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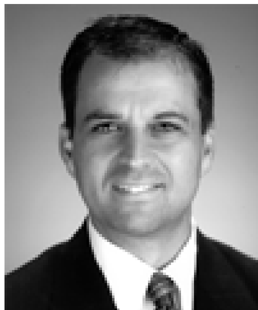
New Impetus to Reform Medical Professional Liability



BY CHAD C. KARLS

Introduction

Efforts to overhaul the process used to adjudicate claims of medical malpractice in the United States have gained some traction in Washington this year.

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H.R. 5, a bill designed to reform Medical Professional Liability (MPL) was introduced in the House on January 24 2011.[1] One day later, President Obama said he was willing to consider ideas designed to reduce the cost of health care, including ''medical malpractice reform . . .'' in his State of the Union address.[2] In contrast, the health care reform bill the President signed less than a year earlier devoted only seven of its 906 pages to MPL reform, and only to authorize funds to study the issue.[3] Twenty-five million dollars, a relatively small amount, was allocated in the 2010 bill, and that only to encourage groups to come up with possible alternatives to the current MPL system. In stark contrast the President's current proposed budget suggests allocating $250 million—ten times as much—to ''provide incentives for State medical malpractice reform.''[4]

Interest in MPL tort reform has been spurred, in part, by the deficit reduction debate now going on in the 112th Congress, and by a revised Congressional Budget Office (CBO) analysis that significantly increases the projected net savings from such reform, from a 2008 es-

[1] H.R. 5, the ''Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011,'' submitted January 24, 2011. http://www.govtrack.us/congress/bill.xpd?bill=h112-5

[2] Remarks by the President of the United States, January 25, 2011. http://www.whitehouse.gov/the-press-office/2011/01/25/remarks-president-state-union-address

[3] ''The Patient Protection and Affordable Care Act,'' pps. 648, 686, 891, 892, 893, 895 and 896. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

[4] ''Fiscal Year 2012 Budget of the U.S. Government,'' Table S-8, p.191. http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/budget.pdf

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timate of approximately $5.6 billion,[5], to $54 billion over the same 2010-2019 time period.[6]

In an October 2009 letter to Utah Senator Orrin G. Hatch, the CBO cited new studies[7] that projected lowering the cost of medical malpractice would also lower net costs by encouraging a reduction in the use of health care services. In its previous 2008 projection the CBO had only looked at the impact of MPL tort reform on direct costs such as malpractice insurance premiums, awards and administrative costs. The new analysis incorporated the effect of an accompanying gradual reduction in the use of health care as a result of changed patterns of behavior by medical providers.[8]

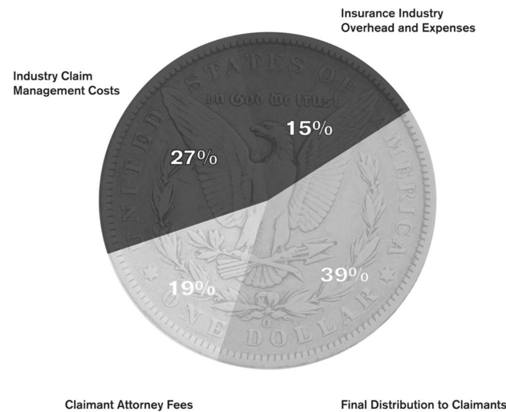
The CBO's cost savings projections may be new, but the reactions from different sides of the MPL debate have been true to form. MPL insurance companies and healthcare providers applauded the CBO's revised figures, welcoming any reform effort that might reduce the overall cost of malpractice claims. Patient rights groups, plaintiffs' attorneys and consumer advocates argue that the debate is not solely about economics, and that the current system benefits the public by encouraging doctors and other health care providers to be cautious in providing care.

Both sides have evidence to support their claims, and both can offer horror stories from extreme cases to advance their positions. The great majority of MPL claims occur somewhere in the middle, however, and could be disposed of far more efficiently than they are under the current system.

