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The Risk of Risk Management

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THE RISK OF RISK MANAGEMENT

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I. RISK MANAGEMENT COMES TO THE LEGAL PROFESSION

Charles Dickens famously begins his *A Tale of Two Cities* with the lines, "It was the best of times, it was the worst of times . . . ."[1] These lines might be applied with equal force to the large American law firm's experience over the last two decades. Until the recent economic downturn that is the inspiration for the present symposium, law firm profits soared and elite lawyer ranks swelled.[2] Yet, all has not been well in the glass towers of the mighty. A series of ethical scandals ensnared the best and the brightest, from Kaye Scholer in 1992,[3] to Milbank Tweed in 1997,[4] to those representing Enron in 2001.[5] Recent economic difficulties have heightened large law firm awareness of and vulnerability to missteps.[6] The dangers to the firms and their lawyers include not just malpractice claims but "criminal prosecution (of individual lawyers and law firms collectively), professional discipline, claims for disgorgement of fees, malicious prosecution, sanctions, and other allegations of wrongful conduct in the course of law practice, and even law firm dissolution."[7]

One aspect of the elite firm response to the heightened dangers posed by legal missteps has been the adoption of risk management techniques of the

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1. CHARLES DICKENS, A TALE OF TWO CITIES 8 (Huber Gray Buehler & Lawrence Mason eds., The MacMillan Co. 1922) (1859).

2. Rita Henley Jensen, *Minorities Didn't Share in Firm Growth*, NAT'L L.J., Feb. 19, 1990, at 1.

3. *See* Robert W. Gordon, *A Collective Failure of Nerve: The Bar's Response to Kaye Scholer*, 23 LAW & SOC. INQUIRY 315 (1998); William H. Simon, *The Kaye Scholer Affair: The Lawyer's Duty of Candor and the Bar's Temptations of Evasion and Apology*, 23 LAW & SOC. INQUIRY 243 (1998); David B. Wilkins, *Making Context Count: Regulating Lawyers After Kaye, Scholer*, 66 S. CAL. L. REV. 1145 (1993).

4. *See* MILTON C. REGAN, JR., EAT WHAT YOU KILL: THE FALL OF A WALL STREET LAWYER (2004).

5. *See* John C. Coffee, Jr., *Understanding Enron: "It's About the Gatekeepers, Stupid,"* 57 BUS. LAW. 1403 (2002); Susan P. Koniak, *Corporate Fraud: See, Lawyers*, 26 HARV. J.L. & PUB. POL'Y 195 (2003); Donald C. Langevoort, *The Organizational Psychology of Hyper-competition:* Corporate Irresponsibility *and the Lessons of Enron*, 70 GEO. WASH. L. REV. 968 (2002).

6. *See generally* Symposium, *The Economic Downturn and the Legal Profession*, 78 FORDHAM L. REV. 2051 (2010).

7. Anthony E. Davis, *Legal Ethics and Risk Management: Complementary Visions of Lawyer Regulation*, 21 GEO. J. LEGAL ETHICS 95, 98–99 (2008).

sort used in business, finance, and the medical world.[8] This move has been trumpeted by some[9] and sharply criticized by others.[10] It has led to the installation of such mechanisms as "in-house advisors and internal controls, outside consultants and external audits, conflicts of interest protocols, and continuing legal education training."[11] It is the aim of this essay to explore the implications of the rise of legal risk management by viewing it through the lens of risk management's impact on the practice of medicine—a place where it has been in use for a considerable period.[12]

II. RISK MANAGEMENT IN THE OPERATION OF THE LARGE AMERICAN HEALTH CARE PROVIDER

Perhaps it would be best to begin with a definition of what risk management means in the context of the American hospital. According to Dr. Steve Kraman and attorney Ginny Hamm, leading reformers of the risk management process, the term

> usually refers to self-protective activities meant to prevent real or potential threats of financial loss due to accident, injury, or medical malpractice. When a malpractice claim is made against an institution in the private sector, risk managers coordinate the defense against patients, their dependents, and their attorneys. The medical institution and the patient often become adversaries . . . .[13]

This definition provides a series of valuable insights about the nature of risk management in the medical context. Its mission is to protect the institution in which it operates from legal claims. What it defends against are lawsuits based on missteps that a court might find warrant the awarding of damages. Its efforts often result in the triggering of an intensely adversarial relation with injured patients who previously received care and medical advice from the health care provider. The risk management team is a specialized group that focuses not on the delivery of health care but on the legal consequences that may arise from iatrogenic injury.

