



State of Vermont  
Agency of Administration  
Health Care Reform

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# **Report on Impact of Vermont Malpractice Reform**

Act 171 of 2012, Section 24e

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*Submitted to the*

**Senate Committee on Health and Welfare**

**Senate Committee on Judiciary**

**House Committee on Health Care**

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## Executive summary

In 2005, at the direction of the Vermont General Assembly, the Vermont Medical Malpractice Study Committee produced an extensive report analyzing the connection between medical malpractice premiums and medical malpractice laws.<sup>1</sup> Building on the findings from this report, the 2012 proposal to the legislature entitled Medical Malpractice Reforms, authored by the office of the Secretary of Administration, recommended four measures to reform Vermont's medical malpractice liability laws with the intent of reducing health care costs, medical errors, and protecting patients' rights.<sup>2</sup>

The legislature adopted two of these reform measures in Act 171 of 2012. Section 24a institutes the mandatory submission of a certificate of merit at the time of filing of a medical malpractice claim, and section 24b addresses the implementation of confidential pre-suit mediation. These two reform measures were passed by the legislature and were set to take effect on injuries occurring on or after February 1, 2013.

The Administration set out to assess the impact these changes in the medical liability laws have had on the state of medical malpractice in Vermont. Unfortunately, it is premature to evaluate the probable impact of these reforms, because of the way the effective date was structured in the statute. A retrospective analysis using quantifiable data and stakeholder interviews suggests that, at present, there is no direct evidence of either provision having an appreciable impact on consumers, physicians, or the provision of healthcare services due to the applicability of the law to few cases at this time. Moreover, we found no evidence that the reforms stated herein negatively impacted the rights of consumers to due process of law and to access to the court system at this time.

Given the short period of time between implementation and measurement, and as a result, the small number of cases which may have been influenced by these reforms combined with the lack of available data – we recommend that a follow up retrospective analysis be done on or after February 1, 2017. This represents exactly one year following the date after which the statute of limitations will have run for many of the relevant cases. With this date, the Agency of Administration will have a robust number of cases on which to base a report.

Secondly, as the state of Vermont currently does not track metrics regarding certificate of merit and pre-suit mediation, the institution of such measurements would help to more clearly assess impact during reevaluation. To accomplish this the Administration recommends measuring rates of cases going to pre-suit mediation and recording the number of patients unable to access the courts given their inability to obtain a certificate of merit.

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<sup>1</sup> Medical Malpractice Liability Insurance in Vermont, Vermont Medical Malpractice Study Committee (VMMSC), 2005.

<sup>2</sup> Medical Malpractice Reforms Report and Proposal of the Secretary of Administration, Secretary of Administration, 2012.

Lastly, we recommend a recalibration of the outreach strategy to Vermont's providers in order to better bridge the gap between reform and practice.

To come to the above conclusions and recommendations, our team analyzed the impact of these reforms on several quantifiable metrics such as per capita malpractice claim payouts, malpractice insurance rates, and physician retention in the state of Vermont in the period before reform and following reform - and found no conclusive evidence to suggest that these reforms had any verifiable impact on these measures at this time. It is possible that with greater outreach and more time for the law to be applied in practice that these results would change.

In summary, we found a negligible decrease in per capita malpractice payouts from \$4.37 to \$4.36 within the state since the implementation of reform. This decrease occurred while the rest of the nation experienced increasing payouts which reflected the highest payouts in over a decade.

In contrast, through this same period of time, Vermont's providers experienced a 3.1% increase in malpractice premiums. Concurrently, providers in other states, on average, saw a decrease in their premium rates. Physician density, a marker for provider retention in the state was unchanged.

It is difficult to argue that the fluctuations observed in per capita malpractice payouts or premium rates were due directly to the implementation of certificate of merit and confidential pre-suit mediation statutes as opposed to broader ongoing trends. Further, given our constraints regarding study design we cannot argue for a causal link between the variable, in this case, reform implementation, and the relevant impact metrics explained above.

Our subjective interviews with stakeholders seemed to be in alignment with the results we observed in the aforementioned metrics. Overwhelmingly, the most common response we received from stakeholders across the spectrum of Vermont's medical malpractice community was that there has been no observable difference as a result of either one of these measures. A few other common themes emerged regarding these statutes during our interviews. Many in Vermont's medical and expert mediator communities cited a general lack of awareness to these changes. Vermont litigators on both the defense and plaintiff side and others argued that assessing the impact of these reforms at this time was premature at this stage.

## **Legislative charge**

In Act 171 of 2012, the general assembly charged the secretary of administration or designee with reporting to the House Health Care, House Judiciary, Senate Health & Welfare, and Senate Judiciary committees on:

The impacts of secs. 24a(certificate of merit) and 24c(pre-suit mediation) of this act. The report shall address the impacts these reforms have had on:

- (1) consumers, physicians, and the provision of health care services;
- (2) the rights of consumers to due process of law and to access to the court system; and

(3) any other service, right, or benefit that was or may have been affected by the establishment of the medical malpractice reforms in Secs. 24a and 24c of this act

## Data Limitations

A comprehensive assessment of impact is hindered by several factors. First, given the recent implementation of this reform, much of the relevant data needed to assess impact either has not been aggregated yet or is currently not a metric that is commonly measured. For example, a useful metric to assess the impact of certificate of merit statutes on consumers' right to due process and access to the court system would be - an estimation of how many patients affected by medical malpractice were unable to successfully take their case to court because of their inability to attain a certificate of merit. In the Vermont judiciary system there is currently no mechanism to record this number. Similarly, data on how many cases ended in successful pre-suit mediation are not recorded. In this report we sought to make crude estimates at the impact given the available data on medical malpractice on the state and national level.

