Innovative Medical Liability Reform

Traditional and Non-Traditional Methods

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PIONEER INSTITUTE
PUBLIC POLICY RESEARCH

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Contents

Executive Summary

Medical malpractice is a branch of tort law. It is designed to compensate patients for losses experienced when a physician performs a breach of duty by deviating from the standard of care and a resultant negligent injury occurs; it is also intended to deter future negligent behavior. There is widespread agreement that the majority of tort systems in place across the country are driving up the cost of health care indirectly (e.g., by increasing the incidence of defensive medicine) and directly (e.g., by increasing the cost of malpractice premiums).

This fall, the Governor and the Legislature are poised to consider reforms to the state's tort laws. The Governor's proposal focuses on a model of disclosure when an unanticipated outcome takes place, an apology by a health care provider or system, and an offer to compensate patients impacted by medical errors. The disclosure, apology and offer (DA &O) proposal seeks to address the indirect costs of medical malpractice; whether it will be effective in doing so is yet to be seen. What is certain is that the proposal does nothing to address the direct costs of malpractice, in the short term.

Effective medical liability reform must reduce overall health care costs by lowering both the direct and indirect costs of medical liability. Reform should:

- Quickly resolve any case of merit.
- Fully and fairly compensate victims–no more, no less than necessary.
- Obligate offenders to disburse the full cost of their injurious actions–no more, no less.
- Improve the quality of patient care.

Nationwide, the current medical liability system inconsistently achieves these goals. The American Medical Association considers Massachusetts a "crisis state" with respect to medical liability and ranks the state sixth in the nation for mean payments for medical malpractice.

In Massachusetts, it takes six years for a case to make it through the legal system. The cost of a slow trial comes at a price. Victims go uncompensated and have to relive their trauma, and health care providers' wallets and reputations are negatively impacted

The Massachusetts tort system is expensive for doctors and for patients. The average malpractice payout is $465,236. And, according to the Massachusetts Medical Society (MMS), the existing system results in a conservative estimate of $1.4 billion in defensive medicine annually. The impact on overall health care costs is, however, far greater, as the MMS survey on was administered to only eight physician subspecialties, constituting 46 percent of Massachusetts physicians. The estimates did not include the cost of tests and diagnostic procedures ordered by physicians in other specialties, observation admissions to hospitals, specialty referrals and consultations, or unnecessary prescriptions. Defensive medicine results in overutilization of the healthcare system at the expense, and at times, health of patients.

Malpractice suits constitute only a small fraction of the overall number of adverse events that happen during medical care. In fact, it is estimated that only two percent of victims of malpractice ever file a lawsuit, while roughly 37 percent of malpractice suits that are filed, involve no error. Those affected by malpractice need a system that responds in a timely and fair way. Reform must improve on the current system in which victims of malpractice frequently receive less than half of every dollar recovered through settlements or a jury verdict, and numerous meritless cases enter the court system.

Finally, a well functioning accountability system should improve patient care. Incentives must be aligned for all stakeholders to learn from medical mistakes and implement change. Tort reform should also be nuanced enough to differentiate between a mistake, negligence, or gross negligence and punish appropriately.

The Legislature and Governor need to be aggressive in passing meaningful medical malpractice reform. This paper outlines a number of traditional and non-traditional reform options and serves as a primer to highlight the tradeoffs of each proposal.

The Legislature and Governor should not restrict their attempts to fixing medical malpractice to a handful of options; rather, they should consider the full menu of options presented in this paper as they proceed forward on cost containment legislation. Targeted reforms can help physicians practice high quality medicine with a fair accountability system in place if and when something does go wrong. Pioneer will follow this paper with a brief highlighting specific policy recommendations for Massachusetts.

Josh Archambault
Director of Health Care Policy

Introduction

In April 2006, Massachusetts set out to be the national leader in health care reform.[1] Despite significant gains in the percentage of the Commonwealth's insured population since the implementation of the 2006 health care reform, continuing challenges exist with respect to health care costs; these costs ultimately impact the financing and sustainability of health care reform.[2] As part of the discussion of cost containment at both the national and state level, medical liability reform has reentered policy circles as a means of bending the cost curve.

The Patient Protection and Affordable Care Act of 2010 passed by Congress did not include medical liability reform as part of the national health care overhaul. The law did, however, authorize appropriation of $50 million over a five year period, beginning in fiscal year 2011, for the development of state demonstration programs which would evaluate alternatives to current medical tort litigation.[3] Additionally, the act included a "Sense of the Senate,"[4] a nonbinding means of expressing majority opinion, which stated that "health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance."[5] This language signaled an increased willingness to address medical malpractice and liability insurance as part of overall health care reform.

This paper describes Massachusetts' existing medical liability system, including how it has failed to achieve its social objectives, the impact of the system on health care costs, and recent efforts towards reform. It presents policy options for medical liability reform. It examines both traditional and nontraditional avenues of reform along with strategies for advancing medical liability reform in Massachusetts.