The risk management department sketched in this definition is bottom-line oriented. Its job is to protect the financial assets of the hospital from claims asserted through the tort system. As one observer has put it, risk

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8. *See* Anthony V. Alfieri, *The Fall of Legal Ethics and the Rise of Risk Management*, 94 GEO. L.J. 1909, 1933–35 (2006).

9. *See* Davis, *supra* note 7, at 113–24.

10. *See* Alfieri, *supra* note 8, at 1933–40; *see also* David B. Wilkins, *Teams of Rivals? Toward a New Model of the Corporate Attorney-Client Relationship*, 78 FORDHAM L. REV. 2067, 2120 (2010) ("[T]here is a danger that the 'risk management' perspective . . . will paradoxically diminish 'a lawyer's *individual* responsibility for making moral choices about his role in law and society'. . . ." (quoting Alfieri, *supra* note 8, at 1939)).

11. Alfieri, *supra* note 8, at 1910.

12. *See* Paul R. Frisch et al., *Role of Previous Claims and Specialty on the Effectiveness of Risk-Management Education for Office-Based Physicians*, 163 W.J. MED. 346, 348–50 (1995) (charting efficacy of risk management programs since 1979).

13. Steve S. Kraman & Ginny Hamm, *Risk Management: Extreme Honesty May Be the Best Policy*, 131 ANNALS INTERNAL MED. 963, 963 (1999).

management brings "the harsher aspects of business to the practice of medicine."[14] The metrics of success are likely to be the number of suits successfully defended and the number of dollars expended on litigation. In conjunction with this work, risk managers oversee the institution's relationship with those providing insurance coverage to pay awards made against the hospital for medical malpractice. An essential element of the insurance relationship is to maintain effective "cooperation with the insurance company in defense of [claims]."[15] Such contractually required cooperation has serious implications for the care provided to patients after they have suffered injury at the hands of the medical staff. The chief goal shifts from providing treatment to "paying as little money in settlements as possible,"[16] at least in so far as the risk management/insurance team is concerned.

In order to manage risks, managers must know about them. This spurs risk managers to undertake a sustained effort to gather information both about potential risks and about cases involving medical error.[17] Their goal is to learn as much as possible about legal threats to the hospital so that problems may be contained. At the same time, risk managers are likely to be reluctant to provide any information about what they discover to anyone outside the institution.[18] A team of reformers has observed that risk management departments are, "[f]or obvious reasons," intensely "reluctant to publish their experience."[19]

Risk managers' penchant for secrecy is most pronounced when injurious errors are involved. It is here, specifically, that "risk management models . . . recommend less than full disclosure."[20] The objective is to avoid providing an injured patient with information that might trigger a lawsuit or be used to support one. The squelching of candor arises out of the "self-protective model of risk management" that stresses the fiscal interests of the institution above all else.[21] The logical consequence is the hoarding and withholding of information. Of course, where a patient seeks legal assistance, "direct communication between the doctor and patient ceases."[22]

The erection of a wall of silence between the doctor and patient is contrary to the long cherished medical principle that requires the physician

14. R. B. Vukmir, *Medical Malpractice: Managing the Risk*, 23 MED. & L. 495, 497 (2004).

15. Jonathan R. Cohen, *Apology and Organizations: Exploring an Example from Medical Practice*, 27 FORDHAM URB. L.J. 1447, 1471 (2000).

16. Kraman & Hamm, *supra* note 13, at 966.

17. *See* Stephan Landsman, *Reflections on Juryphobia and Medical Malpractice Reform*, 57 DEPAUL L. REV. 221, 224–25 (2008).

18. *See id.* at 224–26.

19. Kraman & Hamm, *supra* note 13, at 966.

20. Anand Das et al., *True Risk Management: Physicians' Liability Risk and the Practice of Patient-Centered Medicine*, 18 J.L. & HEALTH 57, 65 (2003).