Secondly, our assessment may also be constrained by the realities inherent in the current medical malpractice reporting system. For example, the legislation reads that the reforms will be applied to incidents occurring on or after February 1, 2013.<sup>3</sup> This recent implementation date hinders attempts at effective measurement of impact given its relation to the time period stated in the Vermont statute of limitations regarding medical malpractice cases.

Vermont statute of limitations declares that "actions to recover damages for injuries to the person arising out of any medical or surgical treatment or operation shall be brought within three years of the date of the incident or two years from the date the injury is or reasonably should have been discovered, whichever occurs later, but not later than seven years from the date of the incident."<sup>4</sup> There is an exception for minors and "insane" or imprisoned individuals where the statute of limitations does not run until they are no longer a minor, "insane," or imprisoned.<sup>5</sup>

Anecdotal information provided from experienced litigators who specialize in Vermont medical malpractice litigation points to the fact that most malpractice claims in this state are made within a few months before the statute of limitations runs out. While these claims are largely anecdotal they seem to be in alignment with what is seen at the national level. As one national study on the timeline of medical malpractice cases reports, "...the mean time from the incident date and the date the claim was filed was 22.8 months"<sup>6</sup>

In Vermont, the statute of limitations for incidents occurring after enactment on February 1, 2013 would extend until February 1, 2016. Given the information on time to filing malpractice claims provided anecdotally by litigators in Vermont and verified by data from a national survey noted above, this suggests that malpractice cases which may be impacted by these reforms may only just now be initiating the process of litigation. In short, many of the cases which may have

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<sup>3</sup> 12 V.S.A. § 1042; *see also* sec. 42(j), Act 171 of 2012.

<sup>4</sup> 12 V.S.A. § 521.

<sup>5</sup> 12 V.S.A. § 551.

<sup>6</sup> Seabury SA, Chandra A, Lackdawalla DN, Jena AB. On average, physicians spend nearly 11 percent of their 40-year careers with an open, unresolved malpractice claim. *Health Aff (Millwood)*. 2013;32(1):111

occurred after the date designated have not come through the medical malpractice pipeline as of yet. Our best guess is that with more time we may be able to take a more nuanced look at the impact brought about by this legislation.

In the context of these constraints, we have used the available data on the national and state level to measure the impact insofar as we are able to for this report. As noted above, more time will allow for the aggregation of the proper data regarding the claims which were most likely affected following the start date of the implementation of these reforms.

## **Background information**

### *National Survey of Certificate of Merit Reform*

The 2012 Medical Malpractice Reforms report recommended the implementation of a Certificate of Merit statute as a way to “screen out meritless malpractice claims at the outset by requiring consultation with a qualified expert at the beginning of a lawsuit.”<sup>7</sup> With enactment of section 24a, Vermont became one of 22 states to have standing certificate of merit statutes pertaining to medical malpractice suits. States vary widely in their approach to implementation.

One example of the variation between states is the timing of filing the certificate of merit. The timing issue is relevant because it allows the plaintiff more time to gather information when certifying the merit of the case. Many states choose to mandate that the certificate of merit be filed at the same time as the suit. States currently mandating that a certificate of merit is filed at the same time as the complaint are Florida, Georgia, Illinois, and Michigan. Vermont falls into this category of states.

Other states are more lenient on the timeframe of submission of this document. For example, New Jersey statute illustrates this extended timeframe noting that the plaintiff shall,

“within 60 days following the date of filing of the answer to the complaint by the defendant, provide each defendant with an affidavit of an appropriate licensed person that there exists a reasonable probability that the care, skill or knowledge exercised or exhibited in the treatment, practice or work that is the subject of the complaint, fell outside acceptable professional or occupational standards or treatment practices. The court may grant no more than one additional period, not to exceed 60 days, to file the affidavit pursuant to this section, upon a finding of good cause.”

Other states falling into this category include: Colorado, Maryland, Missouri, North Dakota, Pennsylvania, and Texas.<sup>8</sup>

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<sup>7</sup> Medical Malpractice Reforms Report and Proposal of the Secretary of Administration, Secretary of Administration, 2012

<sup>8</sup> "State Medical Liability and Malpractice Laws." National Conference of State Legislatures, 11 Apr. 2011. Web. 1 June 2014. <http://www.ncsl.org/research/financial-services-and-commerce/medical-liability-medical-malpractice-laws.aspx>

## *Background on Pre-Suit Mediation*

The 2012 report on Medical Malpractice Reforms proposed the implementation of a confidential pre-suit mediation arrangement whereby “Both parties would be required to provide disclosure to one another – the plaintiff of his or her medical records to the extent they are relevant, and the defendant of complete medical records associated with the incident at issue”.<sup>9</sup> This form of medical malpractice reform is known as alternative dispute resolution (ADR). ADR refers to techniques used to resolve conflicts without going to the courtroom. Similar to the implementation of certificate of merit statutes, states vary widely in their approach to implementing ADR in medical malpractice cases ranging from programs using early apology, arbitration, and mediation.

Section 24c recommends, but does not mandate in any way the use of, confidential pre-suit mediation that is optional, nonbinding, and done by a neutral third-party mediator. For the sake of clarity, it is helpful to note that this was a practice which was already in use prior to the implementation of this section. This was stated in the 2012 report and was verified by experts in the malpractice field during the data gathering for this report.

When carried out effectively, analysis has shown that pre-suit mediation can be fruitful for both provider and patient, boasting satisfaction rates of 90% among both plaintiffs and defendants in a recent study.<sup>10</sup> Critically, the literature shows that the two characteristics which predict the highest rate of success are that it be nonbinding and that it remain optional.

