals to Adopt Effective Risk Management Plans*, HOSPITALS, May 16, 1977, at 57.

⁹⁷ Deborah Korleski, *Emergence of a Profession*, *supra* note 96, at 1; JAMES E. ORLIKOFF WITH AUDRONE M. VANAGUNAS, MALPRACTICE PREVENTION AND LIABILITY CONTROL FOR HOSPITALS 32-34 (2d ed. 1988). Indeed, some hospitals hired risk managers only in order to comply with a requirement of their insurance contract. Korleski, *supra*, at 3, ORLIKOFF WITH VANAGUNAS, *supra*, at 34; *cf. supra* text accompanying notes 8-22.

superficial examination. Consequently, patient injury and malpractice loss prevention activities are often accorded second-class status in hospitals when compared with the more financial, and therefore more apparently measurable, areas of risk management.⁹⁸

Another discussion notes that “the most common function associated with risk management programs” is its response “to limit the liability associated with incidents that have occurred.”⁹⁹ Hospital risk managers interact with insurance personnel and lawyers, with the assigned role of making litigation response more efficient and effective. A sample job description for a risk manager published in the mid-1980s prioritized legal and insurance rather than clinical or management expertise, emphasizing that the risk manager should “[s]erve as legal affairs person in conjunction with hospital defense counsel” and possess a “B.A. degree with basic knowledge of insurance industry,” and “[i]nterest in or in pursuit of law courses related to risk management.”¹⁰⁰

However, this professional tilt towards claims, law, and insurance has changed substantially over the past decade or so, as hospital risk managers’ orientation has leaned increasingly towards safety and patient care. I describe this shift below, as part of the discussion of personnel, but to foreshadow that discussion here, many hospital risk managers have worked hard to shift the central preoccupation of risk management towards patient safety improvement.

Just as with Acme, hospitals have processes that are supposed to inform risk management offices about potential claims (Of course, these processes often fail to work the way they are supposed to, because of inertia or because medical staff may be reluctant to admit problems have occurred. But I deal here with design.) First, there is “incident” or “occurrence” reporting. Because of its claims management origin,¹⁰¹ hospital incident reporting has typically covered injuries for which hospitals themselves might be liable—those caused by hospital employees (nurses and custodial staff) rather than by the independent-contractor doctors.¹⁰² Thus, at least by accounts in the 1980s and earlier, the main topics for incident reporting tended to be patient or visitor slips-and-falls, lost patient property, and medication errors.¹⁰³ More recent evidence essentially confirms the

⁹⁸ ORLIKOFF WITH VANAGUNAS, MALPRACTICE PREVENTION, *supra* note 97, at 37.

⁹⁹ Florence Kavaler & Allen D. Spiegel, *Risk Management Dynamics*, in RISK MANAGEMENT IN HEALTH CARE INSTITUTIONS: A STRATEGIC APPROACH 3, 5 (Florence Kavaler & Allen D. Spiegel eds., 2d ed. 2003).

¹⁰⁰ INTERQUAL, CLINICAL RISK MANAGEMENT—A PRACTICAL APPROACH 41-42 (1986).

¹⁰¹ Orley H. Lindgren, Ronald Christensen & Don Harper Mills, *Medical Malpractice Risk Management Early Warning Systems*, 54 LAW & CONTEMP. PROBS. 23, 24 (1991).

¹⁰² *Id.* at 24.

¹⁰³ See OFFICE OF TECHNOLOGY ASSESSMENT, THE QUALITY OF MEDICAL CARE: INFORMATION FOR CONSUMERS 101 (1988); UNITED STATES GENERAL ACCOUNTING OFFICE,

point: A recent discussion based on intense ethnographic observation of surgical units of a large tertiary care urban teaching hospital explains that incident reporting “did not adequately capture the range and number of errors,” and indeed “generally focused on the most mundane errors”—those involving “medications and complications,” rather than “diagnosis, surgery, and treatment.”¹⁰⁴ Lori Andrews, the lead author of the ethnographic study, attributes incident reporting’s failure to “provide an effective early warning system about claims” to various methods by which reporting was discouraged. She mentions, for example, that “new medical residents were actually told by more senior doctors *not* to fill out occurrence reports.”¹⁰⁵

The result of low levels of incident reporting is to compromise incident reporting’s claims management coverage. One report explains:

The incident report has been shown to be an effective tool in identifying physical and environmental hazards and those situations of a clinical nature that result in a minor or transient injury. However, incident reports have not been successful in identifying those episodes of clinical care that eventually generate a lawsuit.¹⁰⁶

On the other hand, in some institutions, incident reporting is quite effective in capturing incidents that lead to claims. I spoke with one medical school’s head of risk management, whose school handles risk management for faculty physicians but not hospitals or residents. Whether for that or another reason, she reports that about 85% of claims and lawsuits brought against the physicians involved an issue previously reported to her office by an incident report or telephone call.¹⁰⁷

Whether they are filed nearly all the time or less consistently, hospital incident reports that *are* filed serve the same kind of claim defense purpose as Acme’s incident reporting, by solidifying the file before memories and evidence can fade. One 1977 discussion that urged safety-related analysis of incident reports complained about this very emphasis: “Too often in the past, the incident report form has been used solely to help establish the hospital’s defense in a lawsuit resulting from a claim.”¹⁰⁸

Different hospitals supplement incident reporting with a variety of other claims-related reports. The Andrews study, for example, examines “potential claims files,” and finds that these reports “did a better job of capturing problems

INITIATIVES IN HOSPITAL RISK MANAGEMENT (1989); Grace Duran, *Positive Use of Incident Reports*, 53 HOSPITALS 60-68 (1979).

¹⁰⁴ See Andrews et al., *Alternative Strategy*, *supra* note 92, at 310; Andrews, *Error in Situ*, *supra* note 92, at 368-69.

¹⁰⁵ Andrews, *Error in Situ*, *supra* note 92, at 368-69.

¹⁰⁶ INTERQUAL, CLINICAL RISK MANAGEMENT, *supra* note 100, at 52.

¹⁰⁷ Interview with medical school director of risk management (Apr. 2005).

¹⁰⁸ Dankmyer & Groves, *Taking Steps for Safety’s Sake*, *supra* note 96, at 60, 61.

in diagnosis, surgery, and treatment,” although they “dramatically underreported the full range of serious errors” observed by the study.¹⁰⁹ Other observers discuss “clinical screening” or “occurrence screening,”¹¹⁰ which use chart-review to locate adverse events that might result in claims. Similarly, in 1991, for example, the heads of one risk management operation, the “Professional Risk Management Group,” described a system in place at nearly all the university teaching hospitals in California, explaining that it was “designed to capture significant medical injuries before claimants’ lawyers do so,” by using both written and phoned reports to initiate claims investigations.¹¹¹

Non-claims-related alert systems coexist with the ones just described. The oldest such system is the hospital institution of the mortality and morbidity conference. M&M conferences are run by and for doctors, to discuss bad outcomes and their sources. Surgical M&M conferences regularly deal with error (here they seem to differ from internal medicine M&M conferences¹¹²). In some hospitals, risk managers may attend occasional M&M conferences and start a potential claims file as a result,¹¹³ but the system is really aimed at professional acculturation and peer-review more than risk or claims management.

A more recent error-review innovation, instituted at the direction of the Joint Commission (previously known as the Joint Commission on Accreditation of Healthcare Organizations), whose seal of approval is necessary for a hospital to remain open, is that every hospital has in place a policy for the reporting, investigation (“root cause analysis”), and systemic response (“action plan”) to every “sentinel event.”¹¹⁴ The Joint Commission explains that a sentinel event is an “unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, ‘or the risk thereof’ includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.” The sentinel event system, which started in 1996, was not initiated as

¹⁰⁹ Andrews, *Error in Situ*, *supra* note 92, at 369.

¹¹⁰ See ORLIKOFF WITH VANAGUNAS, MALPRACTICE PREVENTION, *supra* note 97, at 60-64; INTERQUAL, CLINICAL RISK MANAGEMENT, *supra* note 100, at 71-100.

¹¹¹ Lindgren et al., *supra* note 101, at 26-27.

¹¹² Edgar Pierluissi et al., *Discussion of Medical Errors in Morbidity and Mortality Conferences*, 290 JAMA, 2838 (2003); see also Jay D. Orlander, Thomas W. Barber & B. Graeme Fincke, *The Morbidity and Mortality Conference: The Delicate Nature of Learning from Error*, 77 ACAD. MED. 1001 (2002).

¹¹³ Cf. Joel C. Rosenfeld, *Using the Morbidity and Mortality Conference to Teach and Assess the ACGME General Competencies*, 62 CURRENT SURGERY 664, 664 (2005) (describing risk management as one of the goals of the M&M conference).

¹¹⁴ JOINT COMMISSION, SENTINEL EVENT POLICY AND PROCEDURES (Updated: July 2007), available at <http://www.jointcommission.org/SentinelEvents/PolicyandProcedures/>. Many states enforce impose a parallel adverse event reporting requirement. See Lucian L. Leape, *Reporting of Adverse Events*, 347 NEW ENG. J. MED. 1633 (2002).

a claims management system.¹¹⁵ Indeed, critics have charged that it threatens to increase hospital liability exposure.¹¹⁶ But it may serve, like other types of reporting, to notify risk management personnel of the possibility of a future claim.