21. Kraman & Hamm, *supra* note 13, at 963.

22. Jonathan Todres, *Toward Healing and Restoration for All: Reframing Medical Malpractice Reform*, 39 CONN. L. REV. 667, 685 (2006).

"to put the well being of the patient ahead of his or her own interests. . . . [An obligation] stated overtly in the Hippocratic oath."[23] In order to deter medical personnel from following this basic ethical imperative, risk managers wildly exaggerate legal risks or provide misinformation about the operation of the legal system to "frighten[]" doctors.[24] Such misstatements can have a powerfully chilling effect on a population of medical professionals that seldom has a clear or accurate picture about how the law works and harbors the strongest anxieties about litigation.[25]

III. RISK MANAGEMENT AND THE RESOLUTION OF DIFFICULT QUESTIONS OF MEDICAL ETHICS

The risk management team, with its particular legal expertise and mission to protect the medical institution from claims arising out of wrongful death and iatrogenic injury, has regularly been drawn into some of the most challenging treatment decisions doctors face—those involving the rendition of care to the terminally ill. Risk managers' advice in such circumstances, all too often, reflects a willingness to brush aside the patient's desires or interests in favor of what is perceived, rightly or wrongly, to be a course of action that will insulate caregivers and hospitals from any conceivable legal claim or adverse publicity.[26]

One of the most troubling examples of this sort of behavior occurred in the notorious case of Samuel Linares.[27] There, the infant Samuel was brought into Rush-Presbyterian-St. Luke's Medical Center (Rush) in Chicago after having swallowed a balloon.[28] The child had suffered severe and irreversible brain damage during the incident and was in a coma. The medical staff, in accordance with its established treatment guidelines,[29] and the wishes of Samuel's parents, concluded that the ventilator keeping the baby alive should be turned off.

This plan was vetoed by the hospital's attorney, Max Brown, on the ground that it might expose the institution and its employees to a number of legal risks—the physicians to a charge of homicide[30] and the hospital to an array of tort and regulatory claims.[31] It has been persuasively argued that

23. Steve S. Kraman, *A Risk Management Program Based on Full Disclosure and Trust: Does Everyone Win?*, 27 COMPREHENSIVE THERAPY 253, 253 (2001).

24. *See* Marshall B. Kapp, *Treating Medical Charts Near the End of Life: How Legal Anxieties Inhibit Good Patient Deaths*, 28 U. TOL. L. REV. 521, 530 (2001).

25. *See id.* at 523; Bryan A. Liang, *The Adverse Event of Unaddressed Medical Error: Identifying and Filling the Holes in the Health-Care and Legal Systems*, 29 J.L. MED. & ETHICS 346, 349 (1997).

26. *See* Lawrence J. Nelson & Ronald E. Cranford, *Legal Advice, Moral Paralysis and the Death of Samuel Linares*, 17 LAW MED. & HEALTH CARE 316, 321–23 (1989).

27. *See id.* at 316–17.

28. *Id.* at 316. Factual material about the Linares case referred to in the text is drawn from Nelson & Cranford, *supra* note 26, unless otherwise noted.

29. *See id.*

30. *See id.*

31. *See id.*

Mr. Brown grossly overstated these concerns.[32] Yet, the hospital staff was cowed by them and refused to turn off the ventilator without a court order insulating the hospital and its staff from liability. The hospital placed the burden of securing such an order on Samuel's family—impoverished and legally unsophisticated members of Chicago's working class. Brown went further and, at one point, intimated that Samuel's parents might have been guilty of neglect and that the hospital might be implicated if it were to cut off the ventilator.[33] Faced with a virtually insurmountable legal barrier, Samuel's father, Rudy Linares, entered the hospital with a handgun, held the hospital staff at bay, disconnected the child's ventilator, and held his baby son in his arms while the infant died.

The incident highlights a number of the problems that may arise when risk managers are placed in charge of decisions about the delivery of medical care in difficult and ethically challenging situations. The doctors at Rush concluded that both medically and ethically the removal of the ventilator was warranted. This decision was blocked, not on medical grounds but on the basis of overblown concerns about legal risks to the hospital and its staff. In other words, an appropriate treatment decision yielded to fears about hypothesized legal consequences. Those fears turned the patient and his family into adversaries upon whom all manner of legal burdens could be imposed and aspersions heaped. It appeared to be of no importance to the hospital's risk mangers that their demands placed an impossible burden on Samuel's family. In fact, the risk managers were busy demonizing their "adversary." Good judgment and decency had yielded to fear. The patient's interests were subordinated to the institution's apparent desire for absolute immunity. Risk management hijacked the treatment process.