Background

An existing ineffective medical liability system

Medical malpractice is a branch of tort law. It is designed to compensate patients for losses experienced when a physician incurs a breach of duty by deviating from the standard of care and a resultant negligent injury occurs; it is also intended to deter future negligent behavior.[6] However, the current medical liability system is inconsistent in achieving these goals. A clear disconnect between negligent injuries and malpractice litigation has been documented. For example, scholars have estimated that two percent of victims of malpractice ever file a lawsuit, while roughly thirty-seven percent of suits involve no error, and victims of malpractice frequently receive less than half of every dollar recovered through settlements or a jury verdict.[7] Thus, many cases of negligence do not result in malpractice claims, whereas malpractice claims that do arise often do not involve negligent injuries, and outcomes of malpractice claims frequently do not reflect the merits of their contention.[8] The resultant system is one that is riddled with flaws and fails to achieve its social objectives: deterring unsafe practices, quickly resolving and fairly compensating patients injured through negligence, and potentiating corrective

justice.[9] Some of the shortcomings of the current medical liability system include:

- A system that may reward undeserving individuals, as in the case of frivolous lawsuits.
- A system that may fail to reward those truly afflicted by a negligent injury, including individuals either unaware of a medical error or injury or individuals unable to obtain representation for or succeed in a jury trial.
- A system that perpetuates a suspicious relationship among patients and physicians, damaging the trust inherent in the doctor-patient relationship.
- A system that fails to promote patient safety and quality improvement because it improperly addresses root causes of medical errors and negligence.
- A system damaging to physicians, both psychologically and financially, regardless of fault.
- A system that enforces the practice of defensive medicine by encouraging a litigious environment.

The medical tort system's failings have grown out of several eras of malpractice crises representative of the cyclic insurance market. These periods have been marked by rapid increases in malpractice insurance premiums and exoduses from the marketplace by malpractice insurers, making it difficult for physicians to find adequate, affordable coverage, particularly if they have a personal history of litigation.[10] The national average time for medical liability cases to reach closure stands at three to five years.[11] The average time to resolution of a medical malpractice claim in Massachusetts is six years.[12] Worse, the system has created a "wall of silence"[13] resulting in little transparency and disclosure, ultimately failing to identify and correct problems within the health care system. Despite the Institute of Medicine's landmark report *To Err is Human*,[14] highlighting the prevalence of medical errors and adverse events, patient safety continues to take a back seat within the medical liability system.

The American Medical Association considers Massachusetts a "crisis state" with respect to medical liability and Massachusetts ranks sixth in the nation for mean medical malpractice payments.[15] Analysis of the medical malpractice insurance market in Massachusetts by the Massachusetts Division of Insurance revealed that the average medical malpractice payout on behalf of practitioners in 2006 was $465,236.[16] Furthermore, analysis of claim payments between 1990 and 2006 showed that Massachusetts' median payment was the second highest in the nation.[17]

The Massachusetts Medical Society's *Investigation of Defensive Medicine in Massachusetts*, published in 2008, highlights the medical liability environment's substantial burden on the health care system in the Commonwealth; this burden is due to the significant costs of defensive medicine and the negative impacts on patient care and physician access.[18] Indeed, Massachusetts faces the same shortcomings and inconsistencies in its medical liability system as those highlighted above. Table 1 presents the current medical liability and malpractice laws in Massachusetts.

Costs of medical liability, both direct and indirect

There are significant costs associated with a poorly functioning medical liability system. The impact of medical liability on overall health care expenditures is difficult to estimate because there are both direct costs (such as litigation fees and indemnity expenses) and indirect costs (such as defensive medicine).[19] In the report, U. S. Tort Cost Trends, 2010 Update, Towers Watson estimated the cost of medical malpractice (excluding defensive medicine) at approximately $30 billion in 2009, noting a 10 percent average annual growth rate in medical malpractice costs since 1975.[20] The Congressional Budget Office (CBO) arrived at a similar estimate of the direct costs of the medical liability system (comprised

Table 1. Medical Liability and Malpractice Laws in Massachusetts

Medical liability provision	Summary of provision
Damage award limit or cap	**Ch. 231 §60H.** $500,000 limit for pain and suffering, loss of companionship, embarrassment and other items of general damages unless there is a determination that there is a substantial or permanent loss or impairment of a bodily function or substantial disfigurement, or other special circumstances. Except as provided, if two or more plaintiffs have received verdicts or findings of such damages in a total amount, for all plaintiffs claiming damages from a single occurrence, transaction, act of malpractice, or injury which exceeds $500,000, the amount of such damages recoverable by each plaintiff will be reduced to a percentage of $500,000 proportionate to that plaintiff's share of the total amount of such damages for all plaintiffs. 16 jurisdictions do not have a damage award limit or cap, 36 jurisdictions have a limit or cap. Connecticut and Minnesota allow for a court to review of the damage awarded, but does not specify a specific limit or cap.
Statute of limitation	**Ch. 260 §4.** Within three years after the cause of action accrues, but in no event shall any such action be commenced more than seven years after occurrence of the act or omission which is the alleged cause of the injury upon which such action is based except where the action is based upon the leaving of a foreign object in the body.
	Ch. 231 §60D. A minor under the full age of 6 shall have until 9th birthday in which the action may be commenced, but in no event shall any such action be commenced more than seven years after occurrence of the act or omission which is the alleged cause of the injury upon which such action is based except where the action is based upon the leaving of a foreign object in the body.
Joint and several liability	**Ch. 231B §1.** Liability by which members of a group are either individually or mutually responsible to a party.
Limits on attorney fees	**Ch. 231 §60I.** No contingent fee agreement, shall be enforced, and no attorney shall recover a fee there under, as a result of services rendered in an action against a provider of health care for malpractice, negligence, error, omission, mistake, or the unauthorized rendering of professional services if, at the time of judgment, the court determines that the amount of the recovery paid or to be paid to the plaintiff, after deduction of the attorney's reasonable expenses and disbursements for which the plaintiff is liable and the amount of the attorney's fee, is less than the total amount of the plaintiff's unpaid past and future medical expenses included in the recovery, unless the contingent attorney's fee: (a) is 20 percent or less of the plaintiff's recovery; (b) is reduced to 20 percent or less of the plaintiff's recovery; or (c) is reduced to a level which permits the plaintiff to be paid his unpaid past and future medical expenses included in the recovery. Sliding scale, not to exceed 40 percent of first $150,000; 33-1/3 percent of next $150,000; 30 percent of next $200,000 and 25 percent of award over $500,000.
Periodic payments	No applicable statute
Payment compensation or injury fund	None provided
Doctor apologies/sympathetic gestures	**Ch. 233 §23D.** Statements, writings or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering or death of a person involved in an accident and made to such person or to the family of such person shall be inadmissible as evidence of an admission of liability in a civil action.
Pre-trial alternative dispute resolution and screening panels	**Ch. 231 §60B.** Every action for malpractice, error or mistake against a health care provider shall be heard by a tribunal consisting of a single justice of the superior court, a licensed physician and a licensed attorney. The tribunal shall determine if the evidence presented if properly substantiated is sufficient to raise a legitimate question of liability appropriate for judicial inquiry or whether the plaintiff's case is merely an unfortunate medical result. The testimony of witnesses and the decision of the tribunal shall be admissible as evidence at a trial.
Affidavit or certificate of merit	No statute provided specific to medical liability/malpractice cases
Expert witness standards	No statute provided specific to medical liability/malpractice cases
Medical or peer review panels	**Ch. 111 §203 et seq.** Medical peer review committees