Under the tort-based MPL system now in place, claims can take an average of three and a half to five years to reach resolution.[9]

Of even greater concern are the high expenses associated with the drawn-out and adversarial nature of litigating cases in the courts. Costs are compounded over the lengthy time it takes to settle MPL claims, with the result that claimants end up receiving as little as 39 cents of every dollar paid by healthcare providers to finance this system. Approximately 60% of the financing costs are eaten up along the way by fees for lawyers and expert witnesses, court costs, and insurance company overhead.[10] [See chart]

Medical Malpractice Costs



Based on a Milliman analysis of more than 30 years of publicly available insurance industry data, the distribution of how premiums are spent in the current tort system of adjudicating claims breaks down as follows:

- 27% is for the insurance industry's claims management costs, which include:
  - Δ 22% for defense counsel, expert witnesses, litigation technology fees, and other court costs; and
  - Δ 5% for insurance company oversight of claims; while
- 15% is spent on insurance company overhead and expenses (e.g., agent commissions, state premium taxes, general expenses, etc.); and
- 19% pays for the claimant's (plaintiff's) attorney.

That leaves 39% for final disbursement to the claimant after the entire adjudication process has finally reached its conclusion.

Nevertheless, any balanced discussion of MPL reform must acknowledge there is a legitimate need to ensure individual claimants' rights are respected and protected, and that parties involved in a case can honestly interpret the facts and circumstances leading to the injury differently. It thus seems likely that some claims—those involving serious injury or death—do need to be pursued within a structured legal process, regardless of cost or length of time needed to reach an appropriate resolution.

But the question remains: Must all MPL actions be handled in such a litigious and hostile manner? Could there be more flexible alternatives to the protracted and costly tort system now in place to handle the majority of cases? Can we forge a new system for the adjudication of MPL claims—one that allows for speedy, amicable resolution with appropriate compensation when circumstances allow, and yet still provides an avenue for tort relief when that route is most appropriate?

Previous reform efforts have tended to focus almost exclusively on keeping awards in check. A report by the Robert Wood Johnson Foundation observed that ''[w]hen no malpractice crisis exists, there is no interest in changing the system. And yet when a crisis does ex-

[5] *Budget Options, Volume 1: Health Care*, Congressional Budget Office (Dec. 2008), pp. 21-22, http://www.cbo.gov/doc.cfm?index=9925 quoted in CBO Budget Office Director Douglas W. Elmendor's December 29, 2009 letter to the Honorable Bruce J. Braley, U.S. House of Representatives.

[6] Letter to the Honorable Orrin G. Hatch from CBO Budget Office Director Douglas W. Elmendorf, October 9, 2009, Table 1, ''Effects of Tort Reform on Mandatory Spending and Tax Revenues,'' p. 4.

[7] The recent studies cited in the CBO's October 9, 2009 letter include: Lakdawalla and Seabury (2009); Baicker, Fisher and Chandra (2007); Avraham, Dafny and Schanzenbach (2009); and Currie and MacLeon (2008).

[8] CBO Letter to the Honorable Bruce J. Braley, ibid.

[9] Based on Milliman analysis of nearly 80,000 individual medical malpractice claims.

[10] Based on Milliman analysis of more than 30 years of insurance industry data reported in state-required annual statements. See also: Studdert, David M., et al. (May 11, 2006), ''Claims, Errors, and Compensation Payments in Medical Malpractice Litigation,'' *New England Journal of Medicine*, which found that only 46 cents of every dollar went to plaintiffs http://www.nejm.org/doi/full/10.1056/NEJMsa054479 ; and ''Improving Malpractice Prevention and Compensation System'' (September 2007), a report on the results of 11 grants made by the Robert Wood Johnson Foundation to evaluate innovative malpractice reform systems, which found that 40 cents on the dollar ended up with claimants at the end of the process. http://www.rwjf.org/pr/product.jsp?id=17392

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ist, the push is to limit monetary awards, not to make fundamental changes.''[11]

The primary goals for any truly effective and efficient system of resolving MPL claims should be to:

- Compensate injured parties quickly, fairly, and appropriately in response to injuries received as part of any adverse medical event related to or caused by treatment; and
- Encourage a transparent healthcare environment dedicated to quality improvement, so that all mishaps, misjudgments, and/or mistakes can be examined and discussed openly, leading to improved patient safety in the long term without exposing healthcare providers to non-meritorious lawsuits.

A review of the many problems plaguing the MPL process makes clear how rarely, if ever, the current system delivers on either of these key objectives.