Turning off ventilators has not been the only context in which risk management concerns have been allowed to trump patients' wishes and sound medical practice. The same sort of problem has arisen with respect to the use of cardiopulmonary resuscitation on patients who do not wish such heroic intervention. Risk management directives have led to the prolonging of a number of such patients' lives without their permission and in situations yielding an abysmal quality of life.[34] Similar problems have arisen where patients or their families seek to terminate the use of feeding and hydration tubes.[35] In one such case the attorney overseeing the hospital's actions stated, "[W]e're getting a heinous result, but we're doing the right thing," by which he appeared to mean, "following the letter of the law and minimizing any institutional risk."[36] Similarly disconcerting risk management activity has been observed in the treatment of profoundly

32. *See id.* at 317–21.
33. *See id.* at 316, 320.
34. *See* Kapp, *supra* note 24, at 526–28.
35. *See id.* at 528–30.
36. Gere B. Fulton, *The "Non-declarant" in a PVS: Adventures in Ohio's Legal Wonderland*, 20 OHIO N.U. L. REV. 571, 581 (1994) (alteration in original).

handicapped newborns.[37] The same sort of troubling intervention has been remarked with respect to the provision of palliative care involving the use of pain-relieving medication. Here risk managers, apparently worried about charges of drug abuse or euthanasia, have frightened medical staffs into limiting their pain control efforts, sometimes to the point of "'tortur[ing]'" patients.[38]

It might be suggested that this description of risk management is a caricature, that risk managers are legally careful but caring, and that their power over physicians' conduct is far more circumscribed than here suggested. It is hard to determine whether the overcautious, fear-mongering, adversarial model of risk management is the approach most institutions use. Yet, careful observers have repeatedly remarked the negative effects of traditional risk management on the delivery of medical care. Dr. Steve S. Kraman, who in the 1980s pioneered a reformed risk management approach that champions "extreme honesty" with patients about medical errors, described the "self-protective model of risk management" as nearly "universal" when he began his reform efforts.[39] In the end-of-life setting one observer, after conducting an extensive set of interviews with medical professionals over a two-year period, concluded that there was "a solid consensus . . . that physicians caring for seriously ill and dying patients are compelled by institutional policies and risk management directives to initiate and continue [inappropriate and undesired] aggressive, life-prolonging medical interventions."[40] While not conclusive, these observations suggest the powerful influence of hospital—rather than patient—centered risk management doctrines. It is perhaps, in part, in reaction to this that hospice care designed specifically to ease the burdens of dying patients has grown in popularity across the United States.[41]

In the enumerated situations, risk management's obsession with any imaginable legal threat to the care-providing institution has been allowed to override sound medical judgments and established ethical treatment principles. It may not be unwarranted to suggest that, in a substantial number of institutions, risk management has undercut appropriate treatment on the strength of overstated legal concerns. Risk management has decreed that legal worries, no matter how tenuous, are more important than the wishes or suffering of patients and the carefully considered ethical appraisals of the medical profession.

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37. *See* Kapp, *supra* note 24, at 525.

38. *Id.* at 532.

39. Kraman & Hamm, *supra* note 13, at 963.

40. Kapp, *supra* note 24, at 524 (footnote omitted).

41. *See generally* Timothy E. Quill, *Risk Taking by Physicians in Legally Gray Areas*, 57 ALB. L. REV. 693 (1994). I am deeply indebted to the dedicated hospice workers of the Hospice by the Sea in Boca Raton, Florida, who eased my mother's passing in the summer of 2009.