Inclusion of the nonbinding nature of the reform here in Vermont is significant as this has been shown to be the most important characteristic when analyzing previous attempts at instituting mediation.<sup>11</sup> Unlike other attempts where the decision in the mediation is binding, a non-binding form of pre-suit mediation preserves the right of the physician to go to trial if he or she feels they are wrongly sued.

While statewide data on programs using nonbinding pre-suit mediation is not available there are numerous studies that have shown the positive impact that these reform efforts have had on individual hospital systems. As cited in the 2012 report on medical malpractice in Vermont, the University of Michigan program has led the way in the implementation of pre-suit mediation. An excellent summary of the data from that program is included in that report.

Similarly, Drexel’s program which uses a nonbinding provision and two co-mediators who are litigators specializing in medical malpractice, has found tremendous success in avoiding litigation with a 85% success rate in a recent evaluation, where success is measured as the percentage of cases which avoided litigation. Another evaluation done at the University of

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<sup>9</sup> Medical Malpractice Reforms Report and Proposal of the Secretary of Administration, Secretary of Administration, 2012.

<sup>10</sup> Szmania SJ, Johnson AM, Mulligan M. Alternative dispute resolution in medical malpractice: a survey of emerging trends and practices. *Conflict Resolution Q.* 2008;26:71–96. doi: 10.1002/crq.224

<sup>11</sup> Sohn, David, and Sonny Bal. "Medical Malpractice Reform: The Role of Alternative Dispute Resolution ." *Clin Orthop Relat Res.* 470(5): 1370–1378. : n. pag. Print.

Pittsburgh medical Center, which has a similar mediation program, showed an 88% success rate and estimated \$1 million savings in defense costs.

Secondly, mediation attempts that are optional have been shown in the literature to be far more successful than those which are court mandated. A recent empirical study evaluated North Carolina's statewide effort to institute court ordered mediation. Their results showed that the rates of successfully avoiding litigation were much lower than expected at only 23.7%.<sup>12</sup> In contrast, optional mediation programs typically have a success rate ranging between 75% to 90%.<sup>13</sup>

In conclusion, section 24C contains two important factors when it comes to the implementation of pre-suit mediation. At present however, there is no concerted effort to measure the rates of successfully avoiding litigation using pre-suit mediation here in Vermont. As the time since implementation of these reforms lapses it might be reasonable to consider instituting a formal mechanism for recording the success rates of this practice here in Vermont.

## **Measuring the Impact of Secs. 24a and 24c**

We set out to define relevant criteria to assess impact using the available data and information gleaned from pre-existing attempts at evaluating the impact of medical liability reform. Working with the constraints regarding availability of data, we chose to measure impact along 4 specific criteria.

- 1) Effect on per capita malpractice payouts
- 2) Effect on provider liability premiums
- 3) Effect on retention of physicians in Vermont
- 4) Stakeholder input

### *Effect on per capita malpractice payouts*

Measuring the impact of medical liability reform on consumers has been notoriously difficult in the past. One measure previously used to assess impact on consumers has been to follow the trend of per capita medical malpractice payouts experienced by consumers across the healthcare system. Using this approach we sought to analyze the change, if any, of per capita malpractice costs in the time before and after implementation of liability reform in Vermont.

This approach is not without its limitations. An analysis of per capita medical malpractice costs would be best served by a longer time frame than one year post reform as in any given year, especially in smaller states like Vermont, a few large settlements or judgments may, in theory,

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<sup>12</sup> Peebles R, Harris C, Metzloff T. Following the script: an empirical analysis of court-ordered mediation of medical malpractice cases. *J Disp Resolution*. 2007;1:101-118

<sup>13</sup> Szmania SJ, Johnson AM, Mulligan M. Alternative dispute resolution in medical malpractice: a survey of emerging trends and practices. *Conflict Resolution Q*. 2008;26:71-96. doi: 10.1002/crq.224



skew results. Further, because it is difficult to separate out the effect of individual reform efforts from broader state and national trends, we cannot attempt to prove direct causation in this case.

Our analysis seeks to note the association, if any, between the two variables – per capita medical malpractice costs and implementation of reform. Limitations notwithstanding, this association may prove insightful as a starting point and may help us to better understand the impact of these reforms when this issue is revisited at a later time period when data is more robust.

Towards this aim we sought to aggregate and compare the per capita malpractice payouts in the time pre-reform and post reform to identify any significant changes that may have arisen. This data was made available through The Department of Health and Human Services which maintains a national registry known as the National Practitioner Data Bank(NPDB).<sup>14</sup>

It's important to note that the data from the NPDB data does not cover all medical malpractice payouts. For example, suits filed solely against hospitals, which are not considered practitioners aren't included – nor are payouts that follow purely verbal requests or that take place during some mediations. Nonetheless, this data offers us insight into the most common malpractice cases and gives us a relevant reference point to compare the pre and post reform time periods.

We used this registry in two main ways to analyze the relevant data in the year prior to implementation (Jan 1, 2012 - December 31, 2012) and the year following implementation (Jan 1, 2013 - December 31, 2013). First, we looked at Vermont's per capita medical malpractice payouts during this period of time. Next, we turned our attention to the national data to note the national trend during this same period of time.

#### Vermont per capita Medical Malpractice Trends 2012 and 2013

We obtained malpractice claim payout data from a large medical malpractice insurance consulting firm – Diederich Healthcare - which publishes its annual report regarding medical malpractice trends using data gathered from the National Practitioner Data Bank noted above. The report and its details are based on an analysis of medical malpractice payouts for 2012(Jan 1, 2012 - December 31, 2012) and 2013 (Jan 1, 2013 - December 31, 2013). Per capita expenses, measured in dollar amounts per person in the state are used in the literature as a crude way to assess the individual cost borne by consumers from medical malpractice across the system. In 2012, the per capita payout was \$4.37. Post-enactment, per capita expenses stayed roughly the same going down marginally to \$4.36.