Drawbacks of the Current System of Resolving MPL Claims

1. Valuation of damages can obscure evaluation of negligence

The decision to file an MPL claim is a joint one between the injured party and his or her attorney. Because MPL cases are pursued on a contingency fee basis (i.e., the attorney only receives compensation if and when a monetary award is made, either through settlement offer or jury finding, most often equal to a third of the award), the attorney's needs and interests may not coincide with those of the plaintiff.

Claims can cost many thousands of dollars to undertake. Attorneys are therefore understandably hesitant to take any case regardless of its legitimacy or the level of negligence involved—if they believe it will not result in an award large enough to cover their expenses. This is just simple economics. It can result, however, in many deserving claims not being pursued.

This is unfortunate, as the patient injured through malpractice who requires $20,000 to be made whole may be just as deserving as the more seriously injured patient who requires $250,000 or more. Also, the retired 82-year-old bachelor who has suffered a malpractice injury may deserve compensation just as much as the 38-year-old single mother of three. Yet many plaintiff attorneys are unlikely to take on either of the former cases in each example because (a) one-third of $20,000 is not a large enough fee, and (b) juries are not always as sympathetic to elderly claimants without families as they are to younger ones with dependents.

2. The adversarial nature of the tort system restricts and chills communication between the parties

Just as the current system discourages the filing and pursuit of many legitimate claims, it also encourages the filing of many claims where the adverse medical event in question was not the result of negligence.[12]

Because doctors and other healthcare providers know they can be sued successfully for harmful outcomes not related to any negligence on their part, they have generally been advised by their attorneys to circle the wagons when an adverse medical event occurs; i.e., they are told not to discuss such events openly with their patients. This denies doctors and other providers the opportunity to express empathy to the patient or family or explain what actually occurred immediately after the event.

When providers and claimants do finally get to be in the same room and listen to each other, it is most often in court or in the form of legal depositions taken in an attorney's office. Such encounters are technical, cold, and contentious, and do not offer the best environment in which to explain to a family how and why their loved one was injured or died.

3. Litigation is often a long and drawn-out process resulting in delayed compensation to deserving claimants

A review of nearly 80,000 individual claims of Milliman insurance company clients found the average time from incident to the report of a claim to be one and a half to two years, and the average length of time from report to settlement another two to three years.

As these are averages, it is likely that more catastrophic injuries—regardless of whether negligence was involved—can take significantly longer to adjudicate. A 2006 Harvard School of Public Health study found that the average time between injury and resolution was five years, but noted that 33% of claims took six years or more.[13]

4. A jury trial may not be the best method of deciding complex medical issues

The issues and technical details that contribute to an adverse medical outcome are often highly complex, involving arcane medical terminology and revealing multiple fine shades of gray when it comes to identifying precisely the proximate cause of the injury and then establishing blame. The esoteric nature of medical care cannot always be fully understood or fairly evaluated by laypeople with no formal training.

To compensate, expert witnesses are often engaged by both plaintiff and defense attorneys to explain and interpret what occurred. In addition to the time and cost this adds to the proceedings, dueling expert witnesses, each hired to present an interpretation that best supports the side paying their fee, often do little to uncover the truth of what actually happened. At best, they may cancel each other out. At worst, they serve to confuse members of the jury, who may not be able to understand how two experts could come to such widely divergent opinions.

5. Fear of lawsuits leads to a high cost for defensive medicine

It has long been widely accepted that the current MPL system encourages doctors and other healthcare providers to practice defensive medicine. i.e., to provide treatments, order tests, and make recommendations for which they do not see a legitimate medical need—solely to protect themselves from later charges of negligence. Earlier studies attempting to quantify this effect reported estimates that varied widely in magnitude and contained anomalous results. More recent studies cited by the CBO in two 2009 letters have now provided stronger evidence for this assertion by examining new

[11] ''Improving Malpractice Prevention and Compensation Systems'' (September 2007), ibid.

[12] A Milliman analysis of nearly 80,000 medical malpractice claims showed that 79% of claims were closed with no payment being made to the plaintiff.

[13] Studdert, et. al, ibid.

data and employing more sophisticated statistical methods.[14]

6. There is no proof that the threat of lawsuits deters injuries

One of the core arguments put forth by the defenders of the current tort system is that it encourages healthcare providers to be more careful and therefore less likely to make errors, but this claim has never been proven, and there are strong arguments for the opposing point of view.

To begin with, healthcare providers are highly motivated to avoid errors for many obvious and compelling reasons that go beyond the purely economic.