IV. RISK MANAGEMENT AND INNOVATION

Risk management has also inhibited a number of innovations intended to improve the delivery of medical care. Over the course of the last twenty years, a movement championing the value of apology in circumstances where there has been an error in medical care resulting in injury to the patient has slowly begun to gather momentum.[42] The movement urges apologies that are completely candid about medical mistakes because this is "the right thing [for a physician and institution] to do"[43] and because it yields a range of positive results both for the patient and the physician.[44] These include, interestingly, a decline in the number of malpractice suits filed.[45] The apology initiative arose, in significant part, out of the efforts of Dr. Kraman who introduced a program of full and candid apology at the Veteran's Administration (VA) Hospital in Lexington, Kentucky, in 1987.[46] Since then, his approach has spread both within the VA system[47] and to a number of large private health care providers.[48] Independent of this movement, the American Medical Association (AMA) has endorsed candor, stressing the need for truthfulness about iatrogenic injuries so that patients may be enlisted in the corrective treatment process.[49]

Dr. Kraman has noted that traditional risk managers resist the idea of apology, a reaction he attributes to "the self-protective model of risk management."[50] They have been inclined, as already noted, to champion something far "less than full disclosure."[51] They have been joined in this by a large number of medical malpractice insurers who "fear that [doctors'] statements may be used against them in court."[52]

Risk management has also served as an impediment to an even more critical reform—the speedy and accurate reporting of medical errors and

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42. *See* Jonathan R. Cohen, *Advising Clients To Apologize*, 72 S. CAL. L. REV. 1009 (1999); Cohen, *supra* note 15, at 1447; Kraman & Hamm, *supra* note 13, at 963; Landsman, *supra* note 17, at 228–29.

43. Kraman, *supra* note 23, at 254.

44. *See* Randall R. Bovbjerg & Laurence R. Tancredi, *Liability Reform Should Make Patients Safer: "Avoidable Classes of Events" Are a Key Improvement*, 33 J.L. MED. & ETHICS 478, 482 (2005); Cohen, *supra* note 15, at 1473–74.

45. *See* Kraman & Hamm, *supra* note 13, at 964–66 & fig.; Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609, 1612 & tbl.5 (1994).

46. *See* Kraman & Hamm, *supra* note 13, at 964.

47. *See id.* at 965.

48. *See generally* Peter Geier, *Emerging Med-Mal Strategy: 'I'm Sorry,'* NAT'L L.J. July 17, 2006, at 1.

49. *See* Bovbjerg & Tancredi, *supra* note 44, at 482. This responsibility is grounded in the American Medical Association's declaration that doctors have an ethical duty to "at all times deal honestly and openly with patients [and provide them] all the facts necessary to ensure understanding of what has occurred [so that they will] be 'able to make informed decisions regarding future medical care.'" *Id.*; *accord* Das et al., *supra* note 20, at 67–68.

50. Kraman & Hamm, *supra* note 13, at 963.

51. Das et al., *supra* note 20, at 65.

52. Kraman, *supra* note 23, at 254 (citing Cohen, *supra* note 15, at 27).

their precursors, near misses.[53] Such reporting offers perhaps the best way to address mistakes. Through the analysis of such reports, dangerous practices may be identified and protocols fashioned to curtail them.[54] This is precisely what was done in commercial aviation, and it helped make that industry one of the safest in the United States.[55] There is real urgency to the need to identify risks and reduce errors because, according to a 1999 Institute of Medicine report,[56] anywhere from 44,000 to 98,000 Americans die in hospitals *each year* because of medical errors.[57] What is more, in the time since the disclosure of this enormous death toll, little progress has been made in reducing it.[58] "[S]ignificant reduction of injury remains a distant prospect . . . ."[59]

Unfortunately, but not surprisingly, risk managers have stood in the way of error reduction through reporting. Their secretive ways clash directly with efforts to share information. As already noted, risk management is the antithesis of the open experience-sharing systems being called for to identify and address the medical error problem.[60] Moreover, it should be remembered that risk management is not dedicated to the eradication of error but to the curtailment of successful lawsuits.[61] Empirical research has suggested that risk management may not reduce "error and injury."[62] In the experience of the present author, when risk managers were approached by doctors and medical reformers and asked to participate in reporting systems, they did what was within their power to block the implementation of such a program.[63]

V. PERVERSE INCENTIVES

How did risk management come to wield the power that has allowed it to move major health care providers along the secretive and adversarial (to patients) path it has championed? In part, the answer would appear to reside in basic organizational principles. Departments succeed when they

53. *See* Liang, *supra* note 25, at 357–58.