#### National per capita Medical Malpractice Trends 2012 and 2013

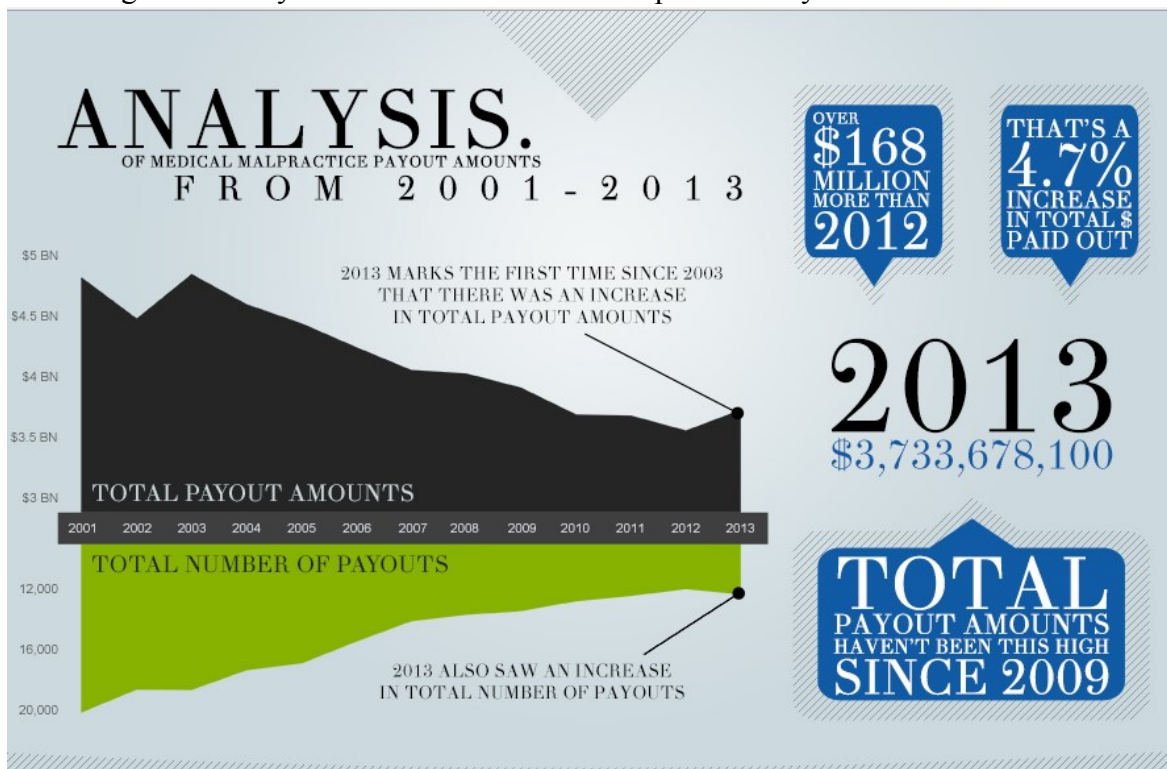
Looking at the national trend may serve to put what we observe at the state level in Vermont in context. Nationally, the trend in the period after reform goes in the opposite direction of Vermont's data. Whereas the per capita payouts decreased slightly in Vermont, nationally, the total number and amount of per capita payouts rose in 2013 for the first time since 2003.

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<sup>14</sup> According to DHHS, the data bank is “.a confidential information clearinghouse created by statute in 1986 to improve health care quality, protect the public, and reduce health care fraud and abuse in the U.S.” Of critical importance to this report is the registry of malpractice claims data which can be analyzed to identify malpractice trends nationally as well as on a state-by-state basis.

Furthermore, the total medical malpractice payouts in the country increased to \$3,733,678,100 representing a 4.7% increase from 2012 to 2013 as shown in Figure 1. This total is the highest annual total since 2009. In total, 38 states had more medical malpractice payouts in 2013 as compared to 2012.<sup>1516</sup>

Figure 1: Analysis of National Medical Malpractice Payout Amounts in 2013



Source: Diederich Healthcare Annual Medical Practice Report

State rankings of per capita medical malpractice payouts

Compared to other states, Vermont currently ranks as having one of the lowest per capita medical malpractice costs. This seems to not have been affected in one way or the other in the year following liability reform. According to the results of Diederich Healthcare's 2012 annual report, Vermont was the sixth lowest overall in per capita spending on medical malpractice payouts, pre-enactment of these two statutes.<sup>17</sup> It fell behind Indiana, Missouri, Wisconsin, Texas, and North Dakota (which had the lowest overall per capita spending in medical malpractice payouts). Post-enactment in 2013, Vermont maintained its sixth placed ranking in their 2013 annual report.

<sup>15</sup> 2014 Medical Malpractice Payout Analysis, Diederich Healthcare <http://www.diederichhealthcare.com/the-standard/2014-medical-malpractice-payout-analysis/>

<sup>16</sup> 2013 Medical Malpractice Payout Analysis, Diederich Healthcare, <http://www.diederichhealthcare.com/the-standard/2013-medical-malpractice-payout-analysis/>

<sup>17</sup> Id.

### *Effect on medical liability premium rates*

Another commonly used measure to follow the impact of liability reform is the medical malpractice insurance premium rate experienced by physicians. The most convenient way to measure this premium rate is to quantify the annual base premium rate. This is the amount for an insurance policy that is used to calculate the premium for reinsurance of a provider. Analysis of the trend in this annual base premium rate affords us a window into estimating the effect of these two statutes on medical malpractice insurance premium rates.