Second, although MPL insurance premiums may impose a high cost to physicians, the vast majority have no recent malpractice claims. Individual physicians are not sued often and as a result claims histories can vary widely from year to year.[15] Premium rates, therefore, have only little to do with the individual past histories of healthcare providers. Medical specialty and geographic location are much more decisive factors than track record when it comes to establishing MPL premium rates for most individual providers.

Third, regardless of specialty and geography, many doctors are part of a large group practice or work at hospitals. These institutions often purchase the necessary insurance and then internally allocate the cost to individual providers. Given the difficulty of predicting any individual provider's future claims along with the internal allocation procedures, individual doctors may not necessarily see a strong correlation between their claims history and the premium they pay.

Finally, even if the threat of having to pay out a large settlement or award could encourage doctors to be more careful than they already are, that dynamic does not operate universally under the current system. Once malpractice insurance is purchased it tends to be complete, without deductibles or coinsurance; rarely does the plaintiff's attorney collect any monies beyond the MPL insurance policy limit. The current system, therefore, largely shields providers from the direct financial burden of large malpractice awards and so presents no real financial inducement for doctors to avoid making errors.

Where We Are Now and How We Got Here

Over the years, an insurance mechanism comprising public and private insurers has evolved around the current, tort-based adjudication system.

Currently, there is a regulated commercial insurance marketplace with total direct written premiums of about $10 billion annually. Approximately two-thirds of this market comprises monoline specialty MPL insurers, many of which are owned and governed by healthcare providers; the last third is made up of multi-line insurance companies.

Because this side of the market is regulated by state insurance departments, there is publicly available and verifiable financial and claims data on all of the companies that participate within it. The full size and extent of the captive, self-insured market, however, cannot be known with any degree of certainty. Estimates range from about as large as the public market (around $10 billion) to nearly twice as large ($20 billion).

The historical financial results of the MPL insurance industry have proven cyclical in nature. As a result, healthcare providers have experienced three significant increases in their MPL premiums over the past 35 years. The first occurred during the mid-1970s, the second in the mid- to late 1980s, and the third and most recent in the early to mid-2000s.

Each time rates have spiked, it has led to claims of a developing crisis in the MPL market, with providers asserting that a corresponding crisis in consumer access to healthcare is not far behind. Providers, the argument goes, will leave the field of medicine—or at least those specialties and regions most vulnerable to liability—for less litigious areas if rates continue to rise.

This has been true for certain disciplines in some areas of the country. For example, the *Los Angeles Times* reported that dozens of Las Vegas area physicians closed their offices in response to MPL insurance premium increases in 2002.[16] During the mid-2000s, while some physicians left certain areas of the country in response to rate hikes, this occurred primarily in areas experiencing the sharpest rise in premiums. Other parts of the country did not see significant disruptions to their local healthcare delivery.

For their part, some opponents of reform claim that higher premiums are caused primarily by bad investments and intentional overcharging on the part of insurers,[17] assertions that are not consistent with the facts.

Possible Avenues to Reducing MPL Costs

Several modifications to the current MPL system have been suggested over the years, and some have been tried, with varying degrees of success.

Among those deserving consideration include:

- Special injury funds;
- Medical or health courts;
- Caps on non-economic damages;
- Established clinical guidelines;
- No-fault insurance;
- Early intervention programs; and
- Enterprise insurance.

1. Special Injury Funds

While not an entirely new concept to MPL, special injury funds are programs operated by individual states to afford doctors and other healthcare professionals liability insurance coverage for specific injuries.

Special injury programs recognize that certain procedures are medically complex and that a bad outcome could result in catastrophic injury to the patient, often involving lifelong complications for the patient as well as the family. The costs associated with providing for the injured patients' needs can easily add up to several

[14] CBO letters cited in Endnotes 4, 5 and 6, above.