54. *See* Maxine M. Harrington, *Revisiting Medical Error: Five Years After the IOM Report, Have Reporting Systems Made a Measureable Difference?*, 15 HEALTH MATRIX 329, 330 (2005); Liang, *supra* note 25, at 357–60.

55. *See* Paul Barach, *The End of the Beginning: Lessons Learned from the Patient Safety Movement*, 24 J. LEGAL MED. 7, 20–21 (2003); Landsman, *supra* note 17, at 234; Liang, *supra* note 25, at 357–58.

56. COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn et al. eds., 2000) [hereinafter TO ERR IS HUMAN].

57. *Id.* at 26.

58. *See* Drew E. Altman et al., *Improving Patient Safety—Five Years After the IOM Report*, 351 NEW ENG. J. MED. 2041, 2042–43 (2004); Bovbjerg & Tancredi, *supra* note 44, at 478; Harrington, *supra* note 54, at 331; Lucian L. Leape & Donald M. Berwick, *Five Years After* To Err Is Human*: What Have We Learned?*, 293 JAMA 2384, 2385–90 (2005).

59. Bovbjerg & Tancredi, *supra* note 44, at 478.

60. *See supra* notes 18–22 and accompanying text.

61. *See* Todres, *supra* note 22, at 676–77.

62. Liang, *supra* note 25, at 348.

63. Landsman, *supra* note 17, at 224–25.

are able to expand their authority and increase their staffs.[64] They achieve these ends by showing how vital they are to the well-being of the organizations of which they are a part[65] and by taking on the nasty chores that others do not wish to handle.[66]

Outsized malpractice judgments have become a significant threat to modern American hospitals.[67] Such judgments can wipe out profits and empty coffers. Avoiding such judgments may be critical to institutional success. By addressing the threat posed by malpractice litigation, risk managers provide what may be perceived within the organization as a critical service. It is a short step from that view to the conclusion that particularly risky cases—like those in which a patient may die or suffer catastrophic injury—require legally driven management. What risk managers are expected to do in such circumstances is to work to secure the maximum legal protection from liability for the institution. The orientation here is not towards care, or the reduction of error, but the tamping down of the risk of successful legal action. Risk managers may be given even greater latitude in these matters because doctors are ignorant of and fearful about the operation of the legal system.[68] The more risk managers take charge, controlling the flow of information and demanding protective court determinations, the safer the institution may (rightly or wrongly) feel. News about the incidence of error is suppressed and the power of the courts is, to all appearances, being successfully invoked to protect the hospital. The incentives here work against cooperation with patients or corrective action based on candid recognition of error.

End-of-life decisions are difficult and emotionally wrenching. They engender deep feelings, both in those directly affected and in medical personnel.[69] Such matters require doctors, as well as family members, to make irrevocable decisions. It is dangerously attractive, at least to some medical professionals, to cede such "nasty" decisions to lawyers and the courts.[70] In this way the difficult and distressing can be given over to others. Risk managers, with their insistence on things like court orders and legal control, lift responsibility from caregivers' shoulders. Some treaters

64. *See* V. CLAYTON SHERMAN, CREATING THE NEW AMERICAN HOSPITAL 116–36 (1993) (discussing streamlined management systems and how the best departments should be rewarded with more responsibility).

65. *See* CHIP CALDWELL, GREG BUTLER & NANCY POSTON, LEAN-SIX SIGMA FOR HEALTHCARE 81–114 (2d ed. 2009) (discussing how managers who reduce waste in their departments enhance their role within the organizational structure and make themselves more valuable members of the organization).

66. *See generally* V. CLAYTON SHERMAN, RAISING STANDARDS IN AMERICAN HEALTH CARE 193–214 (1999) (acknowledging the need for recognition of hospital departments and staff that undertake tough projects and succeed).

67. *See* Hillary Rodham Clinton & Barack Obama, *Making Patient Safety the Centerpiece of Medical Liability Reform*, 354 NEW ENG. J. MED. 2205, 2205 (2006).

68. *See* Das et al., *supra* note 20, at 65; Kapp, *supra* note 24, at 537–46; Liang, *supra* note 25, at 349; Nelson & Cranford, *supra* note 26, at 321.

