



Perspective

Malpractice Reform — Opportunities for Leadership by Health Care Institutions and Liability Insurers

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In February 2010, the Illinois Supreme Court ruled that the state's cap on noneconomic damages in medical malpractice cases violated the Illinois constitution.¹ This development has contributed to

growing pessimism about traditional approaches to medical liability reform. In some quarters, interest is shifting to innovative reforms that can be implemented by health care institutions and liability insurers without requiring changes in the law. These approaches provide a better balance between the interests of providers and those of patients and illuminate a path around the political gridlock over tort reform. They also afford opportunities for health care institutions and liability insurers to take the lead in reforming the processes for providing compensation for medical injuries.

Here, we focus on emerging models of disclosure of medical

injuries and early resolution of cases ("disclosure and offer" programs). Other models of private reform, including mandatory binding arbitration and voluntary mediation, have reportedly had some success but have failed to become widespread. The market may be more receptive to disclosure-and-offer approaches, which link the compensation system to improvements in patient safety.

In general, private, institution-led reforms have many advantages. First, most of the reforms can be pursued without legislation. In some states, it is nearly impossible to effect liability reform because of political divisions fostered by powerful interest groups. In others, the

legislature is dysfunctional and unable to accomplish major reform or is hamstrung by budgetary problems. Initial optimism that federal health care reform legislation would include major liability reform eventually faded, though the Obama administration has made a substantial commitment to supporting demonstration projects in which health care systems or states implement innovative reforms.²

Second, institutional reforms can be led by physician champions and other insiders, promoting buy-in from clinical and risk-management staff. Third, because most private approaches do not abridge legal remedies, they may be more palatable to consumer groups, trial-lawyer organizations, and patients. Fourth, private approaches can be tailored to each institution's unique culture, systems, and resources. Finally, institution-led approaches represent

Policy Mechanisms for Encouraging Institutional Malpractice Reforms and Potential Benefits.	
Policy Mechanism	Potential Benefits
Funding of rigorous evaluations of existing programs	Bolster the evidence base for particular reform models, reducing uncertainty and perceived risk for institutions
Federal and state funding for demonstration projects	Bolster the evidence base for particular reform models, including information about generalizability of anecdotal successes Encourage institutions to design and test new approaches Reduce the direct financial costs of implementing reforms
For institutions that implement reforms, provision of subsidized reinsurance or other mechanisms to limit the institution's potential financial losses	Reduce the financial risk of implementing reforms
Provision of "pay for performance"—type incentives for institutions that implement successful reforms	Provide financial incentives for implementing and evaluating reforms
Passage or strengthening of state laws that provide legal protection for disclosure, apology, and settlement statements	Reduce the legal risk associated with implementing disclosure-and-offer programs
Relaxation of reporting requirements to the National Practitioner Data Bank and state medical boards, or clarification that they do not apply to disclosure-and-offer program payments	Reduce perceived collateral adverse effects of agreeing to early settlement offers
Clarification that state insurance departments will look favorably on proposals for disclosure-and-offer programs or other modifications to claims-management processes	Reduce administrative barriers to adopting new approaches to insurance or claims management

a market solution governed by market forces. Insurers and health care organizations (and perhaps even clinicians and patients) can “vote with their feet,” and successful programs can be expanded and replicated, while unsuccessful ones are discontinued.

The disclosure-and-offer approach has been implemented by a handful of hospital systems and liability insurers, building on an early experiment at the Veterans Affairs hospital in Lexington, Kentucky.³ Three distinct models have emerged. All begin with an organizational policy of full disclosure of adverse events and training and support for clinicians to aid them in making disclosures. All share a general philosophy of risk management that holds that being candid about medical injuries, apologizing when appropriate, and providing for the patient's financial needs (in at least a limited way) through a quick, accessible process will eliminate the impetus for

most patients or families to sue and will spur institutional learning and safety improvement. The models diverge in their specific approaches to compensation.

In what we call the “reimbursement model,” the institution offers to reimburse the patient for some out-of-pocket expenses related to the injury and for “loss of time.” The program has a predetermined limit on reimbursement (typically about \$25,000 for expenses and \$5,000 for loss of time), and reimbursement is offered without an investigation into possible provider negligence. Patients who accept the money do not waive their right to sue. However, injuries that are clearly due to substandard care, as well as fatal injuries and cases in which a claim has been filed or an attorney is involved, are excluded and handled through traditional claims processes. The best-known example of this model is the “3Rs” program operated by COPIC Insurance, a private,

physician-directed medical liability company in Colorado.