Source: Adapted from "Medical Liability/Malpractice Laws. " NCSL Home. National Conference of State Legislatures. Last updated September 23, 2010. http://www.ncsl.org/?tabid=18516 Accessed April 23, 2011.

of malpractice insurance premiums, settlements, awards, and administrative expenses not covered by insurance) in 2009, estimating a cost of approximately $35 billion, or nearly 2 percent of total health care expenditures.[21]

In Massachusetts, medical malpractice insurance can be obtained through three entities: traditional insurance companies licensed by the Division of Insurance; surplus lines carriers, which are non-Massachusetts licensed insurers allowed to issue coverage through licensed brokers to individuals who cannot obtain coverage from traditional insurers in Massachusetts; and risk retention groups, which are insurers formed under federal law (The Federal Liability Risk Retention Act of 1986) and in which policyholders are also equity holders.[22] The combined medical malpractice premiums collected by these groups in Massachusetts increased from $198 million in 2001 to $322 million in 2009, an increase of 63 percent over eight years.[23]

Much of the increase in Massachusetts' malpractice premiums occurred in the early 2000s when the medical malpractice insurance market was in a state of unrest nationally. Several factors contributed to this spike in malpractice premiums: a decline in insurance company investment revenues, increased reinsurance expenses, premium rate changes that did not keep up with incurred claims during the late 1990s when insurers were attempting to gain market share, and decreased coverage availability as certain insurers stopped renewing policies.[24] An example of this unrest occurred in 2003, when ProMutual Insurance Group increased annual premium rates by 20 percent for physicians; ProMutual Insurance Group is Massachusetts' largest medical malpractice insurer, with approximately 43 percent of the total market.[25] While ProMutual's annual premium growth rate has stabilized, averaging 3.1 percent from 2005 through 2010,[26] this example illustrates physicians' vulnerability to the cyclical nature of the medical malpractice insurance market, exposing them to significant uncertainty and rate volatility.

Of particular interest and debate are the indirect costs associated with the medical liability system: specifically, the impact of defensive medicine on health care spending. Defensive medicine is defined as occurring when "doctors order tests, procedures, or visits, or avoid certain high-risk patients or procedures, primarily (but not necessarily solely) because of concern about malpractice liability."[27] In response to the threat of litigation, physicians assume either assurance behaviors (consisting of ordering or providing ancillary, unnecessary services designed to reduce adverse outcomes, deter malpractice claims or to preempt litigation by proving adherence to standard of care measures) or avoidance behaviors (avoidance of high risk patients or procedures).[28] Most experts agree that defensive medicine exists, particularly among physicians in high-risk specialties and physicians practicing in areas with higher malpractice premiums.[29] Additionally, it is clear from physician surveys that defensive medicine pervades medical culture, and that high levels of concern about malpractice litigation predominate.[30] The primary divide among industry experts exists over the magnitude of defensive medicine's cost impact on overall health care spending.