[15] Mello, M.M. & Brenna, T.A. (2002). Deterrence of medical errors; theory and evidence for malpractice reform. Texas Law Review 80:1595-638. http://heinonline.org/HOL/LandingPage?collection=journals&handle=hein.journals/tlr80&div=54&id=&page=

[16] Gorman, Tom (March 4, 2002). ''Physicians Fold Under Malpractice Fee Burden.'' *Los Angeles Times*. http://articles.latimes.com/2002/mar/04/news/mn-31012

[17] Sloan, Frank & Chepke, Lindsey (Spring 2008). ''From Medical Malpractice to Quality Assurance.'' Issues in Science and Technology On-Line. http://www.issues.org/24.3/sloan.html

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million dollars. These injured patients are arguably those with the greatest and often most immediate needs, yet within the confines of the current adjudication system the patient commonly finds himself or herself mired in the system for many years as the attorney, along with the insurance company, begin the multi-year process of preparing the case for trial. Given the economic stakes involved, both the patient's attorney's and the insurance company's actions are understandable. What is not always understood, however (or at least not always kept at the forefront of the discussions), is the perspective of the patient.

Special injury funds can offer an alternative for just these types of claims and seem to work best when they are narrowly focused, managed like a true insurance vehicle with accrual-based financial considerations, and protected against outside political interference. Both Florida and Virginia have special injury funds currently in place that apply to claims involving birth-related neurological injuries.

The Virginia Birth-Related Neurological Injury Compensation Program, established in 1987, appears to be an effective way to compensate birth-related neurologically impaired children. According to a November, 2002 report of the Joint Legislature Audit and Review Commission of the Virginia General Assembly, ''[o]verall, it appears that the benefits offered by the program are generally more advantageous to birth-injured children than a medical malpractice award in Virginia.''[18] The same report does, however, go on to list several challenges faced by the program, including one subheading that reads, ''The Birth-Injury Fund Is Actuarially Unsound, Although There Is No Threat of Short-Term Deficit.''[19] Another model that bears watching is in New York, where a special injury fund focused on neurologically impaired infants has just been established.[20]

2. Medical or Health Courts

As noted earlier, the facts and testimony delivered at medical liability trials can become dense and arcane, difficult for lay juries to adequately evaluate. Some have proposed the establishment of special medical or health courts, which like family, bankruptcy, or landlord-tenant courts could be set up to hear only cases involving one type of legal conflict—in this case, medical liability claims.[21]

Special medical liability courts could go a long way toward speeding up resolution and reducing the costs of adjudication and the idea is worth further discussion, but there are issues that would have to be addressed. Would cases be heard by special judges alone, or by a predetermined pool of experts in the medical specialty relevant to the claim? It seems unlikely that any one judge, even one with medical training, could be fully conversant with enough areas of medicine to deal with all of the complexities involved in different cases.

Regardless of whether claims are heard by medically trained judges alone or judges and expert juries of medical professionals, the plaintiffs' bar is unlikely to agree to any system that appears to turn all of the decision-making power in the adjudication process over to the medical community. In February 2006, the House of Delegates of the American Bar Association passed a resolution specifically opposing the creation of health care tribunals.[22]

3. Caps on Non-Economic Damages

The modification to the current system most often supported by the medical community is caps on damages, particularly on non-economic damages that are difficult to quantify with any degree of precision, such as pain and suffering or loss of companionship.

Caps have been cited as one of the reforms most likely to lead to lower liability costs and ultimately reduce the premiums paid by providers. The use of non-economic damage caps at the state level goes back to the passage of the Medical Injury Compensation Reform Act of 1975 (MICRA) in California. The MPL debate has often pivoted on the topic of these caps in the years since, though recently there seems to be renewed support across party lines. The Bipartisan Policy Center's Debt Reduction Task Force report issued in November of 2010 estimates federal savings of $300 billion over 30 years if laws establishing caps on non-economic damages were enacted.[23] Another bipartisan report issued around the same time by President Obama's Commission on Fiscal Responsibility and Reform also recommended Congress enact ''statutory caps on punitive and non-economic damages'' among several other suggested MPL reforms.[24] And the proposed MPL reform legislation introduced in January of this year appeared to follow that advice, suggesting a cap of $250,000 for non-economic damages and provisions to restrict the amount plaintiff attorneys can receive.

To see what effect caps might have, if any, on MPL costs, consider an analysis of the experience of Texas, which has had a $250,000 cap on non-economic damages since September 1, 2003. Milliman analysis looked at the average amount of payments recorded in the National Practitioner Data Bank (NPDB) per physician for every state in the union, plus the District of Columbia, for the four-year period just prior to the imposition of the cap in Texas—1999 to 2003—and then again for the four years 2005 to 2009, a period beginning two years after the Texas cap was put in place.