69. *See* Quill, *supra* note 41.

70. *See* Kapp, *supra* note 24, at 542–43.

embrace this sort of intervention. It provides a "pretext" for medical staff not to have to face the hardest choices.[71] In recent times courts have, increasingly, been drawn into the most difficult medical decisions. This has not been because of their special expertise about medical activity at life's end but so that doctors can avoid some of the challenges presented.[72] Risk managers facilitate this off-loading and in this way enhance their importance.

What is shunted aside as risk managers step in is the doctor-patient relationship. In its place is substituted a process grounded in legal disputation. Risk management thrives in a climate where the threat of liability is serious. Its place is secure so long as there are adversaries to fear. It is likely to devote its energy to a ceaseless effort to identify threats that require its continuing exercise of authority.

VI. IMPLICATIONS FOR LEGAL PRACTICE

It might be suggested that the medical experience with risk management is irrelevant to the legal world. Hospitals face a vastly larger volume of malpractice litigation than their legal counterparts.[73] The problems addressed in medical malpractice litigation frequently involve what might be described as technical missteps rather than the ethical lapses encountered in legal malpractice. Doctors often find malpractice principles incomprehensible[74] while lawyers must demonstrate basic proficiency concerning the rules of legal ethics to gain admission to the bar.[75] Yet, all of these distinctions are matters of degree rather than kind. Legal malpractice claims are on the rise,[76] and it is naïve to think that lawyers are any more skilled at their craft than doctors are at theirs. The technical/ethical distinction is not particularly compelling. A doctor's lack of candor with a patient about risks and alternatives that violates requirements about informed consent,[77] for example, does not seem very different from the sorts of claims clients may make when lawyers behave unethically by withholding critical information.[78] Finally, it is open to question whether lawyers who do not specialize in matters of attorney misconduct have any more refined notions of the parameters of liability

71. *See id.* at 543.

72. *See id.* at 524.

73. Ellen Wertheimer, *Calling It a Leg Doesn't Make It a Leg: Doctors, Lawyers, and Tort Reform*, 13 ROGER WILLIAMS U. L. REV. 154, 158 (2008).

74. *See supra* note 68 and accompanying text.

75. *See generally* NAT'L CONFERENCE OF BAR EXAM'RS & AM. BAR ASS'N SECTION OF LEGAL EDUC. AND ADMISSIONS TO THE BAR, COMPREHENSIVE GUIDE TO BAR ADMISSION REQUIREMENTS (2010), *available at* http://www.ncbex.org/fileadmin/mediafiles/downloads/Comp_Guide/CompGuide_2010.pdf.

76. Rachel M. Zahorsky, *Clients, Law Firms Get 'Savage' As Legal Malpractice Claims Increase*, A.B.A. J., Feb. 17, 2009, http://www.abajournal.com/news/article/clients_law_firms_get_savage_as_legal_malpractice_claims_increase/.

77. *See* Canterbury v. Spence, 464 F.2d 772, 779–83 (D.C. Cir. 1972).

78. Vincent R. Johnson & Shawn M. Lovorn, *Misrepresentation by Lawyers About Credentials or Experience*, 57 OKLA. L. REV. 529, 568–76 (2004).

than do doctors.[79] Medicine's experience may have more than passing value in helping lawyers appraise the utility of risk management.

Medicine's record suggests that the creation of a risk management unit within a law firm might be likely to have a number of significant consequences for the firm. First, it would mean the establishment of a department dedicated to the protection of the firm from the legal claims of clients and others rather than the provision of zealous legal representation to those clients. Its allegiance would be to the firm and its goal to cut exposure to risk. This is a very different orientation vis-à-vis clients and, in the medical setting, has resulted in significant tension with traditional principles regarding care and loyalty. Second, such a unit would have the same institutional imperatives as its medical counterpart. It would be inclined to expand its reach by emphasizing the dangers posed to the institution. This would tend to shift the firm's focus and allegiance from clients to itself. Risk managers in law firms would, doubtless, be working with insurers on a continuous basis. This would give insurers a powerful voice within law firms. That voice, along with the risk manager's, would be likely to influence firm behavior in ways likely to curtail candor.