Similar to our calculation of the effect on per capita medical malpractice payouts, we first analyzed the trend in the relevant timeframe in Vermont and then turned our focus to the national data during the same timeframe.

Of note, several limitations exist in using annual base premium rates as a marker of the impact of medical liability reform. First, as noted in the 2005 Vermont Medical Malpractice Study Committee report, medical malpractice insurance market cycles tend to exhibit greater fluctuations in premiums than other insurance industries because of cyclical changes in insurers' investment income and competition among insurers. Further, the long time period required to resolve claims introduces greater uncertainty to insurers and therefore higher and more variable premiums. Variations in premium rates must be understood in the context of these limitations.

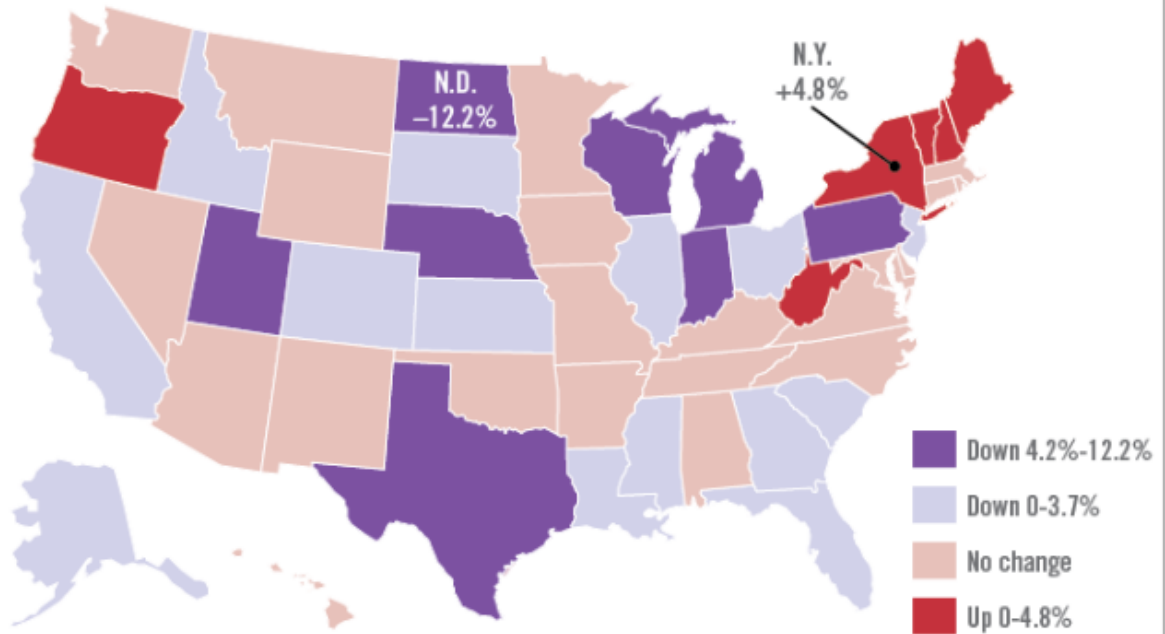
### Vermont Malpractice Premium Rate Trends 2012 and 2013

The Medical Liability Monitor releases a comprehensive annual survey examining medical liability rates across the country. Their analyses use July 1 premium data from the major medical malpractice insurers which comprise 65 to 75% of the liability insurance market in a given state to assess annual trends in annual base premium rates. According to their report, the annual base premium in Vermont increased by 3.1% between their 2012 and 2013 yearly analyses.<sup>18</sup> Shown in Figure 2 on the following page.

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<sup>18</sup> Medical Liability Monitor, Annual Rate Survey Issue – October 2013. Vol 38, No 10  
<http://www.milliman.com/uploadedFiles/insight/2013/MLM-Rate-Survey.pdf>

**Figure 2: State-by-state analysis of percent change in annual base premium rates between 2012 and 2013.**



**Note:** Based on a survey of companies comprising 65%-75% of the liability insurance market.

**Source:** Medical Liability Monitor (October 2013)

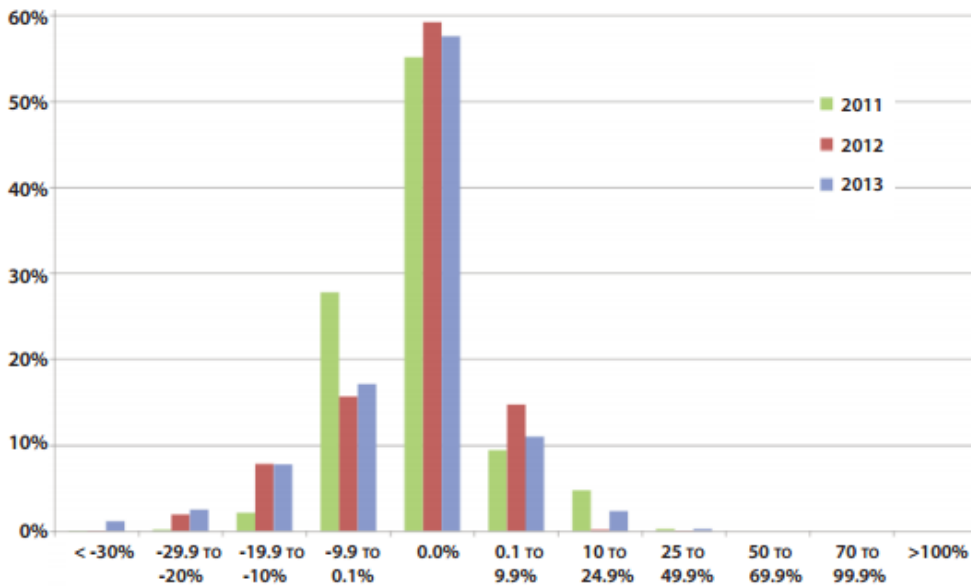
IMNG Medical Media

### National Malpractice Premium Rate Trends 2012 and 2013

Similar to the data analyzed for per capita medical malpractice payouts, understanding the national trend in liability premium rates may serve to clarify if this increase was part of a nationwide trend or may be attributable to state-specific factors. Nationally, as illustrated in Figure 1, the study showed that 6 other states also experienced an uptick in annual base premium rates, while 21 states showed no change and 22 states showed a decrease.