Whatever kinds of reports are used in a given hospital, if a report of a serious incident arrives at a risk management office, risk management personnel decide whether or not to open a claims file and conduct a preliminary investigation. An initial claims file contains medical information and statements by involved care providers. In at least some hospitals, it is carefully constructed so as not to assist plaintiffs. One published list of “Do’s and Don’ts” includes the following:

- **Don’t** include names and addresses of witnesses, even if the form requests such information. Such data make it easier for attorneys to sue the institution. Check with the supervisor on supplying this information. . . .
- **Don’t** admit liability or blame or identify others as responsible. Obviously, this incrimination could be harmful to the agency if a lawsuit ensues.¹¹⁷

Once a claim file is opened and the preliminary investigation is complete, the file most typically awaits the filing of a claim or complaint, which may or may not occur. In recent years, however, a number of large hospital systems have begun programs to conduct a more complete investigation even if no claims is filed. In California’s public and teaching hospitals, even before a claim is made, “immediate investigation and, in selected cases, active intervention [are] undertaken to assist the patient, reduce liability potential, and extract information for purposes of preventing future mishaps.”¹¹⁸ And similarly, the Veterans’ Administration has a program by which it investigates, discloses, and apologizes for adverse events,¹¹⁹ and then attempts restitution by settling any resulting claims.¹²⁰ Some states even require disclosure.¹²¹ But most typically, the

¹¹⁵ JOINT COMMISSION, SENTINEL EVENTS: EVALUATING CAUSE AND PLANNING IMPROVEMENT (2d ed. 1998); Rebecca Voelker, “*Treat Systems, Not Errors, Experts Say*,” 276 JAMA 1537, 1538 (1996) (quoting Dennis O’Leary, President of the Joint Commission for the Accreditation of Health Care Organizations, on the new sentinel event requirements).

¹¹⁶ Paula Krapf, *ISMS, AMA Oppose Sentinel Event Policy*, ILL. MED., Jan. 22, 1999, at 1.

¹¹⁷ Kavalier et al., *Risk Management Dynamics*, *supra* note 99, at 12.

¹¹⁸ Lindgren et al., *supra* note 111, at 26-27.

¹¹⁹ Dep’t of Veterans Affairs, Veterans Health Admin., Disclosure of Adverse Events to Patients, VHA Directive No. 2008-002 (Jan. 18, 2008), available at http://www.ethics.va.gov/ETHICS/docs/policy/VHA_Directive_2008-002_Disclosure_of_Adverse_Events_20080118.pdf.

¹²⁰ See Steven S. Kraman & Ginny Hamm, *Risk Management: Extreme Honesty May Be the Best Policy*, 131 ANNALS INTERNAL MED. 963 (1999); Lee Taft, *Apology and Medical Mistake: Opportunity or Foil?*, 14 ANNALS HEALTH L. 55 (2005).

¹²¹ See William M. Sage, Joshua Graff Zivin & Nathaniel B. Chase, *Bridging the Relational-Regulatory Gap: A Pragmatic Information Policy for Patient Safety and Medical Malpractice*, 59

preliminary file, relatively undeveloped, awaits a claim made directly by a patient or a patient's family member, or by a lawyer on behalf of a patient. Many hospital risk managers work hard to settle claims before a lawyer gets involved.

If a lawsuit does ensue, the next step is detailed investigation by hospital employees. By the time claims files are complete, they are very thick. (For those inclined to secrecy, there's less need to worry about helping the plaintiff after the claim is filed, because the documents generally are likely to constitute privileged litigation work-product.¹²²) A claims file for a claim that does not settle right away is likely to contain medical information, statements, depositions, the views of witness and non-witness expert consultants, and more. Their purpose is to be fodder for lawyers, who use the file information to settle or try the cases. The file detail is necessitated by the same two dominating features of these claims already mentioned—their causal opacity and their seriousness: The majority of injuries to hospital patients are non-compensable to plaintiffs (because they were either not iatrogenic at all, or not preventable); and determining whether anyone associated with the organization violated the standard of care—that is, separating out compensable from non-compensable injuries—is, even for the hospitals themselves, extremely difficult. When liability exists, however, the damages can be very large; a permanently disabled person with ongoing medical and assistive needs might have a potential recovery of many millions of dollars. The result is that for hospitals, liability exposure is of an entirely different magnitude than for retailers, or, indeed, most other types of firms.

A large hospital and its associated physicians (employed, for example, by a university or other central employer), say one with about 1000 staffed beds, might have gross revenues of close to a billion dollars, one-seventh the size of Acme's operation, and might budget \$14 million dollars annually for insurance premiums and malpractice payouts.¹²³ This is close to 1.5% of total budget. Considering the entire system, tort liability as a fraction of total hospital revenues is nearly 30 times what it is for Acme.

VAND. L. REV. 1263, 1283-84 (2006) (describing four states with mandatory disclosure of adverse events to patients, under Fla. Stat. Ann. § 395.1051 (West Supp. 2006); Nev. Rev. Stat. § 439.855 (2006); N.J. Stat. Ann. § 26:2H-12.25 (West Supp. 2006); and 40 Pa. Cons. Stat. Ann. § 1303.308 (West Supp. 2006)).

¹²² See Fed. R. Civ. P. 26(b)(3); *Hickman v. Taylor*, 329 U.S. 495 (1947).

¹²³ Interviews with medical school director of risk management; academic hospital director of risk management. Some sources indicate that this malpractice insurance/payout amount may often be far higher. One informed observer estimates annual insurance premiums and malpractice payouts for a typical hospital of 1000 beds at over \$30 million. Telephone Interview with Marian Dwyer, Director, Risk Management Services, RMF Strategies (Feb. 16, 2005). And a recent profile of Maimonides Medical Center, with 705 patient beds and \$626 million in revenues, put its malpractice insurance bill at \$17.7 million. JULIE SALAMON, *HOSPITAL: MAN, WOMAN, BIRTH, DEATH, INFINITY, PLUS RED TAPE, BAD BEHAVIOR, MONEY, GOD, AND DIVERSITY ON STEROIDS 3* (2008) (the figures appear to be for 2003).

It is important to note that the difference between hospitals and the other organizations described here lies in the liability exposure per lawsuit rather than the amount of litigation. Hospitals do not see more lawsuits than other kinds of entities; if anything, they are subjected to *fewer* claims. The 1000-bed academic hospital just described opens only 100-150 claims annually, of which only 50-100 are lawsuits.¹²⁴ This is not an aberrant number. For example, between them, CRICO's member hospitals (Massachusetts General Hospital, Brigham and Women's Hospital, Beth Israel Deaconess Medical Center, McLean Hospital, and many others) and their doctors open fewer than 300 claims and lawsuits each year.¹²⁵ In both examples, this is fewer than the annual number of claims made against Acme, notwithstanding Acme's much larger scope.

These relatively small numbers of claims coupled with the large magnitude of payouts confirm the point that, on average, claims against hospitals are worth far more than claims against Acme. Vastly more than Acme, then, what hospitals and those who deal with risk management for hospital doctors should be after is not *easy* response to litigation, but *effective*—that is, cost-reducing—response. This is, in fact, what the system just described delivers. The detail of the investigation and the depth of the resulting file would be far too expensive for low-damages claims.

But even though effective claims management is extremely important for hospitals, so too is harm prevention. Over the past two to three decades, the system of hospital claims management just described has become intimately associated with harm prevention, as claims management imperatives have promoted information production and use, the hiring and activity of risk management staff, the use of bureaucratic strategies that themselves reduce harm, and the salience of accident-related losses:

Information production. As with Acme's accident files, hospital incident reports and claims files are produced in order to facilitate tracking, settlement, and defense of claims. And as with Acme, claims information then gets harnessed in the service not only of claims management but of harm reduction. For hospitals, this occurs in two different ways: Claims files are used by researchers, and both claims files and incident reports are used within hospitals to assess safety and quality of care problems at the particular facility, in order to design useful interventions.

¹²⁴ Interview with medical school director of risk management; academic hospital director of risk management.

¹²⁵ Marian Dwyer, Director of Risk Management Services for RMF Strategies (a subsidiary of CRICO), thinks this number is low, compared to many other hospital operations. But the point in text holds even given what she reports is more typical, 350-400 annual claims. Interview with Marian Dwyer, *supra* note 123.

The most developed (and familiar) effort to use closed claim research for clinical insights is sponsored by the American Society of Anesthesiologists. The project includes data from 1975 on; currently over 7000 observations.¹²⁶ In each, reviewing anesthesiologists complete a detailed data form and narrative summary, based on the claims file.¹²⁷ The use of these data to reform anesthesiology practice and routines is the great success story of the American medical malpractice system.¹²⁸ The ASA's closed claims data have been the field in which anesthesiologists have harvested ideas for systematic clinical improvement,¹²⁹ and the results are spectacular. Anesthesia-related deaths have dropped from their 1970s and 1980s rate of between 1 in 2,000 and 1 in 10,000 to 1 in 200,000.¹³⁰

Especially in the past ten years, other investigators have similarly, if less dramatically, used closed claims as a research base for important patient safety proposals.¹³¹ The research methodology is attractive because it allows a "critical incident" approach, but avoids the enormous expense of generating detailed

¹²⁶ For current information, see <http://www.asaclosedclaims.org>.