The “early-settlement model,” pioneered by the self-insured University of Michigan Health System,⁴ is quite different. There are no preset limits on compensation. Compensation is not generally offered unless the institution, after an expedited investigation, determines that the care was inappropriate. The offer may include compensation for all elements of loss that are compensable in tort cases, including medical expenses, lost income, other economic losses, and “pain and suffering.” To accept the money, patients must agree that it constitutes a final settlement, thus foreclosing a lawsuit. The early-settlement approach is applied to all injuries; there are no exclusion criteria.

The third model, proposed in scholarly work on the basis of the successful experience of several foreign countries, is health courts.⁵ Patients are informed, at the time an injury is disclosed,

that they can file a compensation claim with the provider or its insurer. A panel of experts, aided by decision guidelines, determines whether the injury was avoidable — a determination that turns on whether the injury would ordinarily have occurred if the care had been provided by the best specialist or an optimal health care system; the avoidability standard is more generous than the negligence standard. For avoidable injuries, the institution offers full recompense for economic losses plus an amount for pain and suffering according to a predetermined compensation schedule that is based on injury severity. Some health court proposals envision that patients who are dissatisfied with a decision could bring their case to a second administrative panel or judge provided by the state, with a limited right of judicial appeal.⁵ Alternatively, in voluntary health court models (in which a state process has not been created through legislation), patients could reject the compensation offer and file a lawsuit, unless they had previously waived this right as a contractual condition of receiving care. Although health courts have not yet been adopted in the United States, President Barack Obama recently called for “demonstrations of alternatives to resolving medical malpractice disputes, including health courts.”²²

A key feature of all disclosure-and-offer models is that the information obtained from the investigation and resolution of injury cases is used to improve patient safety. All the countries with health courts maintain and analyze large national databases of medical injuries to identify dangerous conditions or processes and share that information with health

care institutions.⁵ Within U.S. institutions operating disclosure-and-offer programs, the analysis and sharing of data strengthen relationships between risk managers and patient-safety officers, facilitating the implementation of safety interventions. Liability insurers can use other strategies to promote safety, such as offering financial incentives to clinicians for completing disclosure training, following safe practices, and reporting incidents promptly to risk-management officials. Although all these measures can be pursued within traditional claims-management processes, disclosure-and-offer programs create structures and institutional commitments that enhance their effectiveness.

Nevertheless, institution-led malpractice reform has limitations. The development of local programs exacerbates the patchwork nature of compensation for medical injury, which originates from variations among juries and state tort reforms, and can cause inequities in compensation for patients with similar injuries. In addition, institutional innovations are harder to evaluate rigorously than are statewide reforms. More innovative reforms are riskier than more traditional types of reforms. Health courts have not been tested in the United States, and it is unclear to what extent the successes reported by pioneers of the reimbursement and early-settlement models would be generalizable to other institutions. A program's success would probably be affected by the particular organizational structure of the institution, the availability of resources, the institution's tolerance for risk, and the personalities of those involved in implementing the program. Furthermore, the fact that private

reforms generally preserve legal remedies constrains their ability to limit litigation.

Institution-led reform may also be hampered by regulatory requirements. For example, state insurance departments, which regulate the management of malpractice claims, may be more permissive or less permissive in their attitudes toward disclosure-and-offer programs. The federal requirement that all claims payments be reported to the National Practitioner Data Bank may discourage physicians from agreeing to early settlements, though the requirement does not apply to reimbursement programs. Finally, leaving reform to private institutions may result in reforms that are driven more by financial benefits for hospitals than by considerations such as improved performance of the injury-compensation system or “doing the right thing” for patients.

Certain policy measures could stimulate more widespread adoption of private malpractice reforms (see table). This experimentation is not free of risk, but institutions should seize the opportunity to lead rather than wait for tort reform at the federal or state level. Their ingenuity, vision, and commitment to helping injured patients can improve a system that bedevils providers, patients, and policymakers alike.

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