Furthermore, looking at the data for individual provider medical liability insurance premiums across the country shown in figure 3 on the next page, we see that a majority of physicians across the country (57.6%) saw no change in their liability premiums through this same time period. Again we cannot conclude with any certainty that the implementation of confidential pre-suit mediation and certificate of merit statutes are solely responsible for this increase in insurance rates, but this association serves as a reference point for future analyses of these reforms.

**Figure 3: Distribution of Rate Changes by Range (2011- 2013)**



Source: Medical Liability Monitor Annual Rate Survey Issue

*Effect on Physician Retention*

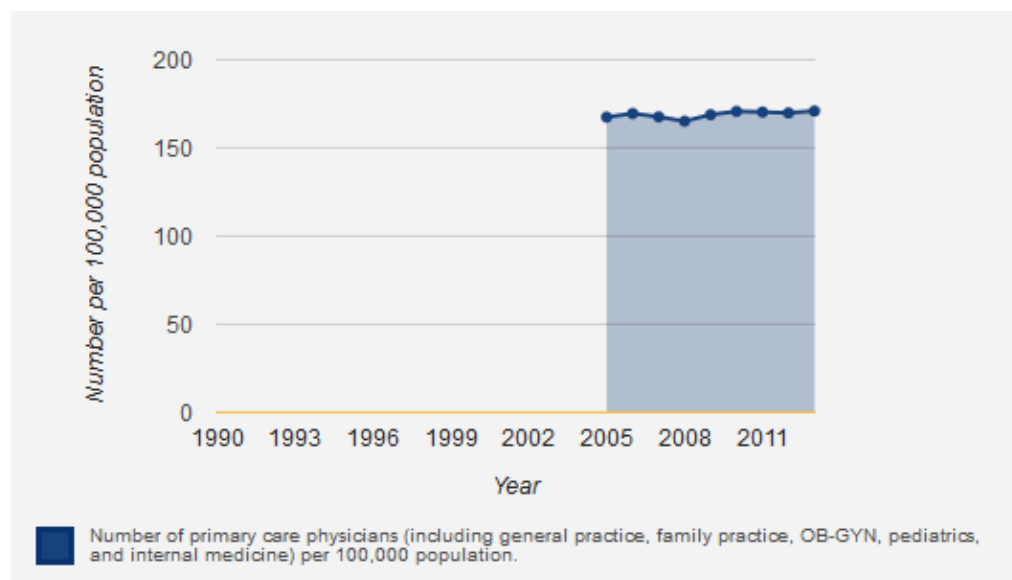
In previous studies attempting to measure the impact of tort reform, using per capita primary care physician rates per 100,000 has served as a useful proxy for measuring the impact of tort reform on the physician practice environment. Primary care physicians is an all-encompassing term including physicians who identify themselves as: family practice physicians, pediatricians, general practitioners, internists, obstetricians, or gynecologists.

In theory, if the physician practice environment were to become more hospitable to physicians practicing in these specialties secondary to changes in medical liability statutes, we should see a greater influx of physicians into the state. Conversely, if reforms were to negatively impact physician practice we would see the reverse occur noted by an efflux of physicians from the state. Again, limitations must be addressed given that it may be too soon to assess changes to the practice environment as a result of these medical liability reforms.

Analyzing the data shown in Figure 4 for Vermont through this time we observe the per capita physician rate was 170.9 per 100,000 in 2013 and 169.8 and 170.3 in 2012 and 2011, respectively. This is illustrated in figure 4. The data suggest that the per capita physician rate stayed roughly the same in the years before and year after implementation of malpractice liability reform. Looking further back at the broader trend shown in figure, the per capita physician rate has not changed appreciably in the period spanning between 2005 - 2013. Of note, the national average is 121 primary care physicians per 100,000 and this has been essentially unchanged in the last few years. Vermont consistently ranks in the top five nationwide when compared to other states along this criteria.

Given the uniformity in the years before and after reform we cannot conclude that the recent medical liability reforms have had much impact on rates of primary care physician practice in Vermont. Keeping in mind the short period of time between implementation and measurement of this metric, and the uncertainty regarding physician awareness of the recent change however, follow-up analyses would prove insightful to look for changes in the trend as a result of their implementation.

**Figure 4: Number of primary care physicians (including general practice, family practice, OB-GYN, pediatrics, and internal medicine) per 100,000 population.<sup>19</sup>**



2013	170.9
2012	169.8
2011	170.3
2010	170.7
2009	168.8
2008	165.1
2007	167.1
2006	169.5
2005	167.4

Source: [United Health Foundation](http://www.americashealthrankings.org). America's Health Rankings

<sup>19</sup>America's Health Rankings  
<http://www.americashealthrankings.org/measures/Measure/VT/PCP#sthash.qbiNwSNC.dpuf>

### *Impact on stakeholders*

We set out to measure the impact on the stakeholders involved in Vermont’s medical malpractice community through subjective interviews of a number of key constituency groups. We separated the community into four constituency groups: Vermont plaintiff lawyers, Vermont defendant lawyers, providers, and specialized mediators. Further, we used the office of the healthcare advocate as a proxy for the voice of consumers on this issue.