Studies that attempt to quantify the indirect costs of medical malpractice, including defensive medicine, vary in their estimates.[31] Few reliable cost estimates incorporating defensive medicine exist because of the difficult nature of the analysis, including issues of data availability and study design. A 2006 PricewaterhouseCoopers report, extrapolating from previous cost estimate studies, estimated that 10 percent of health care costs are associated with medical liability and defensive medicine.[32] However, another study recently published by Mello, Chandra, Gawande and Studdert estimated the annual cost of the medical liability system, including defensive medicine, in 2008 dollars to be $55.6 billion or 2.4 percent of overall health care expenditures.[33]

In Massachusetts, a 2008 survey of physicians conducted by the Massachusetts Medical Society (MMS) found that 83 percent of physicians in Massachusetts had practiced defensive medicine.[34] With regards to the so-called negative defensive medicine[35] or avoidance behaviors, 38 percent of physicians surveyed reported reducing the number of high-risk services or procedures performed, while 28 percent reported reducing the number of high-risk patients seen. This report estimated the annual cost of defensive medicine in Massachusetts to be about $1.4 billion in 2006 dollars or 2.8 percent of Massachusetts' projected 2006 total health expenditures.[36] However, this estimate represents only the costs associated with eight physician subspecialties, constituting 46 percent of Massachusetts physicians. The estimates did not include the cost of tests and diagnostic procedures ordered by physicians in other specialties, observation admissions to hospitals, specialty referrals and consultations, or unnecessary prescriptions. Thus, MMS concluded that the total cost of defensive medicine in Massachusetts is likely to be significantly more. Although inconsistent estimates exist, the amount of money spent because of defensive medicine and the overall medical liability system is considerable.

Reform of the medical malpractice system can certainly impact direct malpractice costs, but questions remain about whether reform of the system also can reduce the indirect costs and by how much. A 2009 update from the CBO estimated that enacting a series of traditional tort reforms (including but not limited to a $250,000 cap on noneconomic damages, replacement of joint-and-several liability with a fair-share rule in which defendants would be responsible for a percentage of final award amounts based upon their degree of responsibility, and a one year statute of limitations for adults and three years for children from the date of discovery of an injury) would reduce the federal deficit by approximately $54 billion over a ten-year period from 2009 through 2019.[37] CBO's upward revision of previous estimates was based upon the conclusion that "the weight of evidence [now] indicates that tort reform would reduce the utilization of health care services and, thereby, spending."[38] Although reforms such as those analyzed by the CBO are likely necessary to begin altering physician behavior,[39] fundamentally new approaches to tort reform must also be considered for significant changes in behavior to occur.

Medical Liability Reform

Reform efforts nationally

One current effort at national liability reform is H. R. 5 Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011. This bill was introduced by Representative Phil Gingrey (R-GA, 11th District), a physician, and seeks to create a number of uniform federal standards concerning medical malpractice.[40] Specifically, the HEALTH Act would:

- Limit the statute of limitations to three years after occurrence of injury or one year after discovery, with exceptions;
- Cap noneconomic damages at $250,000 with each party being solely responsible for its percentage of responsibility;
- Restrict attorneys' fees;
- Allow the introduction of collateral source benefits as evidence;
- Limit punitive damages to the greater of two times the amount of economic damages or $250,000;
- Deny punitive damages for cases involving Food and Drug Administration (FDA) approved and compliant products; and
- Implement periodic payments of future damages.[41]

Versions of the bill, first introduced in 2002, have yet to be passed by Congress. Furthermore, with issues of federalism at play and pursuant bipartisan denunciation of the bill by the National Conference of State Legislatures,[42] it is unlikely

that meaningful medical liability reform will soon occur at the federal level.

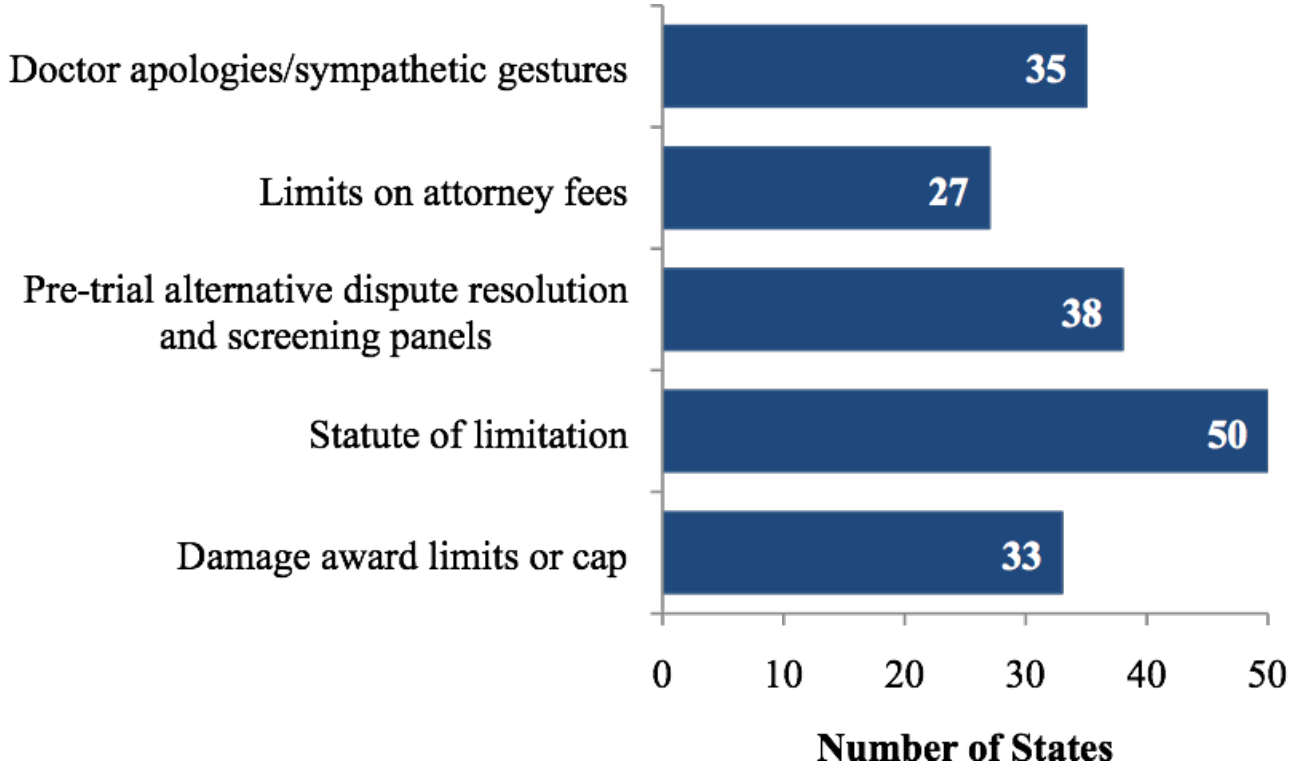
As with other insurance regulation, medical malpractice and tort reform have traditionally been regulated at the state level.[43] Over the years, an increasing number of states have adopted legislation with specific medical tort reform provisions (Figure 1). These laws vary significantly in extent and scope, but they are predominantly based upon traditional tort reforms such as caps on damages and statutes of limitations. For example, California has a $250,000 limit for noneconomic damages, while Nebraska limits total damages to $1.75 million, with health care provider liability limited to $500,000.[44] Such variation tends to reflect local market dynamics and a state's political environment. Accordingly, state-level reforms represent a better option for meaningful changes to the medical malpractice system. Figure 1 summarizes the types of provisions found in states' statutes regarding medical liability and malpractice.