Milliman analysis ranked the results from each state for each of the two four-year periods, from one to 51, with one being the state with the lowest payouts per physician and 51 being the highest. Texas ranked 34th during the 1999 to 2003 period, and fifth when using the 2005 to 2009 data, for a change in ranking of 29 – the largest drop in payouts per physician of any state between those two periods.

The experience in Texas suggests that some version of a cap on non-economic damages might be a viable

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[18] Review of the Virginia Birth-Related Neurological Injury Compensation Program by the Joint Legislative Audit and Review Commission of the Virginia Federal Assembly (November, 2002). http://biotech.law.lsu.edu/policy/BirthInj.HTM

[19] Joint Legislative Audit and Review Commission of the Virginia Federal Assembly, ibid.

[20] ''Hospitals get half a fix for medical malpractice,'' Crain's New York. Available at http://www.crainsnewyork.com/article/20110328/FREE/110329874

[21] See also www.commongood.org for a fuller discussion of this option.

[22] Resolution adopted by the House of Delegates of the American Bar Association (February 13, 2006). http://www2.americanbar.org/sdl/Documents/2006_MY_103.pdf

[23] ''Restoring America's Future: Reviving the Economy, Cutting Spending and Debt, and Creating a Simple, Pro-Growth Tax System,'' p. 66.

[24] ''The Moment of Truth: Report of the National Commission on Fiscal Responsibility and Reform,'' p.39.

part of any MPL reform strategy aimed at reducing costs. That said, caps have traditionally drawn the most intense political objection. Just recently the Medicaid redesign effort in New York, which brought about the neurological special injury fund mentioned earlier, resulted in a failed attempt to install caps. And once a cap is implemented, it can still be repealed—as happened last year in Illinois.[25]

4. Established Clinical Guidelines

Clinical guidelines are not a new idea, but the idea of using them to shield doctors from malpractice lawsuits has gained some purchase of late. The idea is to establish a list of agreed-upon, evidence-based guidelines, which, if followed, would give physicians and other healthcare providers safe harbor from claims of malpractice. In addition, if physicians are in fact protected from medical negligence lawsuits provided they follow such guidelines, this could have an additional and significant benefit of reducing the level of defensive medicine that takes place.

Several versions of this idea have been attempted in the past, the largest of which was in the state of Maine in 1990, when the Maine legislature enacted the Medical Liability Demonstration Project. This program involved doctors working in four specialties,[26] the majority of which participated in the program. The program reached its sunset and was not renewed as it proved less than successful.[27]

Several significant obstacles complicate the role of clinical guidelines with regard to MPL:

- First, advances in medicine are ongoing, which requires constant review and updates to clinical guidelines.
- Second, guidelines often address the uncomplicated, typical case and patient conditions. As a result, legal arguments can be constructed (fairly or not) and may then be advanced that the guidelines are not definitively and precisely applicable. Or, in the event of an unusual case or unusual patient conditions, arguments might be advanced that deviation from guidelines constitutes inappropriate practice and therefore culpability.
- Finally, medical guidelines have not been developed for the totality of conditions and cases that may be presented.

Can these obstacles be overcome? The question might be rephrased: Can guidelines be held in the proper context?

Clinical guidelines are intended to help inform physicians in the practice of quality, efficient care; they can play a role in moving toward a healthcare system founded on best observed medical practices. They are not a substitute for sound clinical judgment in specific cases–especially where unique or extenuating circumstances may be present.

So long as MPL claims continue to be handled through a highly adversarial process (versus a genuine fact-finding process) clinical guidelines may offer only limited help in revamping the MPL environment.

5. No-fault Insurance

No-fault-based compensation systems are currently used as a substitute for tort action in automobile liability and workers' compensation claims. Under the premise that there are claims involving negligence that never get filed because the damages are deemed too small — as well as a number of claims not involving negligence that are vigorously, and expensively, pursued because of the potentially large award — a no-fault system theoretically would address both of these undesirable situations. Appropriately constructed, a no-fault system might be the best structure to address the first of the fundamental goals previously stated: To compensate the injured party in a timely and just manner. Further, as the entire reimbursement model for healthcare is being reexamined, this option might even be funded more broadly than directly from healthcare providers alone.

The idea of a true no-fault medical liability system may seem a radical one, but probably no less radical than when no-fault was first put forward as a method for managing workplace injuries. One can argue the relative merits of workers' compensation as a system, but it has been around in the United States for nearly a century now, and it seems to work well enough not to find itself in regular, widespread crisis.