¹²⁷ Frederick W. Cheney, *The American Society of Anesthesiologists Closed Claims Project: What Have We Learned, How Has It Affected Practice, and How Will It Affect Practice in the Future*, 91 ANESTHESIOLOGY 552 (1999).

¹²⁸ For an account of this history, see Hyman & Silver, *Problem or Solution*, *supra* note 77, at 917-23.

¹²⁹ See ANALYSIS OF ANESTHETIC MISHAPS (Ellison C. Pierce & Jeffrey B. Cooper eds., 1984).

¹³⁰ See Hyman & Silver, *Problem or Solution*, *supra* note 77, at 918, citing Alexander Goldstein & Arthur S. Keats, *The Risk of Anesthesia*, 33 ANESTHESIOLOGY 130, 133 tbl.1 (1970), and Lucian L. Leape, *Error in Medicine*, in MARGIN OF ERROR: THE ETHICS OF MISTAKES IN THE PRACTICE OF MEDICINE 95, 107 (Susan B. Rubin & Laurie Zoloth eds., 2000); Ellison C. Pierce, Jr., *Anesthesia: Standards of Care and Liability*, 262 JAMA 773, 773 (1989).

¹³¹ James E. Ludlam, *Using Malpractice Claims Data to Successfully Attack the Problem of Infant Brain Damage*, in LEGAL MEDICINE 227 (1991); Lorraine M. Jordan, Michael Kremer, Karen Crawforth & Susan Shott, *Data-driven Practice Improvement: The AANA Foundation Closed Malpractice Claims Study*, 69 AANA J. 301 (2001); David M. Benjamin & Robert F. Pendrak, *Medication Errors: An Analysis Comparing PHICO's Closed Claims Data and PHICO's Event Reporting Trending System (PERTS)*, 43 J. CLIN. PHARMACOL. 754 (2003); Barry M. Manuel & Linda M. Greenwald, *Using Medical Malpractice Closed Claims Data To Reduce Surgical Risk and Improve Patient Safety*, BULL. OF AM. C. SURG., March 2007, at 27; F. Dean Griffen et al., *The American College of Surgeons' Closed Claims Study: New Insights for Improving Care*, 204 J. AM. COLL. SURG. 561 (2007); Harry A. Quigley, David S. Friedman, & Steven R. Hahn, *Evaluation of Practice Patterns for the Care of Open-Angle Glaucoma Compared with Claims Data: The Glaucoma Adherence and Persistency Study*, 114 OPHTHALMOLOGY 1599 (2007); Paul D. Hain et al., *Using Risk Management Files to Identify and Address Causative Factors Associated with Adverse Events in Pediatrics*, 3 THERAPEUTICS & CLIN. RISK MGMT. 625 (2007).

information about past events,¹³² and because it tends to turn up iatrogenic injuries. (Of course, the methodology is non-random, which raises its own set of statistical issues, but generally researchers have found the advantages outweigh these concerns.¹³³)

The types of closed claim studies just described are not facility-specific, and it may therefore be unusual to consider them in this study of “deterrence,” usually thought to be a matter of firm or individual behavioral change. But I think it would, in fact, be inappropriate to omit them. The object of this article’s inquiry is how damage actions induce claims management, and how claims management activities, in turn, induce harm reduction. Just as insurers’ safety prescriptions belong in a study of how deterrence is operationalized, so too do care improvements that occur by way of broad research, when that research is made possible because of the existence and depth of claim files.

Moving from broad systemic research to inquiry focused on one facility, closed claims have also emerged as a vital data source for efforts to improve patient safety and quality of care, one hospital at a time. RMF Strategies’ director of risk management explained to me how the company structures the consulting services it provides to hospitals. When her staff works with a facility, she said, closed claims are crucial. Indeed, the first thing they do is to ask for data on all medical malpractice claims: the date of the loss, the date the claim was brought, when it was closed, what the hospital “reserved” for it (that is, how much money a self-insured facility set aside to pay it), what the payout was, information on the injury including severity, nature, and so on, and finally information on the nature of the alleged error, the relevant service (e.g., obstetrics, anesthesiology, nursing). From this, supplemented by interviews, RMF can draw the broad outlines of strengths and weaknesses in the hospital. Next, they benchmark the claim results against other facilities in the RMF database. Finally, they pick the problem areas and sample them, in depth, using the closed case files. She explained to me that “There’s nothing better than a litigation file, because it has so much investigative information.”¹³⁴ Published sources, as well, emphasize and support the similar use of the documentation in closed claim files as guides to loss prevention.¹³⁵

¹³² Two important studies that did undertake this kind of expense are Jeffrey B. Cooper, Ronald S. Newbower, Charlene D. Long & Bucknam McPeck, *Preventable Anesthesia Mishaps: A Study of Human Factors*, 49 ANESTHESIOLOGY 399 (1978), a study that was important in prompting the American Society of Anesthesiologists to undertake its Closed Claims Project, and the Harvard Medical Practice Study, *supra* note 91.

¹³³ See, e.g., *To See or Not to See*, 105 ANESTHESIOLOGY 1071 (2006) (editorial view); cf. Frederick K. Orkin, *Statistical Indiscretions in Papers from the American Society of Anesthesiologists Closed Claims Project*, 104 ANESTHESIOLOGY 615 (2006) (correspondence).

¹³⁴ Interview with Marian Dwyer, *supra* note 123.

¹³⁵ See, e.g., Richard L. Kravitz, John E. Rolph & Kimberly A. McGuigan, *Malpractice Claims Data As a Quality Improvement Tool I: Epidemiology of Error in Four Specialties*, 266

Other hospitals use closed claim files in other ways. For example, some hospitals use them to conduct credentialing reviews, in order to avoid awarding practice privileges to incompetent doctors.¹³⁶ One medical school's risk management office, which deals with over 1000 physicians at several dozen in- and out-patient facilities, works in conjunction with department chairs to analyze closed claims; the chairs can then do followup training on grand rounds, if it seems useful.¹³⁷ (Physician risk management may, however, be less invested than hospital risk management in the systems-focused patient safety approach.) The point is a simple one: In many hospitals, the information gathered so painstakingly and at such great expense in order to manage and defend claims is used, as well, for risk minimization.

Not all risk management and patient safety experts emphasize closed case files quite so heavily. In some hospitals, patient safety improvement efforts rely more on incident reports. Eric Larson, the Medical Director of the University of Washington's Medical Center, described his hospital's use of incident reports in 2002 as "critical to risk reduction and risk management": "[B]y building on a continuous improvement approach and a *system approach to error prevention*, an effective incident-reporting system can have great value as a mechanism to identify risk for the purpose of reducing risk and improving safety for patients.¹³⁸ The theoretical point holds, however; Larson, like those who use claims files, repurposes for harm-reduction documents generated for claims management purposes.¹³⁹

JAMA 2087 (1991); John E. Rolph, Richard L. Kravitz & Kimberly A. McGuigan, *Malpractice Claims Data As a Quality Improvement Tool, II: Is Targeting Effective?* 266 JAMA 2093 (1991); Paul R. Frisch, Sara C. Charles, Robert D. Gibbons & Donald Hedeker, *Role of Previous Claims and Specialty on the Effectiveness of Risk-Management Education for Office-Based Physicians*, 163 WESTERN J. MED. 346, 346 (1995) ("Risk-management education courses are increasingly based on a review of closed claims."); Robert Stanyon, *Total Quality Management, Continuous Quality/Process Improvement, and Evaluation of the Risk Management Program*, in RISK MANAGEMENT IN HEALTH CARE INSTITUTIONS: A STRATEGIC APPROACH, *supra* note 99, at 133, 152-54.

¹³⁶ See Kathleen M. Shostek & Robert F. Pendrak, *Use of Malpractice Data in Medical Staff Credentialing*, J. HEALTHCARE RISK MGMT., Summer 1996, at 16.

¹³⁷ Interview with medical school director of risk management.

¹³⁸ Eric B. Larson, *Measuring, Monitoring, and Reducing Medical Harm from a Systems Perspective: A Medical Director's Personal Reflections*, 77 ACAD. MED. 993, 996 (2002) (emphasis in original).

¹³⁹ Other risk managers or patient safety reformers prefer to rely on sentinel event documentation. The Director of Risk Management at the Brigham and Women's Hospital, in Boston, told me that a team that already does root cause analysis of sentinel events has much less to learn from litigation files. They are detailed, she explained, and full of good information—but they are too old to be much use. But she conceded that in the absence of non-litigation detailed investigation, litigation files could be extremely helpful for accident avoidance. And she, too, uses aggregate closed claims data to track problems that needed solution. Telephone Interview

Personnel. As already described, hospital risk managers were brought into hospitals' organizational structures in order to minimize the cost and maximize the effectiveness of claims processing. Over the past twenty years, however, hospital risk managers have shifted their focus in significant part, though far from entirely, to ex ante patient safety and harm prevention. The transition from claims management to risk management has, it seems, been extremely professionally attractive for risk managers, perhaps because within health care institutions, patient care takes pride of place. The result of risk managers' growing professional orientation towards patient safety is an increasing likelihood that they will find time to concern themselves with harm prevention, instead and in addition to claims management; risk managers accordingly have become likely to use the tools of their claims management tasks for their newer harm prevention goal.