Next, we undertook a network analysis to create a list of key individuals within each constituency group which had been referred to us for their expertise and their ability to provide valuable information regarding this issue. Some constituency groups were harder to get responses from than others and this certainly is a limitation of this approach.

For both statutes, we found general themes in the subjective interviews we carried out and have included excerpts from our stakeholder interviews which exemplify these themes. Importantly, the office of the healthcare advocate, formerly the health care ombudsman, who acts as a voice for consumers in the Vermont healthcare system, noted no recorded complaints regarding either provision in their registry since implementation of these statutes.

<b>Stakeholder</b>	<b># of individuals interviewed</b>
Vermont Plaintiff Lawyer	1
Vermont Defense Lawyer	3
Vermont Mediator	3
Provider	3
Office of the Health Care Advocate	1
Total:	11

### Stakeholder Assessment of Pre-Suit Mediation

We assessed the impact of the confidential pre-suit mediation statute on stakeholders by interviewing trained mediators, malpractice litigators on the defense and prosecution sides, as well as providers. Our interviews unearthed three general themes regarding its impact on these stakeholders. Below we have included a small sampling of excerpts from relevant interviews of stakeholders on this topic.

#### **Lack of awareness**

*“...this is the first I’m hearing about this. In general, it’s a very good idea and I’m happy to hear that we went ahead and made an effort to formalize this practice.”* – Vermont mediator on 6/9/14

*“Are these statutes that have passed and are they law? I wasn’t aware of that.”* – Vermont provider on 6/12/14

One major theme in the feedback from stakeholders in all the four stakeholder groups has in large part been the lack of awareness of the new reform measure. This might be due to its recent implementation or to factors concerning its lack of publicity at the time of enactment.

In particular, physicians tended to be the least aware of the recent change. None of the practicing physicians which our team reached out to for feedback about this reform effort were aware of its implementation. Many agreed that this was, in theory, a good idea but doubted if it had the substance to make the necessary change that it set out to in practical terms. Most surprisingly, however, none of the mediators specializing in medical malpractice mediation, the individuals who presumably would serve in the case of pre-suit mediation, were aware of the change.

### **No Change**

*“Over the last year in my practice there has been no change in the number of pre-suit mediations, nor has there been a change in potential claimant’s willingness to engage in them. I can’t say I’ve seen any indication at all since then that I would be able to attribute to this legislation.”* – Vermont Mediator on 6/10/14

*“...I have seen no impact whatsoever from this pre-suit mediation statute. I haven’t had any change in the amount of cases which we’ve taken to mediation in the past year. Furthermore, my clients don’t seem to be any more or less willing to pursue that avenue.”* – Vermont Malpractice Defense Lawyer

Another theme in the feedback from stakeholders has been the lack of appreciable change in practice of all relevant stakeholder groups since implementation of this reform measure. All of the mediators who specialize in medical malpractice pre-suit mediation noted that in general, there has been no change in either direction of the number of clients coming in seeking pre-suit mediation for medical malpractice claims in the last year. Lastly, the Vermont Defense and Plaintiff lawyers who we spoke with did not note any change in the numbers of cases seeking to mediate. The providers we interviewed had no response on this issue as none were aware of this change.

### **Voluntary nature may dull its effect**

*“...This statute doesn’t change anything, really. We’ve always had a practice of mediating cases here in Vermont even before this law was implemented and since there is no mandate enforcing individuals to seek mediation we can’t expect any major changes.”* – Vermont Malpractice Defense Lawyer

*“The pre-suit mediation measure is irrelevant. It changes absolutely nothing. If there is a case that may be amenable to mediation I go about it in the normal process I would have prior to its implementation. After it sunsets”* – Vermont Malpractice Defense Lawyer

Another resounding theme we heard from the experienced litigators we interviewed concerned the issue of the statute’s voluntary nature and the effect this may have on blunting its impact. The arguments for this are three-fold.



- Many patients are not aware of pre-suit mediation as a viable option to begin with thus leading to small numbers of patients seeking to file for mediation.
- Since would-be claimants who are aware of this option are under no strict mandate to pursue it there may not be much potential for appreciable change.
- Even if a patient were to pursue this course of action, the physician could decline to enter into a mediation arrangement.

Thus, the provision that the pre-suit mediation arrangement must be entered into voluntarily by both the claimant and the physician may end up reducing the overall number of cases going to mediation. Many of the litigators that we interviewed contended that if this measure is to have appreciable impact it ought to be made mandatory. On the other hand, one experienced mediator in the field commented that while “it is never too soon to pursue mediation... a mediation that is forced upon the two parties and not done voluntarily may contradict the essence of what we are trying to do in mediation.”

### Stakeholder assessment of Certificate of Merit

Through our interviews of stakeholders we discovered two general themes regarding the implementation of certificate of merit statutes. Below we have included these themes and representative excerpts from our interviews.

#### **Statute is not an impediment**

*“Any well-trained plaintiff’s attorney already does this irrespective of the need to file a certificate of merit. It is just good practice.” - Vermont plaintiff lawyer*

*“In my experience I can attest to the fact that all of the big names in Vermont on the plaintiff side already do their due diligence and get an expert opinion as one of the initial steps. Most of them don’t need to be told to do this with a statute. This law may affect the very small, almost insignificant, number of inexperienced plaintiff attorneys who are not knowledgeable enough to put this sort of thing into practice.” - Vermont defense lawyer”*

The first major theme through our interviews was that this requirement does not impede the patient’s access to the courts or their right to due process as this statute does not add an extra burden outside of what is normally done by plaintiff attorneys in preparation for a malpractice case. Testimony from expert litigators in the field points to the fact that the vast majority of plaintiff attorneys in Vermont consult with medical experts before filing lawsuits unrelated to the need to obtain a certificate of merit requirement resulting in a certificate of merit having minimal impact on their preparation for litigation certificate of merit to be of minimal significance in their preparations for litigation.