6. Early Intervention Programs

Often, all an injured patient and family may really want is to hear an explanation and perhaps apology from the doctor and to receive a reasonable monetary award—one that will see to immediate medical and other needs with regard to recovery from the event. In an effort to facilitate this type of exchange, as many as 35 states and the District of Columbia have passed what are called ''I'm Sorry'' laws, allowing a physician to discuss openly an adverse outcome with a patient and express empathy.[28]

Along these lines, one MPL insurer has instituted a progressive approach toward managing the physician-patient dialogue in the wake of an adverse outcome. Known as the 3Rs Program, the COPIC Insurance Company encourages its physician insureds to reach out proactively to patients in a structured way to discuss what occurred and how it might have resulted in the adverse medical outcome.

In addition to providing an opportunity for immediate and more direct communication, the 3Rs Program provides up to $25,000 for reimbursement of medical costs, plus another $5,000 to help compensate for the patient's loss of time that often accompanies an adverse outcome. One key element to the program is that at no time

[25] The economic impact of repealing the cap in Illinois is explained here: http://www.milliman.com/news-events/press/pdfs/milliman-analysis-indicates-repeal.pdf

[26] U.S. General Accounting Office (GAO) report (October 1993). ''Medical Malpractice, Maine's Use of Practice Guidelines to Reduce Costs.'' The four disciplines were anesthesiology, emergency medicine, obstetrics and gynecology, and radiology. http://biotech.law.lsu.edu/policy/150172.pdf

[27] A report to the Maine Bureau of Insurance based on analysis conducted by the author and fellow Milliman consulting actuary Robert L. Sanders, FCAS, MAAA, found no cost savings attributable to the program; see In re: Rural Medical Access Program (Docket No. INS 00-3044), Order as to Required Assessment, filed by Alessandro A. Luppa, Superintendent of Insurance, State of Maine, December 19, 2000. https://www.informe.org/pfr/insurance/orders/00-3044.htm

[28] McDonnell, William M., MD, JD & Guenther, Elisabeth, MD, MPH (December 2, 2008). ''Narrative Review: Do State Laws Make It Easier to Say 'I'm Sorry?' '' Annals of Internal Medicine.

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does the patient relinquish his or her right to bring a formal malpractice claim in the future, even if they have received compensation under the 3Rs Program.[29]

7. Enterprise Insurance

With enterprise insurance—sometimes referred to as channeling—providers obtain their MPL insurance through the hospitals, clinics, or healthcare centers where they work. The enterprise takes on the responsibility of insuring against all adverse events that might occur on its premises, and apportions the cost of the premium among its provider staff.

This approach acknowledges that medical errors can be the result of more than one action or treatment decision undertaken by a chain of personnel in an institutional setting, often making it difficult to determine which act or individual was most responsible for the injury or harm.

Enterprise insurance offers the possibility of decreasing the number of medical liability claims by giving healthcare organizations an incentive to create quality assurance programs to improve patient safety and reduce errors. Further, these healthcare facilities typically have more resources and are more accustomed to formalizing and institutionalizing policies and procedures than individual physicians.

[29] COPIC (Fourth Quarter 2009). ''Recognize, Respond, Resolve: A successful approach to disclosure.'' *Physician Insurer*.

Conclusion

These are just a few of the promising innovations for revamping medical professional liability that need to be discussed and explored further. Some will prove viable, some will not. What's important is that the discussion has taken on a higher profile and events are encouraging more flexibility on all sides of the issue.

The best solution is most likely a process that does not lock every claim into a pitched legal battle, but which can adapt nimbly and respond appropriately in the wake of adverse medical incidents. Some combination of the best of the ideas being put forward could achieve buy-in from all sides and bring greater efficiency and cost reduction to the entire medical liability system.

In exploring and evaluating all of these possible ideas, it is important to keep in mind that the two most important criteria for any new system must always be:

- Ensuring access to and fairness within the adjudication system, so that all patients who experience medical errors can obtain the resources and help they quickly need to recover; and
- Promoting ongoing quality assurance and continuous improvement in medical care to reduce the potential for future harm to all patients.

While the problems associated with the current medical professional liability system are not new, there does seem to be a greater opportunity today than ever before to fundamentally improve it, leading to better and more consistent outcomes for all parties.