Reform efforts locally

Massachusetts' 2006 health care reform bill expanded access to health insurance but did little to constrain the growth of health care spending. Between 2006 and 2008, private spending for health care grew 15.5 percent, or about 7.5 percent annually.[45] In February 2011, Massachusetts Governor Deval Patrick introduced a bill entitled "An Act Improving the Quality of Health Care and Controlling Costs by Reforming Health Systems and Payments." Much of the legislation centered on reforming the care delivery system through the adoption of Accountable Care Organizations (ACOs) while transitioning from the predominant fee-for-service payment system to alternative payment structures (such as global payments). To garner provider support for the bill, the governor included limited language addressing medical liability reform.

Specifically, the legislation seeks to achieve reductions of indirect costs by "discouraging the practice of defensive medicine and improving

Figure 1. State Medical Liability/Malpractice Laws



Source: "Medical Liability/Malpractice Laws." NCSL Home. National Conference of State Legislatures. Last updated September 23, 2010. Accessed April 23, 2011: http://www.ncsl.org/?tabid=18516

the quality of health care by requiring open communication between providers and patients during a 'cooling off period' before litigation can commence and limiting the use of a physician's apology in litigation."[46] However, the Governor's bill does nothing to address the direct cost of malpractice cases, in the short term.

Traditional Medical Liability Reforms - Table 2

Effective medical liability reform should seek to reduce overall health care costs by lowering both the direct (e.g., malpractice premiums) and indirect (e.g., defensive medicine) costs of medical liability. Reforms should potentiate quality improvement and patient safety initiatives, a failure of the current medical liability system.[47] Finally, given concerns that medical liability reform may have unforeseen and potentially negative impacts on health outcomes,[48] effective reform should seek to minimize any such consequences.

A recent assessment of the body of existing evidence on the effects of traditional tort reforms on liability measures (claims frequency, indemnity costs, overhead costs, and malpractice insurance costs) and care-related measures (defensive medicine, physician supply and quality of care) by Kachalia and Mello concluded that traditional tort reforms have not significantly improved important liability measures.[49] A number of other comprehensive reviews have also concluded that traditional liability reforms, with the exception of caps on noneconomic damages,[50] are limited in their ability to reduce indirect liability costs and improve quality of care.[51] Empirical analysis of state tort reforms by type and strength found a measurable but limited impact on the number and value of paid malpractice claims.[52] Although traditional reforms provide a mode for cost reduction, they will likely fail to fully alleviate physicians' fears of litigation.[53]

The sum of the evidence shows, however, that caps on noneconomic damages are effective at reducing the size of indemnity awards and appear to be effective at reducing the cost of certain defensive medicine practices as well.[54] Thorpe found that states with caps on damages have 17.1 percent lower malpractice premiums than those states without caps.[55] Additionally, Hellinger and Encinosa used multivariate modeling and estimated that caps on noneconomic damages reduce state health care expenditures by three to four percent.[56] Nonetheless, caps on noneconomic damages alone will not entirely address the problems of the medical malpractice system. Given the impact of the malpractice environment on patient quality of care, physician practice patterns, and subsequent costs of defensive medicine, meaningful reform must also address these problems.

Nontraditional Medical Liability Reforms - Table 3

A number of nontraditional reforms have emerged. Nontraditional reforms seek to expand the goal of medical liability reform to create a tort system in which patient safety serves as the centerpiece, and factual claims are appropriately compensated.[57] Thus, nontraditional reforms not only aim to decrease malpractice premiums, as with certain traditional reforms, but also seek to change the physician practice environment in order to reduce the practice of defensive medicine. Accordingly, nontraditional tort reforms may hold promise for changing the medical malpractice system in a manner that is beneficial to everyone involved.