Hospital risk managers' professional focus on claims had substantial staying power, but the shift was urged (if not taken) as early as the 1970s in professional journal articles and other professional sources. For example, in an article entitled "Taking Steps for Safety's Sake," in the *Journal of the American Hospital Association*, the authors explained: "Risk management is not solely reactive, as some mistakenly believe. The *potential* for incidents needs to be dealt with if the hospital's risk management program is to stand any chance of success. Claims handling, after the incident has taken place, is only a small part of the entire risk management process."¹⁴⁰ The article urged risk managers to conduct systematic review and analysis of incident reports. (Another article in the same issue of the same journal noted that any such effort would face the inertia of physicians, who were, the article implied, somewhat uninterested in a risk-management approach to patient safety.¹⁴¹)

Hospital risk managers' professional association is the American Society for Healthcare Risk Management (ASHRM), founded in 1980. Every year since, ASHRM has pushed for the expansion and acknowledgement of its members' contribution to patient safety, not just to hospitals' bottom line. A retrospective description of the organization's first 25 years, for example, labeled 1984 to 1988 "[t]he 'quality' era."¹⁴² ASHRM's journal documents the continuing effort by

with Janet Barnes, Director of Risk Management, Brigham & Women's Hospital (Boston, MA) (Feb. 24, 2005).

¹⁴⁰ Dankmyer & Groves, *Taking Steps for Safety's Sake*, *supra* note 108, at 60, 61.

¹⁴¹ See J. AM. HOSP. ASS'N, May 16, 1977, at 63, 66 ("the big claims are medically related and, with few exceptions, far too little has been done because of an inability to coordinate the physician component with the hospital component. . . . Little interest in taking action, however, has been evinced by the American Medical Association to date").

¹⁴² ASHRM, CELEBRATING 25 YEARS: A BRIEF HISTORY OF THE AMERICAN SOCIETY FOR HEALTHCARE RISK MANAGEMENT, 1980-2006, at 10 (2006), available at <http://www.ashrm.org/ashrm/aboutus/pdf/ASHRM25Book.pdf>.

professional leaders to prioritize health care quality. For example, a 1995 article stated: “Early warning systems should be designed to identify adverse events and poor quality of care, not potential lawsuits. The goal of the risk manager, which is sometimes forgotten in day-to-day activities, is to improve the care of patients. If that can be achieved, litigation will be reduced to minor and frivolous claims.”¹⁴³

The transition in the profession’s leaders’ conceptualization of hospital risk management took many years, but it appears at this point to be complete. Where insurance or legal training were once the prerequisite for risk management jobs,¹⁴⁴ nursing has become the more typical professional background.¹⁴⁵ This change is reflected in ASHRM’s presidents’ backgrounds, as well.¹⁴⁶ The organizational results are marked. In 2002, seizing the opportunity presented by the growing patient safety movement,¹⁴⁷ ASHRM pronounced its “vision” to be “safe and trusted health care,” and promulgated a new version of its mission statement focusing on care, rather than finance: “[T]o advance safe and trusted patient-centered health care delivery, ASHRM promotes proactive and innovative management of organization-wide risk.”¹⁴⁸ In 2004, it published a report on a “new health care role,” the patient safety officer, urging its members to take every “opportunity to highlight their current contributions to patient safety, develop additional skills and expand their profile.”¹⁴⁹ After highlighting the ways in which risk managers were suited to become patient safety officers, because they already “possess the breadth of experience in identifying, managing and reducing risk,” the publication warned that the opportunity of professional expansion itself came with a risk of professional eclipse: “Whether the health care industry turns to risk managers to fulfill that role [of patient safety officer] . . . depends in part

¹⁴³ William C. Quinlan, *How do Risk Managers Really Learn About Potential Claims*, J. HEALTHCARE RISK MGMT., Spring 1995, at 3.

¹⁴⁴ *Id.*

¹⁴⁵ See advertisements, *ASHRM Forum*, available from 2001 to present at <http://www.ashrm.org/ashrm/news/publications2.html>.

¹⁴⁶ ASHRM, *CELEBRATING 25 YEARS*, *supra* note 142, at 30-43.

¹⁴⁷ For foundational documents in the patient safety movement, see Lucian L. Leape, *Error in Medicine*, 272 JAMA 1851 (1994); INSTITUTE OF MEDICINE, *TO ERR IS HUMAN*, *supra* note 90; INSTITUTE OF MEDICINE, *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* (2001). For background, see Agency for Healthcare Research and Quality, *Web M&M, In Conversation with... Lucian Leape, MD*, <http://www.webmm.ahrq.gov/perspective.aspx?perspectiveID=28>. See also ASHRM, *CELEBRATING 25 YEARS*, *supra* note 142, at 23 (“Meanwhile [in 2001], patient safety arrived as a distinct discipline.”).

¹⁴⁸ See ASHRM, *CELEBRATING 25 YEARS*, *supra* note 142, at 25.

¹⁴⁹ ASHRM, *THE GROWING ROLE OF THE PATIENT SAFETY OFFICER: IMPLICATIONS FOR RISK MANAGERS*, June 2004, at 3, available at <http://www.ashrm.org/ashrm/resources/files/Monograph.PSO.pdf>.

on risk managers' ability to leverage their existing skill sets and enhance them with the skills required to lead a patient safety program."¹⁵⁰

Thus at the current moment in the evolution of the profession of hospital risk management, safety is not justified serving the monetary goal of liability reduction but rather the reverse: Risk management's focus on money is itself likely to be justified with reference to the resulting impact on safety. For example, another ASHRM publication explains: "[A]n organization's ability to deliver safe, quality care depends in large part upon its financial strength. Every dollar spent on professional liability losses is a dollar that might be spent on patient care."¹⁵¹

In summary, it has been a major effort of many hospital risk managers to try to move the core of risk management away from claims management and towards patient safety improvement. This is a professional project still in progress, but it is evidently high on the agenda of the kinds of risk managers who run professional societies, put on conferences, and write academic and quasi-academic articles. The result is that members of the profession act to use for patient safety the materials and techniques developed for claims management efficiencies.

Bureaucratization. Hospital claims management imperatives—the desire to respond efficiently and effectively to claims, *ex post*—have a notable bureaucratizing effect. A major organizational strategy chosen for its claims management usefulness is documentation, which can prevent harm as well as assist in rebutting claims.

It has long been observed that the existence of malpractice lawsuits sometimes induces doctors and nurses to spend more time and effort on documentation more readily (and cheaply) introduced in court—for example, devoting more time to charting observations than they otherwise might. As one guide to health institution risk management states, “The absence of . . . documentation makes defending a medical malpractice action against the hospital difficult. In the words of one plaintiffs’ attorney: ‘If it’s not in the chart, it never happened.’”¹⁵² Another publication advises doctors, “if litigation occurs,” “[i]ncomplete, illegible and inconsistent drug documentation . . . suggest[s] careless, negligent prescribing practices when none occurred.”¹⁵³ Similarly, an article on risk management in

¹⁵⁰ *Id.*

¹⁵¹ ASHRM, DIFFERENT ROLES, SAME GOAL: RISK AND QUALITY MANAGEMENT PARTNERING FOR PATIENT SAFETY, June 2007, *available at* <http://www.ashrm.org/ashrm/resources/files/Monograph.07RiskQuality.pdf>; *see also* Kavalier & Spiegel, *Introduction*, in RISK MANAGEMENT IN HEALTH CARE INSTITUTIONS, *supra* note 99, at xxvi (“[M]onetary awards from litigation drastically reduce the resources available to render high-quality health care to those in need.”).

¹⁵² Kavalier et al., *Risk Management Dynamics*, *supra* note 99, at 25.

¹⁵³ Kathi Burton, *Prescribing Medications and Malpractice Suits: Clear, Consistent Documentation is the Key*, 94 W.VA. MED. J. 272, 272 (1998).

obstetrics counsels “since legal action may be initiated as long as 21 years following the delivery in the case of an injured newborn, it is important that medical record documentation be accurate, objective, and complete, and provide the rationale to support all patient management decisions, including the decision not to intervene.”¹⁵⁴ In addition, the potential for litigation (and its concomitant necessity of proving up adequate care) may sometimes lead medical providers to prefer the types of care that produce a written record—giving an EKG instead of a particularly thorough chest exam,¹⁵⁵ for example.