In the medical world, risk management appears to have done little to assuage doctors' fears of the legal system. Indeed, physician anxiety about the law has grown and has been used to expand the reach of risk management.[80] It is to be expected that risk managers would use fear to advance their agenda within law firms. Again, the professional population served is not terribly sophisticated about the risks it faces and may be susceptible to such manipulation. As has been the case in medicine, risk management may foster a climate of fear within the profession and a desire to loosen restrictions on professional conduct.[81]

The study of errors in the medical arena suggests that many are due to systemic failures rather than the glaring and anomalous mistake of a single individual.[82] The implication of this insight is that error reduction comes through the improvement of systems rather than the chastisement of individuals.[83] Risk management's orientation is not systems but individual cases. It is not generally concerned with systemic improvement.[84] The outlook is likely to be shared by legal risk managers. There is already a tendency in law firms to look at misdeeds as the failing of a single lawyer

79. *See generally* David A. Grossbaum & Marian C. Rice, *The Art of Risk Management for Lawyers Representing Lawyers*, 76 DEF. COUNS. J. 405 (2009).

80. *See* Das et al., *supra* note 20, at 65.

81. *See generally* Grena Porto-Spillmann, *Analyzing the Needs of the Institution and Establishing a Risk Management Department*, *in* ESSENTIALS OF HOSPITAL RISK MANAGEMENT 11–30 (Barbara J. Youngberg ed., 1990) (supporting the notion that risk management departments, if necessary, can shape a state's regulatory requirements).

82. *See* TO ERR IS HUMAN, *supra* note 56; Liang, *supra* note 25, at 347.

83. *See* Liang, *supra* note 25, at 347.

84. *See supra* notes 14–22 and accompanying text.

or group of lawyers and to throw those at fault under the bus.[85] Perpetuating this approach does little to enhance error prevention and may intensify the climate of fear. In the end what may arise is a situation where lawyers are afraid to act, where, in other words, they face "moral paralysis." That condition has been observed among doctors working in regimes wedded to risk management[86] and might be equally likely among attorneys.[87]

Risk management may negatively affect the relation between law firms and those they deal with. There are empirical data suggesting that risk management does not work, either to curtail risk or to reduce errors.[88] If firms come to rely on ineffective risk management regimes they may periodically face the devastating claims that Kaye Scholer, Milbank Tweed, and the rest have had to address. Having a faulty risk management regime may make the firm more vulnerable by engendering a false sense of security. The risk may thus be heightened not just for the firm but for those with whom it deals.

One thing that medical risk management seems to do is to turn those being treated into adversaries at the first sign of trouble. It may be anticipated that this adversarial shift will also occur in the legal setting. Such a shift has the most serious implications for lawyers, whose obligation is to be zealous and loyal.[89] As the firm focus shifts to self-protection, there may be a turning away from the client and an enhanced desire to secure official blessing (particularly that provided by a reviewing court) for the firm's actions. This shifts the emphasis from sound and loyal legal assessment by the firm's attorneys to third-party judges. The negative consequences in medicine of such an effect, particularly in end-of-life situations, have been remarked above.[90] The result may be ham-fisted responses to difficult and highly nuanced legal problems—a retreat to simplistic self-protective solutions.

VII. A WORD OF CAUTION

Both lawyers and doctors are members of learned professions. The vast majority of the members of both professions struggle daily to do the right thing in their professional ministrations. They regularly make difficult ethical judgments and make them well. They do not cut their patients or clients adrift. They do not duck hard questions. They do not shirk their professional responsibilities. The problem is that shouldering such a burden is challenging and that the promise of an easy solution is always tempting.

85. *See* David A. Hyman, *A Second Opinion on Second Opinions*, 84 VA. L. REV. 1439, 1454 & n.70 (1998).

86. *See* Nelson & Cranford, *supra* note 26, at 321.

87. For some of the *limiting* effects of risk management in the legal context see Alfieri, *supra* note 8, at 1933–40.

88. *See supra* note 62 and accompanying text.

89. MODEL RULES OF PROF'L CONDUCT R. 1.3 cmt. 1 (2007).

90. *See supra* note 40 and accompanying text.

Risk management too often seems to make such a promise. When it does so its blandishments are misleading and dangerous. Risk management's record is marked by serious questions in the medical world. Lawyers should go slow before embracing it.