While the empirical evidence supporting the efficacy of nontraditional reforms is currently limited and partially based upon theoretical application, nontraditional tort reforms hold promise for achieving sweeping change to the medical liability system. New approaches are currently being tested and studied empirically. For example, as part of its Medical Liability Reform and Patient Safety Initiative, the Agency for Healthcare Research and Quality (AHRQ) awarded $23 million in demonstration and planning grants in 2010 for projects focused on

Table 2. Descriptions and Objectives of Traditional Medical Liability Reforms

Reform	Description	Objective
Caps on damages	Limitations are placed on the monetary compensation that can be awarded in a malpractice trial for noneconomic losses ("pain and suffering"), economic losses, or both. A cap may apply to the plaintiff, limiting the amount that the plaintiff may receive, or to a defendant, limiting the total amount that the defendant may be required to pay.	To reduce the number of very large awards and the high degree of variation (including perceived arbitrariness) in "pain and suffering" awards, improving insurers' ability to predict liability and set insurance prices accurately.
Pretrial screening panels	Expert panels review malpractice cases at an early stage and provide opinions about whether claims have sufficient merit to proceed. Typically, a negative opinion does not bar a case from going forward, but to proceed, a plaintiff may be required to post a bond, and the negative opinion will be admissible evidence at trial.	To reduce the number of non-meritorious claims that are filed or advanced. To reduce the time and money expended in resolving claims of questionable merit by encouraging plaintiffs to abandon such claims or agree to a modest settlement. Also, for claims that go to trial, panel decisions can provide juries with a neutral source of expertise.
Certificate-of-merit (COM) requirements	The plaintiff must present, at the time of filing a malpractice claim or soon thereafter, an affidavit certifying that a qualified medical expert believes that there is a reasonable and meritorious cause for the suit.	To reduce the number of non-meritorious claims that are filed or move forward.
Limits on attorneys' fees	Limitations are placed on the amount that a plaintiff's attorney may take as a contingency fee. Typically expressed as a percentage of the award, but may also incorporate a maximum dollar value.	To discourage plaintiff's attorneys from accepting certain cases, particularly those involving small damages and claims of marginal or no merit, by diminishing the attorney's expected return on investment.
Joint-and-several liability (JSL) reform	In malpractice trials involving multiple defendants, JSL reform limits the financial liability of each defendant to the percentage of fault that the jury allocates to that defendant. Without this statutory reform, a plaintiff may collect the entire judgment from one defendant, regardless of that defendant's extent of fault.	To eliminate any unfair disadvantage that defendants with deep pockets may have in multiple-defendant cases.
Collateral-source rule reform	Eliminates a traditional rule that even if injured plaintiff has received compensation from other sources (e.g., health insurance), the amount of that compensation should not be deducted from the amount that a defendant who is found liable must pay.	To lower the amount of damages that defendants pay and to eliminate perceived unfairness of double compensation for plaintiffs.
Periodic payment	Allows or requires insurers to pay malpractice awards over extended period of time rather than in lump sum. Insurers are also able to retain any amount that is not collected during a plaintiff's lifetime.	To enable insurers to spread their expenses over time, allowing them to better predict year-to-year liability costs and purchase annuities that lower total costs.
Statutes of limitations and repose	Limit amount of time patient has to file a malpractice claim after being injured or discovering an injury.	To reduce the difficulties of litigating claims when evidence has grown stale. By shortening the period of time associated with malpractice claims, they also aim to help insurers better predict liability costs.

Source: Adapted from Kachalia A, Mello MM. New directions in medical liability reform. N Engl J Med 2011;364:1564-72.

Table 3. Descriptions and Objectives of Nontraditional Medical Liability Reforms

Reform	Description	Objective
Schedule of noneconomic damages	An alternative to a flat cap that adjusts the amount of damages awarded for pain and suffering according to the severity or the injury. A dollar value range for "pain and suffering" awards is assigned to each severity tier. The schedule is used by juries and judges either as an advisory document or as a binding guideline.	Achieves the goal of a flat cap on noneconomic damages while avoiding the inequities that occur in applying a single, relatively low dollar amount to all injuries regardless of severity level; setting damages to match (and not exceed) societal expectations about what constitutes appropriate compensation for particular injuries; and, avoid the negative ramifications of unpredictability in damages awards, including instability in the cost of liability insurance, weakened deterrence of medical error, and loss of public faith in the legitimacy of the compensation system.
Administrative compensation systems or "health courts"	Routes claims into an alternative process involving specialized judges, decision and damages guidelines, neutral experts, and a compensation standard that is broader than the negligence standard.	Decrease the high overhead costs associated with medical tort system; create more representative and consistent decisions; capture and catalog events to drive patient safety initiatives.
Disclosure-and-offer programs	Liability insurers and self-insured hospitals provide support to physicians disclosing unanticipated outcomes to patients and make rapid compensation offers, when appropriate.	To encourage honesty and transparency around unanticipated care outcomes, expedite compensation to injured patients, reduce malpractice claims and average payouts, and reduce overhead costs for claims processing.
"Safe harbors" for adherence to evidence-based practice guidelines	Strengthens a physician's ability to use his/her adherence to accepted, evidence-based clinical practice guidelines as a defense to a malpractice claim.	To help prevent or quickly dismiss claims that lack merit and to reduce the prevalence of defensive medicine.
Enterprise liability	A legal doctrine assigning liability to a health care organization for tortious injuries that occur within its facilities or are caused by its clinical staff affiliates, including but not limited to its employees, thus reducing or eliminating individual physician liability.	Addresses perceived unfairness of individual physicians holding sole responsibility for "systems failures" leading to preventable injuries within an organization, incentivizes organizations to invest in patient safety initiatives, ensures patients are compensated for injuries, and improves insurers' ability to accurately estimate experience ratings.
Contract liability	Patients contract with either individual physicians or larger organizations such as health plans or hospitals in order to establish predetermined rules for compensation in the event of negligent injury.	Seeks to circumvent the existing medical tort system. Patients can contract for the rules that maximize their welfare. If done properly, it is the most market-effective.