There are those who call choices like these, usually disparagingly, “defensive medicine”¹⁵⁶ But as one recent study of the reported magnitude of defensive medicine explained, actually these could well be very good treatment decisions. Its authors noted: “Defensive medicine may reduce or improve quality, depending on the circumstances.”¹⁵⁷ EKGs are valuable diagnostic tools, for example, and ease consultation where it is useful. The article on medication documentation quoted above also notes that the types of errors sometimes observed—ambiguous or incomplete notes, “[i]llegible handwriting and carelessly written decimal points and numbers,” and the like, “can cause . . . errors and injury” and “compromise quality patient care.”¹⁵⁸ And, more generally, good (though not excessive) charting is essential for high quality healthcare.¹⁵⁹ The reason for this last observation is particularly pertinent. Good medical charting requires the charter to engage in certain inquiries that are necessary for good

¹⁵⁴ Kavalier et al., *Risk Management Dynamics*, *supra* note 99, at 25.

¹⁵⁵ See Jerry R. Green, *Medical Malpractice and the Propensity to Litigate*, in *THE ECONOMICS OF MEDICAL MALPRACTICE* 193, 197 (Simon Rottenberg ed., 1978) (noting a tendency among health care personnel to prioritize “[t]he attributes of care readily observable in court”—“typically . . . those procedures for which records are kept: tests ordered, X-rays, frequency of reexamination, length of hospital stay”); David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 *JAMA* 2609, 2612 (2005) (identifying extra imaging studies among the most common “defensive acts” by physicians).

¹⁵⁶ See Green, *Medical Malpractice*, *supra* note 155, at 197 (“Focusing on these aspects of care when others that would be more efficient are bypassed is defensive medicine.”). Oddly, given the frequent repetition of the idea that malpractice liability risk encourages documentation, such documentation is not usually included in less abstract definitions of defensive medicine. See, e.g., Studdert et al., *Defensive Medicine*, *supra* note 155, at 2609. This fact does not alter the point in text.

¹⁵⁷ Studdert et al., *Defensive Medicine*, *supra* note 155, at 2616.

¹⁵⁸ Burton, *Prescribing Medications*, *supra* note 153, at 272.

¹⁵⁹ See, e.g., Douglas L. Wood, *Documentation Guidelines: Evolution, Future Direction, and Compliance*, 110 *AM. J. MED.* 332 (2001). The point generalizes to non-hospital settings as well. See, e.g., Susan Keane Baker, *Minimizing Litigation Risk: Documentation Strategies in the Occupational Health Setting*, 48 *AAOHN J.* 100, 100 (2000) (“Effective documentation strategies have the dual benefit of improving care and decreasing the risk of malpractice litigation in the occupational health setting.”).

medical care—charts often follow the SOAP method, for example (*subjective, objective, assessment, and plan*),¹⁶⁰ which reminds providers to think about and investigate each of these topics. And good medical charting is vital, too, for continuity of care.¹⁶¹ Here, as in so many areas, written recordkeeping can structure conduct in a very productive way. So practices engaged in as claims management practices—in this case, generation of contemporaneous written patient and treatment records—turn out to have a harm-reduction payoff.

Using a still broader perspective, one would expect that the kinds of evidence that potential defendants believe lend themselves to error-free adjudication in the event of litigation-provoking accidents would, for exactly the same reasons, lend themselves to other quality control systems. It is for precisely this reason that written records are a standard bureaucratizing strategy. Development of the systems perspective that currently seems so promising for patient safety depends on bringing into hospitals quality assurance techniques that have worked in other arenas. These include document creation and auditing.¹⁶² Records created because of they make ex post response to litigation more efficient and effective can also make systems analysis and improvement more efficient and effective.

Salience. Finally, dealing with actual claims and the claims management apparatus—taking part in incident reviews, depositions, and the like—may reinforce doctors’ and others’ awareness that accidents do happen, and their desire to avoid litigation, countering optimism bias and bolstering deterrence. Note, however, that only a fraction of the limited empirical evidence available supports this point: Some studies have found that doctors who have been sued report changed practices due to the malpractice environment at a higher rate than doctors who have not been sued; more such studies find no significant difference.¹⁶³ As

¹⁶⁰ Lawrence L. Weed, *Medical Records that Guide and Teach*, 278 *NEW ENG. J. MED.* 593 & 652 (1968); KATHLEEN WATERS & GRETCHEN A. MURPHY, *MEDICAL RECORDS IN HEALTH INFORMATION* 74 (1979).

¹⁶¹ See, e.g., Alice Epstein & Gary H. Harding, *Risk Management in Selected High-Risk Hospital Departments*, in *RISK MANAGEMENT IN HEALTH CARE INSTITUTIONS*, *supra* note 99, at 325, 346 (“Physicians and risk managers alike have found [diligent charting necessary] to ensure the best continuum of care.”).

¹⁶² See Donald M. Berwick, *Continuous Improvement as an Ideal in Health Care*, 320 *NEW ENG. J. MED.* 53 (1989); AL ENDRES, *IMPLEMENTING JURAN’S ROAD MAP FOR QUALITY LEADERSHIP: BENCHMARKS AND RESULTS* (2000); Larson, *Measuring, Monitoring, and Reducing Medical Harm*, *supra* note 138.

¹⁶³ Compare, e.g., Carol S. Weisman, Laura L. Morlock, Martha Ann Teitelbaum, Ann C. Klassen & David D. Celentano, *Practice Changes in Response to the Malpractice Litigation Climate: Results of a Maryland Physician Survey*, 27 *MED. CARE* 16, 21-23 (1989) (finding differences in reported response of “providing more services”—increased tests or monitoring, consultation, preventive services), with David M. Studdert et al., *Defensive Medicine*, *supra* note 155, at 2615 (finding that litigation history had no significant effect on reported tendency to practice defensive medicine); Peter A. Glassman, John E. Rolph, Laura P. Petersen, Melissa A.

one study suggested, “the signal to practice defensively may have been broadcast so widely that individual experience is overshadowed by collective anxiety.”¹⁶⁴

C. Prisoner litigation

For this article’s third and final claims management case study, I look at prisons and jails.¹⁶⁵ The key feature of the claims docket in prisons and jails is the combination of high volume and low plaintiffs’ success rate. More types of injuries are federally actionable for prisoners than for people whose relationships with the state are less all-embracing.¹⁶⁶ And, in any area of law in which prisoners retain legal rights similar to those of nonprisoners, those rights tend to run not against many different persons, firms, or agencies, but against one litigating opponent—the prison or jail that holds them. As the Supreme Court has noted:

For state prisoners, eating, sleeping, dressing, washing, working, and playing are all done under the watchful eye of the State, and so the possibilities for litigation under the Fourteenth Amendment are boundless. What for a private citizen would be a dispute with his landlord, with his employer, with his tailor, with his neighbor, or with his banker becomes, for the prisoner, a dispute with the State.¹⁶⁷

At prisoners’ civil rights litigation’s peak in the federal court system, in 1995, nearly 1.6 million jail and prison inmates¹⁶⁸ filed about 40,000 lawsuits in federal

Bradley & Richard L. Kravitz, *Physicians’ Personal Malpractice Experiences Are Not Related to Defensive Clinical Practices*, 21 J. HEALTH POL. POL’Y & L. 219 (1996).

¹⁶⁴ Glassman et al., *Physicians’ Personal Malpractice Experiences*, *supra* note 163, at 235.

¹⁶⁵ By prison, I mean a state or federally operated facility that houses convicted felons; by jail, I mean a county or city (or very occasionally federally) operated facility that houses some combination of pretrial detainees, felony convicts awaiting sentencing or transfer to prison, and misdemeanor and felony convicts serving relatively short terms. For a fuller discussion of the operational and litigation differences between these types of facilities, see Schlanger, *Inmate Litigation*, *supra* note 4, at 1579 n.76 & 1686-89; Anne Morrison Piehl & Margo Schlanger, *Determinants of Civil Rights Filings in Federal District Court by Jail and Prison Inmates*, 1 J. EMPIRICAL LEG. STUD. 79 (2004).

¹⁶⁶ *Compare* *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (holding that “deliberate indifference to serious medical needs of prisoners” violates the Eighth Amendment), *and* *Youngberg v. Romeo*, 457 U.S. 307, 324 (1982) (holding that a mentally retarded person involuntarily committed to a government institution has “constitutionally protected interests in conditions of reasonable care and safety”), *with* *DeShaney v. Winnebago County Dep’t of Soc. Servs.*, 489 U.S. 189, 201 (1989) (distinguishing *Estelle* and *Youngberg*, and holding that, ordinarily, state and local governments have no constitutional obligation to protect citizens from harm by private actors).

¹⁶⁷ *Preiser v. Rodriguez*, 411 U.S. 411, 492 (1973).

¹⁶⁸ BUREAU OF JUSTICE STATISTICS, CORRECTIONAL POPULATIONS 2006, *available at* <http://www.ojp.usdoj.gov/bjs/glance/tables/corr2tab.htm>.

court¹⁶⁹; even in 2006, after a huge decline caused by prisoner-specific federal tort reform enacted in 1996,¹⁷⁰ over 2.2 million prisoners¹⁷¹ filed over 20,000 federal cases.¹⁷² As Table 1 shows, in fiscal year 1998, the last year for which I have the necessary data, prisoners confined by the Federal Bureau of Prisons (then the third-largest of the nation's prison systems, housing 120,000 prisoners¹⁷³), filed nearly 4000 administrative tort claims, and over 400 tort and civil rights actions.¹⁷⁴ State and local prisoners add to their federal lawsuits many more cases in state court. In 1999 in California—then the largest prison system, with over 160,000 inmates¹⁷⁵—the Department of Corrections reported that 585 new cases were filed¹⁷⁶ (the Department's entire active docket was over 2000 cases, about one-fifth of them federal).¹⁷⁷ This litigation rate is far far higher than for the other organizations described in this article.

