Invited Commentary

Should Malpractice Settlements Be Secret?

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In this issue of *JAMA Internal Medicine*, Sage et al[1] report a novel study of nondisclosure provisions among Texas malpractice settlement agreements. Nearly all the settlements contained at least one type of disclosure restriction, and approximately 40% barred claimants from discussing the facts surrounding their injury. Nearly a quarter prohibited claimants from alerting a professional regulatory body to what happened.

Related article

The study provides a rare—albeit limited—glimpse into the world of settlements. The data come from one hospital system in one state, and the sample of settled claims (n = 124) is commensurately small. The researchers did not observe the process that led to the provisions, so they cannot shed light on whether they represent negotiated tradeoffs or an accepted boilerplate. Nevertheless, the findings are provocative. How concerned should patient safety advocates be about the use of nondisclosure provisions?

Rationales for Nondisclosure Provisions

Although some states require judicial approval of some types of settlement agreements (eg, those made in a child's name), generally, the parties determine the terms. Confidentiality provisions are subject to negotiation, although plaintiffs may or may not seek to alter them. Frequently, when cases resolve during mediation, confidentiality is one of the terms that is negotiated. A plaintiff may, for example, agree to keep the names of the treating physician(s) and other health care personnel confidential but secure the ability to discuss the amount of the settlement and the facts surrounding it.

Defendants may desire confidentiality for several reasons. As Sage and colleagues note, reputation protection is a chief concern. Where error has occurred, defendants may wish to avoid negative publicity that may lead patients to seek care elsewhere. Where they have rectified the conditions that led to harm, they may think such publicity misleads patients about the level of safety in their organization.

Physicians and hospitals may agree to settle claims even though they believe error did not occur or that someone or something else is responsible for the error. In such cases, defendants may feel particularly strongly about not having the settlement publicized. Defendants may also worry that news of a settlement will provoke other claims.[2] It could embolden plaintiff's attorneys or alert other patients, who believe they have experienced similar injuries, that compensation is available.

Plaintiffs in malpractice litigation often wish to ensure that other patients avoid similar harm.[3] So why do they accept provisions that prevent other patients from learning about a risk? One reason, Sage and colleagues suggest, is that defendants may be willing to pay extra and settle more quickly. Claimants, therefore, may face a tradeoff between obtaining the compensation to which they think they are entitled and serving their public-interest objective. Some may be unable to obtain a settlement in any amount absent a nondisclosure agreement because the defendant is unwilling to risk reputational damage.

Nondisclosure Provisions and Patient Safety

Cast in the light of "buying silence" about medical error, nondisclosure provisions appear unseemly. We suspect, however, that most types of nondisclosure provisions do not impede efforts to improve patient safety to the extent that Sage and colleagues fear.

Although the authors assert that "safety improvement requires greater transparency to patients and the public," all forms of transparency are not equal. Consider 4 distinct types of communication about adverse events: within health care organizations, with affected patients and families, with regulatory bodies, and with the public and media. The first is by far the most crucial for patient safety.[4] Most safety improvement efforts take place on the initiative of physicians and other health care personnel and their institutions, often in response to disturbing cases in which patients were harmed. Internal reporting and surveillance of adverse events and internal peer-review and risk-management investigations cannot be effective without a willingness to communicate openly within the organization. Sage and colleagues note that nondisclosure provisions in settlements do not threaten these processes.

Second in importance, in our view, is openness with patients and families, including acceptance of responsibility for errors. Having to conduct these difficult conversations is a catalyst for physicians and hospitals to answer the question, "Are we going to do anything to prevent this from happening again?" Disclosure and apology are also crucial in creating a culture of accountability for safe care. Nondisclosure provisions in settlement agreements do not restrict this type of transparency. Possibly, they encourage it: physicians may be more willing to be honest if they have some prospect of negotiating the patient's agreement not to take the story public.

Third in importance is reporting to regulatory bodies, such as state boards of licensing and health departments. We rank such reporting third because these agencies pursue corrective action in few of the reported instances of adverse events or malpractice payments. That may be justifiable, given the blunt tools (such as license suspension) available to regulators and the likelihood that most reports do not establish the incompetence of a health care practitioner or an ongoing dangerous condition.

Regulatory agencies usually become aware of adverse events and malpractice settlements after reports by health care facilities or liability insurers. Nondisclosure provisions in settlement agreements should not interfere with this reporting. However, nondisclosure provisions jeopardize

another source of information: reports by patients. Although we suspect the safety gains associated with patient reporting are small because most reports do not prompt action by regulators, on balance, nondisclosure provisions that prohibit patients and their families from complaining to regulatory bodies are not justifiable.

Fourth in importance is public transparency—the form of transparency most affected by nondisclosure provisions. In theory, allowing claimants to talk about their experience with friends and family and in traditional and social media might prompt safety gains in 3 ways. First, adverse publicity could force change within health care organizations, although organizations may already be motivated to address harmful events that are serious enough to prompt news media coverage. Second, public disclosure could provide useful information to potential patients who are choosing physicians or hospitals. However, the available evidence concerning public reporting of quality indicators suggests that consumers rarely use such information.[5] The potential for settlement information to avert future injuries by steering patients to safer physicians and hospitals seems limited. Third, talking about medical errors allows patients and families to become potent advocates for safety improvement. They may share their stories in forming or joining advocacy organizations, inspire donations to charitable foundations to prevent errors or support those who have been harmed, or exert pressure on the institution to improve safety. Provisions that prevent families from discussing what happened to them greatly undercut the power of their advocacy and impair patient safety efforts.

Recommendations

Some types of nondisclosure provisions can never be justified, and others should remain subject to negotiation. Because patients should not be forced to choose between compensation and acting on a perceived ethical obligation to try to prevent harm to others, settlement agreements should not restrict reporting to regulatory bodies. Adopting state statutes that prohibit these provisions involves less burden and uncertainty for plaintiffs than requiring plaintiffs to challenge them in court.

Restrictions on public disclosure of the facts of the event, without identifying the health care professional(s) or institution, are also hard to justify. Defendants ordinarily should not insert them. There may be very unusual situations in which the parties agree that, all things considered, such a provision is reasonable. Such cases, however, should be exceptional.

Other types of nondisclosure provisions may be justifiable in a broader range of cases and should remain negotiable, including restrictions on disclosing the health care professional's or institution's name and the settlement amount. Public access to settlement amounts helps future litigants and mediators gauge what constitutes a fair settlement in similar cases, expediting resolution. However, there may be cases where the settlement is inflated by special circumstances that are unlikely to be repeated (eg, deliberate alteration of records), and keeping the amount confidential may be reasonable. Preserving some latitude for confidential resolution of malpractice claims may create a safe space for the most important kind of transparency—open communication about error within health care organizations—to occur.

ARTICLE INFORMATION

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