†Descriptions and objectives modified or taken from the following sources:
(1) Mello MM, Kachalia A, Goodell S. Medical malpractice—update. Princeton, NJ: Robert Wood Johnson Foundation, 2011, and (2) Mello MM, Kachalia A. Evaluation of options for medical malpractice system reform. Washington, DC: Medicare Payment Advisory Commission, 2010. (3) Author contribution.

new approaches to addressing medical liability reform and patient safety.[58]

Advancing Reform in Massachusetts

Governor's Disclosure, Apology & Offer Proposal: Strengths and Weaknesses

Patients understandably expect to be informed of medical injuries and adverse events.[59] When failures in communication occur, however, patients are more likely to initiate litigation in the event of an adverse outcome.[60] With the patient safety and quality movement well established, physician ethos around error disclosure is shifting towards increased transparency.[61] Evidence of this is the development of disclosure and offer programs, an emerging, promising model for medical error disclosure and early case resolution.[62] Disclosure and offer programs share two core elements: 1) timely and forthright disclosure of medical errors and injuries when they occur with corresponding apologies, and 2) some form of financial compensation.[63]

The early-settlement model[64] established by the closed (self-insured) University of Michigan Health System (UMHS) has emerged as an exemplar of disclosure and offer practices.[65] The UMHS model is unique because it uses an expedited review process in which reported errors and injuries are investigated in a timely fashion and, if inappropriate care is identified, compensation is offered, including "pain and suffering" damages. However, patients agreeing to accept an offer waive their right to further litigation, accepting the award as a final settlement.[66] Evidence of the model's efficacy for expediting patient compensation, improving patient safety review processes, and decreasing litigation costs is promising. Although unable to establish causality, retrospective review of claims pre- and post-program implementation at the University of Michigan found a significant decreases in total claims, claims rates, time to resolution of claims, and liability costs.[67]

Concerns about a disclosure, apology and offer model's translatability across the broader health care system exist, principally because of the nature of a closed system in which self-insurance exists without ceilings on physician's claim payments. Under such a system, physicians are more wholly protected, thus allowing for a high rate of compliance with the disclosure model. There are also questions about this model's effectiveness in systems where physicians' affiliation with a hospital or health care enterprise is less formal. Concerns have been raised about compliance and capacity to institute such a program in smaller or rural hospitals or in an ambulatory setting, for example. Several AHRQ-funded demonstration projects currently underway in Illinois and New York explore the applicability of the disclosure and offer model across different types of hospitals and health care systems.[68]

These laws have other potential shortcomings. Gallagher, Studdert and Levinson note "approximately two-thirds of state apology laws protect only the expression of regret, not accompanying information related to causality (our care caused your injury) or fault (this should not have happened).[69] Despite the good intentions of such laws, further initiatives and/or stronger language must be adopted in order to affect broader adoption of transparent disclosure behavior.

Seeking to encourage the adoption of disclosure and offer programs, at least 35 states now have apology laws providing certain protections for information expressed in disclosures of medical adverse events, typically apologies or expressions of regret.[70] An additional 11 states, including Massachusetts, have introduced bills in the 2011 legislative cycle proposing or amending such laws.[71]

As stated previously, Governor Patrick's recently introduced legislation, "An Act Improving the Quality of Health Care and Controlling Costs by Reforming Health Systems and Payments," includes language addressing medical liability

reform in Massachusetts. Specifically, section 19 ("Clinician-Patient Communication and Grievance Resolution") and section 20 ("Treatment of Provider Apology in Litigation") propose changes to the current malpractice system. Section 19 would establish a number of requirements of claimants and health care providers prior to commencement of legal action in a medical tort case. These requirements include 180-day written notice, with exceptions, by claimants to providers prior to legal action; specific statement requirements (including items such as a description of the factual basis of the claim and the alleged action that should have been taken to comply with the alleged standard of care that was breached); provider response requirements; and timely provider and claimant access to pertinent medical records. These measures encourage the aforementioned cooling-off period. Section 20 (b) specifically addresses medical apologies, stating:

> In any claim, complaint, or civil action brought by or on behalf of a patient allegedly experiencing an unanticipated outcome of medical care, statements, affirmations, gestures, activities or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error, or general sense of concern which are made by a health care provider, facility or an employee or agent of a health care provider or facility, to the patient, a relative of the patient, or a representative of the patient and which relate to the unanticipated outcome shall be inadmissible as evidence in any judicial or administrative proceeding and shall not constitute an admission of liability or an admission against interest.[72]

The introduction of this legislation corresponds with the Massachusetts Medical Society's March 2011 presentation of its initial findings of a joint, AHRQ-funded study with the Beth Israel Deaconess Medical Center assessing the feasibility and barriers to implementation of a disclosure, apology and offer (DA&O) approach to medical liability reform in Massachusetts.[73] The most important barriers to incorporating DA&O, as identified in the "Roadmap for Transforming Medical Liability and Improving Patient Safety in Massachusetts" presentation, included Massachusetts' charitable immunity law, physician discomfort with disclosure and apology, attorneys' interest in maintaining the status quo, and coordination across insurers.[74] Massachusetts' charitable immunity law (Massachusetts General Laws, Chapter 231, Section 85K) significantly limits liability for nonprofit hospitals in Massachusetts. Therefore, the burden of medical liability in Massachusetts is borne by physicians; this law could be a significant impediment to the success of DA&O programs in the Commonwealth.