But although prisoners' lawsuits are frequent, payouts are far less so. Even under the loosest definition of plaintiff success, prisoner plaintiffs are rarely successful. As I have previously demonstrated, prior to 1996:

¹⁶⁹ See ADMINISTRATIVE OFFICE OF THE U.S. COURTS, JUDICIAL BUSINESS OF THE UNITED STATES COURTS 1997, at 132 tbl. C-2a, Prisoner Petitions: Civil Rights, and Prisoner Petitions: Prison Conditions, available at http://www.uscourts.gov/judicial_business/c2asep97.pdf (note that these are cases filed, remanded, or transferred; filings alone are slightly smaller in number).

¹⁷⁰ Prison Litigation Reform Act, Pub. L. No. 104-134, §§ 801-810, 110 Stat. 1321, 1321-66 to -77 (1996) (codified at 11 U.S.C. § 523; 18 U.S.C. §§ 3624, 3626; 28 U.S.C. §§ 1346, 1915, 1915A; and 42 U.S.C. §§ 1997-1997h).

¹⁷¹ BUREAU OF JUSTICE STATISTICS, CORRECTIONAL POPULATIONS, *supra* note 168.

¹⁷² See ADMINISTRATIVE OFFICE OF THE U.S. COURTS, JUDICIAL BUSINESS OF THE UNITED STATES COURTS 2007, at 149 tbl. C-2a, Prisoner Petitions: Civil Rights, and Prisoner Petitions: Prison Conditions, available at <http://www.uscourts.gov/judbus2007/appendices/C02ASep07.pdf> (note that these are cases filed, remanded, or transferred; filings alone are slightly smaller in number).

¹⁷³ ALLEN J. BECK & CHRISTOPHER J. MUMOLA, BUREAU OF JUSTICE STATISTICS, PRISONERS IN 1998, Aug. 1999, NCJ 175687, available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/p98.pdf>, at 5 tbl. 5.

¹⁷⁴ Beth Mellen Harrison, Legal Claims Initiated by Federal Prisoners, Fiscal Years 1992-2001 (May 2003) (unpublished manuscript, on file with author), at 62 tbl. 4.4, 69 tbl. 4.7. This paper is based on data provided to me by the Bureau of Prisons in response to a Freedom of Information Act request.

¹⁷⁵ ALLEN J. BECK, BUREAU OF JUSTICE STATISTICS, PRISONERS IN 1999, Aug. 2000, NCJ 183476, available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/p99.pdf> at 3 tbl. 5.

¹⁷⁶ Letter from C.A. Terhune, Director, California Department of Corrections, to Sen. Richard Polanco, Chair, California Joint Legislative Committee on Prison Construction and Operations (August 7, 2000) (on file with author).

¹⁷⁷ Inmate Litigation Log, spreadsheet accompanying letter from C.A. Terhune, Director, California Department of Corrections, to Sen. Richard G. Polanco, Chair, California Joint Legislative Committee on Prison Construction and Operations (June 30, 2000) (on file with author).

[I]nmates typically *won* some relief in about one percent of their federal civil rights cases; they received something worth settling for in another six to seven percent; and they either simply gave up and decided to quit, or received something justifying the withdrawal of the lawsuit, in another six to eight percent of cases.¹⁷⁸

These low success rates make prisoners by far the least successful group of federal plaintiffs,¹⁷⁹ and subsequent data (though still incomplete) show even lower success rates in more recent years.¹⁸⁰ Not only are payouts few and far between, the damages paid tend to be extremely low; the median in 1993 federal trial verdicts for prisoner plaintiffs was just \$1000.¹⁸¹ (Note that the expense of complying with injunctive orders can, by contrast, be extraordinarily high. But injunctive litigation is beyond the scope of this article.¹⁸²)

When prisoners' very high claiming rate is balanced with their low success rate, the result is that litigated or settled damages are, in prisons and jails (as in retailing but not hospitals), a tiny piece of the very large correctional budgets. Between 1992 and 1998, for example, the Federal Bureau of Prisons (total average budget over those years, \$2.6 billion¹⁸³) paid out an annual average of less than \$150,000 in administrative settlements, and only a little more than \$2 million, on average, in litigation settlements and judgments.¹⁸⁴ Litigation payouts formed a similarly small proportion of California's prison outlay; in 1999, the state (total prison budget, \$4.6 billion) paid out just \$6.2 million in settlements and judgments, a sum that includes both payments to prisoners and attorneys fees for successful plaintiffs.¹⁸⁵ In both these two very large correctional jurisdictions, then, damages litigation payouts are on the order of one-tenth of one percent of total budget, an order of magnitude less than for hospitals.

Table 1's comparison of Acme's sales revenues to a large prison system's budget demonstrates that Acme is an enterprise similar in size to the federal

¹⁷⁸ Schlanger, *Inmate Litigation*, *supra* note 4, at 1597.

¹⁷⁹ *Id.* at 1598.

¹⁸⁰ *Id.* at 1658-64, sets out figures up through fiscal year 2002. The most recent data, on file with the author, confirm the same trends through 2004.

¹⁸¹ *Id.* at 1602-03; *see id.* at 1622-23 for a discussion of the causes of these low damages.

¹⁸² For discussion of prisons and jails and injunctive civil rights cases, *see* Margo Schlanger, *Civil Rights Injunctions Over Time: A Case Study of Jail and Prison Court Orders*, 81 N.Y.U. L. REV. 550 (2006).

¹⁸³ Data derived from U.S. Department of Justice, Budget Staff, Justice Management Division, Budget Trend Data: 1975 Through the President's 2003 Request to the Congress: Total Federal Prison System (Spring 2002), *available at* http://www.usdoj.gov/jmd/budgetsummary/btd/1975_2002/2002/html/page109-112.htm.

¹⁸⁴ Beth Mellen Harrison, *supra* note 174, at 67 tbl. 4.6, 78.

¹⁸⁵ Letter from C.A. Terhune to Richard Polanco, *supra* note 176. California also paid out another \$2.3 million in special master fees in some large injunctive cases. *Id.*

Bureau of Prisons or the California Department of Corrections. Moreover, Acme's payouts are not too different from those by correctional agencies: Acme's 2005 experience of \$3 million in total payouts for torts is roughly comparable to California's 1999 experience of \$6 million in total payouts to prisoners and their counsel, or to the Bureau of Prisons' average payout of \$2+ million. The crucial difference is that Acme's payouts occur on vastly fewer disputes, and on much less formal litigation.

In addition to having a larger litigation docket, jails and prisons have a more formal non-litigation complaint system than hospitals or retailers. In jails and prisons, litigation coexists with a formal administrative grievance system; prisoners' use of available grievance procedures is currently mandatory if they wish to litigate a claim.¹⁸⁶ Grievance systems can undertake any degree of review of prisoners' complaints, from basically none to a full-fledged investigation. As Dora Schriro, currently head of corrections in Arizona, has written,

Prisons routinely rely on formal problem solving processes notably the inmate grievance procedure and lawsuits to address prisoner complaints. Grievance procedures and lawsuits are not the first steps citizens ordinarily take. Moreover, cumbersome and time consuming, they don't work very well. All too often issues are dismissed for technical reasons, not on their merits and rarely do inmates prevail. Far less frequently the underlying conditions causing or contributing to the problems are addressed.¹⁸⁷

But sometimes, grievances are investigated quite comprehensively and institutional changes made. A New York State amicus brief before the U.S. Supreme Court recently characterized grievance systems as crucial for self-regulation:

For decades, prison grievance procedures have played an important role in prison administration. Inmate grievances provide timely feedback to state officials about problems that arise in correctional

¹⁸⁶ See Prison Litigation Reform Act, 42 U.S.C. 1997e. For the case in which the Supreme Court established this interpretation of the PLRA, see *Woodford v. Ngo*, 548 U.S. 81 (2006). For copies of the grievance policies in nearly every state, see Prison and Jail Grievance Policies, available at <http://law.wustl.edu/Faculty/index.asp?id=6430>. See also Brief for the Jerome N. Frank Legal Services Organization of the Yale Law School Supporting Respondent, *Woodford v. Ngo*, 548 U.S. 81 (2006) (No. 05-416), available at http://www.law.yale.edu/documents/pdf/Woodford_Amicus_brief.pdf.

¹⁸⁷ Dora Schriro, Correcting Corrections: The Arizona Plan: Creating Conditions for Positive Change in Corrections, statement given before the Commission on Safety and Abuse in America's Prisons at 17 (Feb. 9, 2006), available at http://www.prisoncommission.org/statements/schriro_dora.pdf; see also Dora Schriro, *Correcting Corrections: Missouri's Parallel Universe*, SENTENCING & CORRECTIONS: ISSUES FOR THE 21ST CENTURY, May 2000, at 1, 6, available at <http://www.ncjrs.gov/pdffiles1/nij/181414.pdf> ("Problem solving in prison is often adversarial. Riddled with formalities, inmate grievance mechanisms short-circuit many complaints.").

facilities. In individual cases, grievance procedures enable prison administrators to take prompt remedial action that may satisfy the inmate and obviate the need for litigation. From a systemic perspective, such procedures allow prison officials to monitor trends in prisoner complaints before unwise institutional policies or patterns of inappropriate conduct by correctional officers lead to frustration among the inmate population, potentially triggering prisoner unrest or disturbances. Grievance procedures also allow state officials to create factual records of any disputes that may eventually be litigated in court, and to filter out meritless inmate claims, thereby reducing the States' costs of defending against frivolous prisoner litigation.¹⁸⁸

In their litigation environment of many cases but few awards, jails and prisons' most pressing need in claims management is simply to respond to what is for some agencies a barrage of litigation. Once they are sued, jail organizations and prison departments of corrections need to be able to file an answer; they need to be able to produce, in court, their version of events, including the relevant policies, documents, and witnesses. In addition, they need to be able to provide more than inevitably self-interested and therefore discountable testimony by individual officers about their own conduct. These priorities drive the connections of claims management to harm reduction or constitutional compliance behind bars, which occur chiefly by way of bureaucratization, personnel, and the increased salience of litigation:

Information Production. In the other case studies, I have discussed at some length the ways in which the information produced for claims processing can be used, as well, for harm prevention. This is not unheard of in jails and prisons. Sometimes litigation exposes a problem previously hidden to senior officials, and they then act to ameliorate it. For example, it was jail strip-search litigation that brought to senior officials attention the (plainly unconstitutional) policy in the Miami jail of performing visual body cavity examinations of all women arrested, no matter the charge or circumstances.¹⁸⁹ And as New York's brief, quoted above, explains, there are correctional administrators who use grievance filings in ways similar to those I have been investigating: to track trends, understand problems, and so on. But the grievance system is not really a claims management system—it is more of a claims substitute. And overall, it is rare in corrections

¹⁸⁸ Brief of the States of New York et al. as Amici Curiae Supporting Petitioner, *Woodford v. Ngo*, 548 U.S. 81 (2006) (No. 05-416).

¹⁸⁹ Telephone Interview with Randall Berg, Director, Florida Justice Institute (June 5, 2007). For a full account of this case, *Haney v. Miami-Dade County*, No. 1:04-CV-20516 (S.D. Fla. filed Mar. 5, 2004), see Margo Schlanger, *Jail Strip Search Cases: Patterns and Participants*, 71 *LAW & CONTEMP. PROB.* 65, 67-73 (2008).

that claims management information is used to strategize harm reduction. Claims management does not have an important impact on harm reduction by this path.

Bureaucratization. Only over the past thirty-five years have prisons (and to a lesser extent jails) entered the modern bureaucratic state. Jim Jacobs explained in 1980:

Until recently, prisons operated as traditional, nonbureaucratic institutions. There were no written rules and regulations, and daily operating procedures were passed down from one generation to the next. Wardens spoke of prison administration as an “art”; they operated by intuition. The ability of the administration to act as it pleased reinforced its almost total dominance of the inmates.¹⁹⁰

Litigation has been an important driver of this profound transformation.¹⁹¹ Two of the methods by which litigation has had an effect are related to claims management. First, knowing that they will be sued dozens or even hundreds of times each year, correctional agencies have developed practices that make responding to those lawsuits easier and more routine as well as more effective. They now produce contemporaneous records: They write incident reports, videotape cell extractions, keep easily copied shift logs and the like. And they develop written policies and procedures easier to present in pleadings and testimony.¹⁹²

In addition, particularly in the 1970s and 1980s, an interest in easing defense against claims pushed jails and prisons to use standard operating procedures. Written policies and procedures could be offered in court proceedings as deserving of deference, because they were at least rational, and more aggressively, expert. In addition, they could provide circumstantial evidence of due care or compliance. Prison and jail accreditation norms echo this approach—the American Correctional Association’s accreditation standards frequently require the existence of a written policy on some given topic, without specifying what that policy should say or examining whether it is followed in practice.¹⁹³ As the ACA itself explains, accreditation provides “a defense against lawsuits

¹⁹⁰ JAMES B. JACOBS, *NEW PERSPECTIVES ON PRISON AND IMPRISONMENT* 54 (1983) (reprinting chapter originally published in 1980). For an account of the transformation in one prison, see JAMES B. JACOBS, *STATEVILLE: THE PENITENTIARY IN MASS SOCIETY* (1977).

¹⁹¹ See generally *id.* at 54-54; Malcolm F. Feeley & Roger A. Hanson, *The Impact of Judicial Intervention on Prisons and Jails: A Framework for Analysis and a Review of the Literature, in COURTS, CORRECTIONS, AND THE CONSTITUTION: THE IMPACT OF JUDICIAL INTERVENTION ON PRISONS AND JAILS* 25-28 (John J. DiIulio, Jr., ed. 1990).

¹⁹² The federal Bureau of Prisons is perhaps the most markedly bureaucratic system. For many of its policies, see <http://www.bop.gov/DataSource/execute/dsPolicyLoc>.

¹⁹³ See Elizabeth Alexander, *What’s Wrong with the ACA?*, 15 NAT’L PRISON PROJECT J. 1 (2001).

through documentation and the demonstration of a ‘good faith’ effort to improve conditions of confinement.”¹⁹⁴

In total, then, prison and jail organizations’ interest in minimizing the ex post cost of claims management and defense has been an important component in the bureaucratization of American corrections. And bureaucratization is particularly useful in corrections, because both inadequate control and the abuse of discretionary power can be so harmful to prisoners. Non-bureaucratic prison regimes, to quote John DiIulio, “bounced between the poles of anarchy and tyranny; between the Hobbesian state of inmate predators and the autocratic, arbitrary regime of iron-fisted wardens.”¹⁹⁵ Bureaucratic jails and prisons can be harsh and inhumane, but it is uncontroversial that prison and jail inmates are better off when their incarcerating facilities have, for example, written policies, stated rules of conduct for their staff, and the variety of practices and procedures that allow supervisors to monitor line officers.¹⁹⁶ The point that prison litigation has encouraged use of these minimal bureaucratic features is not novel. The contribution of my account¹⁹⁷ is the observation that these salutary changes were provoked by claims management imperatives—the need to respond to litigation, as much as anything substantive about the litigation.

Personnel. In addition to developing a set of institutional strategies for facilitating organizational processing of and response to lawsuits, prison and, to a more limited extent, jail systems have devoted staff to claims management. In fact, every state department of corrections has both low- and high-level personnel who spend significant portions of their time dealing with prisoner litigation. There are litigation officers, compliance officers, risk assessment personnel, and lawyers and paralegals in corrections departments and in offices of attorneys general. The higher ranked among this group have their own professional networks, as part of the National Association of Attorneys General and the American Corrections Association. Even though most jails are far smaller than most prisons, let alone prison systems, and small jails in particular are far less likely to employ readily available lawyers with expertise in inmate litigation, jails, too, often institutionalize some lower-priced staffing arrangement to deal with

¹⁹⁴ AMERICAN CORRECTIONAL ASSOCIATION, STANDARDS FOR ADULT CORRECTIONAL INSTITUTIONS xvi (4th ed. 2003); *see also, e.g.*, William J. Rold, *The Legal Context of Correctional Health Care*, in NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE, STANDARDS FOR HEALTH SERVICES IN PRISONS 137-47 (2003).

¹⁹⁵ JOHN J. DI IULIO, JR., GOVERNING PRISONS: A COMPARATIVE STUDY OF CORRECTIONAL MANAGEMENT 236 (1987).

¹⁹⁶ The most prominent and unambivalent supporter of correctional bureaucratization is John DiIulio. *See id.* at 236-41. For a brief discussion of the potential downsides of bureaucratization, *see Schlanger, Inmate Litigation, supra* note 4.

¹⁹⁷ I have, however, made this point before, in Schlanger, *Inmate Litigation, supra* note 4, at 1667.

prisoners' cases, for example assigning an officer to be the "litigation officer" (in addition to other tasks) in charge of coordinating responses to filed cases.¹⁹⁸

Brought inside correctional organizations' routines to respond to litigation, staff in these categories begin to play other roles as well; it is these roles that are important to understand in an analysis of claims managements impact on damage action deterrence. First and foremost, litigation personnel in corrections organizations act as law transmitters: Given the nearly omnipresent ambiguity of legal requirements, staff inevitably must partially construct the law in order to create a coherent account of its regulatory demands. The content of that account is as much about organizational and interorganizational politics as it is about what courts or legislatures say. As mentioned in Part II, in the deeply oppositional world of corrections, claims management personnel may seek to ensure that they are not too deeply identified with prisoners by their colleagues. But over the past 15 years, I have observed and talked to dozens of officers and lawyers assigned to manage corrections litigation. It is obvious to me that often though not always correctional litigation staff echo Edelman and Suchman's description of corporate officers in charge of implementing "[p]ractices designed to promote (or merely to symbolize) workplace safety, or equal employment opportunity, or environmental protection," by "becom[ing] internal advocates for the values that the practices symbolize."¹⁹⁹ Perhaps this is because jobs predictably attract people who think the job is important, or because litigation staff learn from experience that compliance is easier than corrections officials had feared.²⁰⁰ Or perhaps litigation staff exaggerate, consciously or unconsciously, the degree of liability exposure in order to underscore their own vital role within the organization and enhance their professional standing.²⁰¹ Regardless of the cause, the personnel hired to do the

¹⁹⁸ See *id.* at 1665.