The Governor's current legislation seeks principally to encourage the adoption of DA&O programs by hospitals and health care institutions across the state by providing specific health care provider apology protections. The Massachusetts Medical Society has identified numerous and challenging barriers to implementing such programs, and there exists a lack of understanding of the applicability of such programs to non-closed health care systems. These barriers threaten the potential success of a DA&O medical liability reform approach. With the onus of liability predominantly on physicians given the charitable immunity law in Massachusetts and the overall medical liability environment still tenuous as reviewed previously, more ambitious changes to the medical liability system may be needed at this time.

Enterprise liability, joint and several liability, and caps

A number of specific reforms are of interest. Given legislative interest in Accountable Care Organizations as a model of care delivery, there is an opportunity for experimentation with enterprise liability. Enterprise liability transfers liability from the individual to an organization.[75] One of the potential benefits of such a system

is that individual and organizational incentives may be better aligned so as to bring about systemic changes in patient safety and quality improvement.[76] An enterprise liability initiative would have to address the existing charitable immunity law in Massachusetts. Furthermore, joint and several liability reforms should be adopted, allowing for the financial liability of defendants to be limited to a percentage of fault as determined by a jury. Additionally, in order to gain the full benefits of a cap on noneconomic damages, Massachusetts legislators should review current law and consider imposing caps or damage schedules in cases of ordinary malpractice.

Safe harbor

Another tort reform that should be considered carefully is the implementation of a safe harbor law. Safe harbor laws provide increased protections to physicians who utilize established clinical practice guidelines. Several states conducted demonstrations of this model in the 1990s; however, the demonstrations were limited and not designed for purposeful appraisal.[77] Safe harbor laws are challenging because they must strike a proper balance so as not to institute purely guideline-driven medicine in which providers are unable to practice with sufficient autonomy and utilize their independent medical judgment in individual cases. However, safe harbor laws remain attractive for their increased protection of physicians and their potential for decreasing defensive medicine. Indeed, the model is currently being evaluated in Oregon through a yearlong planning grant funded by AHRQ that will establish evidence-based guidelines for defining the legal standard of care, and develop legislation for providing safe harbor protections to such guidelines.[78]

New idea of contract liability

A complete discussion of medical liability reform and alternatives to medical tort litigation would be remiss without mention of contract by liability.[79] As a progressive option for medical liability reform, contract by liability seeks to circumvent the existing medical tort system. Under such a system, patients contract with either individual physicians or larger organizations–such as health plans or hospitals–to establish predetermined rules for compensation in the event of negligent injury. Proponents of contract by liability argue that patients would be as well served, if not better served, by this system as they are under the current medical liability system, because they "would contract for the rules that maximize their welfare."[80] Specifically, proponents argue that such a system would allow for greater flexibility to negotiate liability rules that would better reflect a patient's risk preference and ability to pay for medical care, thus providing economic appeal over the current system.[81] Opponents to liability by contract argue that such contracts represent "contracts of adhesion" because providers have greater authority and increased bargaining power over patients and that some patients may lack sufficient information to make educated decisions regarding liability rules.[82]

Goodman, Villareal and Jones advocate for a model in which patients could contract for voluntary, no-fault insurance which would guarantee compensation for an adverse medical event (allowing for higher compensation if a patient were to pay an additional higher premium) while excluding them from traditional tort litigation.[83] Although an interesting option, there is a legal precedent against contract liability for medical malpractice (without an alternative compensation mechanism)[84] and as a result must be configured with such a condition in mind.

Legislation in Massachusetts seeking to address rising health care spending and enact medical liability reform should incorporate money for demonstration projects within the Commonwealth, with additional monies being sought through a federal grant from appropriations within the Patient Protection and Affordable Care Act.

To be successful, meaningful medical liability reform must pull from both successful traditional tort reform measures, as well as incorporate innovative nontraditional strategies. This paper discusses a number of approaches for nontraditional tort reform, and legislators and stakeholders should act together to find the right mix of such reforms in Massachusetts.

Conclusion

In the current era of health care reform, continued inaction with respect to medical liability is unacceptable. Recent health care reform has aimed to fundamentally restructure the organization, delivery and financing of health care. As a result, physicians face increasing pressures to take on additional risk and institute more cost-effective care. If such initiatives are expected to be successful in helping to slow the growth of health care expenditures, then physicians must be afforded changes to their practice environment and changes in the medical liability system aimed at promoting increased patient safety and improved quality.

Rather than serve as a quid pro quo for physicians, medical liability reform should bring stakeholders together to generate a more fulfilling tort system. Such a system must ensure patients' rightful compensation for negligent injury while providing assurances to physicians that allow for practice in a medically sound fashion without the need for excessive care. Unfortunately, the current health care system does not reward transparency or address doctors' fears of being drawn into long, inefficient litigation. Accordingly, the time for meaningful medical liability reform in Massachusetts is now.

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