¹⁹⁹ Edelman & Suchman, *When the "Haves" Hold Court*, *supra* note 63, at 962-63.

²⁰⁰ I am thinking here, for example, of the limited due process rights constitutionally owed prisoners, which were strenuously resisted when first announced, but which prisons and jails now tend to meet without difficulty and provide even when the Constitution does not so require. The head of the Federal Bureau of Prisons, James Bennett, reported in 1974 that recently imposed due process requirements "have not only watered down measurably the authority of the wardens but have imposed burdens almost impossible to implement within present appropriations and available legal talent. . . . The erosion of official authority and need for speedy trial and action could have unforeseeable consequences if efforts to achieve full due process are pressed too far[,] but be prepared." James V. Bennett, *Who Wants To Be a Warden?*, 1 NEW ENG. J. PRISON L. 69, 72 (1974). But after the Supreme Court declared twenty years later in *Sandin v. Connor*, 515 U.S. 472 (1995), that prisoners have no due process rights with respect to ordinary disciplinary hearings, prisons have not reverted to pre-due-process practice, and in fact very few have changed how those hearings are conducted, at all.

²⁰¹ See, e.g., Edelman et al., *Legal Ambiguity and the Politics of Compliance*, *supra* note 63, at 77.

tasks needed for responding to litigation frequently simultaneously contribute to reducing unconstitutional misbehavior within prison and jail systems.

Salience. Finally, it would be difficult to overstate the salience of litigation in correctional settings. Litigation is an almost obsessive interest of correctional staff and administrators. It is the subject of training, policy, gossip, and anxiety. This is a puzzle, for two reasons. The first is that in nearly all prison and jail litigation, individual officers do not pay the litigation costs or any damages, and face few or no consequences related to either settlements or judgments.²⁰² The second, already stated, is the low payout risk, even for the agency itself. One would think that hardly anyone would even notice the many lawsuits—that they would be considered an annoyance, rather than a serious problem. The contrary state of affairs suggests that it may be the claims management issues, rather than the liability risks, that makes prisoner litigation loom so large in the minds of corrections officials and staff. Significant money rarely changes hands in prison and jail cases, but because there are so many lawsuits, prison and jail administrators very often need to deal with them—they need to prepare affidavits, locate records, investigate claims, sit for depositions, and the like. This likely makes the threat of liability far more cognitively available.

CONCLUSION

This article contributes to the project of opening up the black box of damage action deterrence, of understanding *how* litigation incentivizes care within large risk-creating organizations. The case studies presented suggest that the structures, policies, and practices that potential defendants adopt in order to become cheaper and more effective respondents to lawsuits—the claims management infrastructure they build—can also have consequences for risk and care. The three case studies illustrate four ways in which organizations' claims management routines and structures can promote care-taking. In all three—the retailer Acme,

²⁰² The typical on-the-books arrangement, usually statutorily enacted, is that the correctional agency indemnifies its officers unless the act on which a lawsuit is predicated was outside the "scope of employment" or was intentional or malicious. See SCHUCK, *SUING GOVERNMENT*, *supra* note 4, at 85-88. Agency-provided defense and near-universal indemnification are the rule in practice. See, e.g., Theodore Eisenberg & Stewart Schwab, *The Reality of Constitutional Tort Litigation*, 72 CORNELL L. REV. 641, 686 (1987); John Jeffries, Jr., *In Praise of the Eleventh Amendment and Section 1983*, 84 VA. L. REV. 47, 49-50 (1998); Cornelia T.L. Pillard, *Taking Fiction Seriously: The Strange Results of Public Officials' Individual Liability under Bivens*, 88 GEO. L.J. 65, 74-80 (1999) (citing evidence that the federal government agrees to 98% of the requests for defense of constitutional tort actions against federal employees, and almost without exception pays any damages assessed once it has provided representation). For additional discussion and authority, see Schlanger, *Inmate Litigation*, *supra* note 4, at 1671-72 & nn.389-391.

hospitals, and prisons—I have suggested that the claims management personnel and the increased salience of litigation threat caused by various claims management endeavors contribute to harm prevention. In Acme and in hospitals but not much in prisons, the information generated for claims management is then used, secondarily, for harm prevention. And in hospitals and prisons but not in Acme, claims management imperatives have promoted various bureaucratizing strategies like documentation and implementation of standard operating procedures, which strategies likely contribute to harm prevention. These four connections between claims management and harm prevention—information, personnel, bureaucratization, and salience—find support in sociological, economic, and psychological theory. Much work remains, however. How common are the types of interventions I have just described? And are they effective? These and many other questions require more systematic empirical investigation than I have attempted.

In addition, this article has dealt only implicitly with the question of *who* does claims management. As I stated Part III, I chose the three case studies by looking for organizations that handle their claims management internally, rather than outsourcing this function. My thought was that a dynamic relationship between claims management and harm prevention is most likely to exist when firm operations and claims are handled within one organizational structure, shrinking the organizational distance that must be traversed by any proposed harm prevention techniques with a claims management source. If claims management and loss prevention are ever interdependent,²⁰³ internal claims management seemed the most likely field in which to find an effect, and therefore most appropriate for this article's project of hypothesis generation.

Although I did not choose them for this characteristic, the organizations featured in Part III share another important institutional attribute—for none of them does insurance relieve the pressure of most liability. Acme self-insures up to \$500,000, more than nearly all its claims. Likewise, large teaching hospitals very often use a form of self-insurance known as captive insurers,²⁰⁴ in which the hospital owns the primary insurer and therefore retains all but catastrophic risk. For prisons, states pay any damages owed, without insurance. (Counties and

²⁰³ Cf. Young & Hood, *Risk and Outsourcing Risk Management*, *supra* note 31, at 118 (suggesting that “interdependency” between claims management and core functions of a governmental organization might push against outsourcing claims management).

²⁰⁴ See Michelle M. Mello, Carly N. Kelly, David M. Studdert, Troyen A. Brennan & William M. Sage, *Hospitals' Behavior In A Tort Crisis: Observations From Pennsylvania*, 22 HEALTH AFF. 229 (2003). For an introduction to captive insurance companies, *see, e.g.*, International Association of Insurance Supervisors, Issues Paper on the Regulation and Supervision of Captive Insurance Companies (Oct. 2006), *available at* http://www.iaisweb.org/_temp/Issues_Paper_on_Regulation_and_Supervision_of_Captive_Insurance_Companies__October_2006_.pdf.

cities sometimes directly pay damages assessed against jail officials; other times, they pool the relevant risks in various ways.²⁰⁵) Just as for insurers, contracted liability risk incentivizes efforts at loss prevention (as the regulatory insurance scholarship described in this article's introduction discusses), presumably this shared risk retention contributes to these organizations' observed readiness to adapt operations to reduce the risk of harm they cause.

For each case study organization, then, there is no outsourcing of any of the three areas of operations related to damage actions. Each retains in-house liability, claims management, and loss-prevention. One would expect in such circumstances that the connections between the three would be at their tightest. Organizational theory and work on the economics of information suggest that *within* organizations it is quite ordinary to see the kinds of transformations and synergies discussed above. Repurposing seems most likely to happen if the firm managing claims is also the firm managing risk-creating operations, and the firm bearing liability risk, and least likely if all three are separated. But it would be valuable to test this theory. Can it be demonstrated, for example, that firms with in-house claims management offices reach systematically different results with respect to harm prevention than those that use third-party claims managers? Does the answer depend on any particular features of the organizations in question? (For example, perhaps the benefit of in-house claims management is less for highly decentralized firms.) In addition, among the issues future work ought to examine are the various combinations among the three.²⁰⁶

The operationalization of deterrence is a crucial subject of research. To understand the regulatory effects of the tort system or of other damage-action regimes we need to analyze more thoroughly just how it is that the threat of litigation and liability operates on risk causing organizations. I hope I have demonstrated that study of claims management is a key part of that project.

²⁰⁵ See Schlanger, *Jail Strip Search Cases*, *supra* note 189.

²⁰⁶ George Cohen provides an example of the kind of insight that might result, in his investigation of legal malpractice insurance and loss prevention. He suggests that law firms tend to buy loss-prevention advice bundled with their liability insurance because transaction costs—related to both contracting and information—are minimized by the use of one contractor for two services, and because insurers can bond their information by liability indemnification. Cohen, *Legal Malpractice Insurance and Loss Prevention*, *supra* note 19.