## **No effect observed**

*“It sounds like a very reasonable idea, I just haven’t seen anything change in the way surgeons in my department do things because of it. Now granted, that most likely stems from the fact that most of us did not know the legislature passed this recently... Most of my guys don’t pay much attention to the political discourse that comes out of the legislature. We recognize the constraints they are working with and we know that many times what they say is couched in more complicated language to protect themselves. We get it. As a result, most of our information comes from within the community because we know that that’s the final word.” – Vermont Provider*

*“I haven’t seen any differences in the cases or the number of cases with or without merit that I’ve seen since the implementation of the certificate of merit rule. It may be premature to assess this kind of thing given how long it takes for claims to come through.” -Vermont Defense Lawyer*

The next general theme which we discovered in our stakeholder interviews regarding the certificate of merit statute was that no effect had been observed since its implementation. As exemplified by the excerpt from a Vermont provider working as a department chief, many providers had not been aware of the implementation of this statute. Therefore, gauging the effect that this may have had on their practice was inherently obfuscated. When defense and plaintiff lawyers were asked the same question, many denied seeing any effects of this statute often responding that it was much too soon to try to gauge its impact at this point.

## **Recommendations**

In conclusion, our goal in this report was to describe the impact that these statutes have had, as best we can discern them. In our view, the evidence that these reform measures had any impact on the state of medical malpractice in Vermont is inconclusive. On the question “Were sections 24a and 24c good policy?”, we cannot offer a concrete answer at this time. To adequately answer this question we offer three key points for consideration.

### Re-evaluation at a later date

As many of the experienced litigators we interviewed noted, it may have been premature to measure impact at this early stage – little more than one year after implementation. Given the short period of time between implementation and measurement, and as a result, the small number of cases which may have been influenced by these reforms it is recommended that a follow up retrospective analysis be done on or after February 1, 2017. This represents exactly one year following the date after which statute of limitations will run out on cases filed when these reforms took effect. With this date, the Agency of Administration would have approximately one year’s worth of cases, which include certificates of merit, to report to the legislature on. This new date would allow for the proper amount of time to lapse to assess impact and to investigate whether this requirement represented a barrier to due process in any way, shape, or form.

### Institute tracking of Certificate of Merit and Pre-suit mediation metrics

The state of Vermont currently does not track measures which may help to further elucidate the effects of these reforms. To rectify this in time for the re-evaluation occurring at the suggested later date we recommend that the state look at tracking the two specific metrics stated below:

- Success rate of cases going to pre-suit mediation
  - o This will give us a better understanding as to the extent that this measure is helping potential claimants through early disclosure and successful avoidance of litigation.
  
- Number of patients unable to access the courts given their inability to obtain a certificate of merit.
  - o This metric will allow us to better understand how many meritless cases have been avoided by the medical malpractice system due to their failure to obtain consent from an expert validating that the case did indeed have merit. On the flipside, looking at the negative ramifications of this statute, this number may also be used as a starting point for a measure of the number of patients who may have been denied access to the courts and their right to due process

This, of course, would require the capacity within the court system to track these measures, which is outside of the purview of this study, but is an important consideration.

### Recalibrate outreach strategy to Vermont's Providers

One of the resounding themes which stood out in our stakeholder interviews was the general lack of awareness that many of Vermont's providers had on this issue. One provider, a prominent surgeon in the state, mentioned that one way to reach out to specialty physicians would be to contact the Vermont chapter of each specific specialty. For example, to ensure that surgeons were kept abreast of the change in medical liability laws we would reach out to the Vermont Chapter of the American College of Surgeons (ACS) which has considerable traction within the Vermont surgical community.

Given the lack of pre-existing channels of communication to these groups, the Agency of Administration is limited in its ability to carry out this targeted outreach and would defer to other groups which are more knowledgeable in the realm of provider outreach. We recommend collaboration between pre-existing provider groups in Vermont and the National Medical Specialty Societies housed within the American Medical Association. If key groups like the American College of Surgeons, American Academy of Family Physicians, American College of Emergency Physicians, and American College of Radiology among others could be reached through these lines of communication we believe much could be done to build awareness in provider groups around this issue

Similarly, groups that have experience in the legal community and mediation community could also be called upon to spread awareness, in a more targeted fashion, about these recent changes in medical malpractice law. This formula of targeted outreach when combined with broader outreach through preexisting channels may help to more easily spread the message to stakeholders on the ground.

## Addendum

Since this report was submitted, the Journal of American Medical Association Internal Medicine published a study on defensive medicine. This study illustrates the complexity of the issue of defensive medicine, medical malpractice reform, and physicians' attitudes and adds to the literature review provided to the general assembly in the Medical Malpractice Reforms Report and Proposal of the Secretary of Administration submitted in 2012.

The study aimed to determine whether tort reform would reduce the practice of defensive medicine and added health care costs. Defensive medicine that is performed solely to avoid liability adds unnecessary cost to the system. In the study, providers at three different hospitals determined what portion of their previous day's orders was attributable to defensive medicine on a scale of 0 (not at all defensive) to 4 (completely defensive). The study found that while 13% of costs were judged to be at least partially defensive, only 2.9% of costs were done solely as a practice of defensive medicine. These findings suggest "that only a small portion of medical costs might be reduced by tort reform." Furthermore, the study found that physicians who wrote the most defensive orders actually spent less than those who wrote fewer defensive orders. The study concludes that "physicians' attitudes about defensive medicine [do] not correlate with cost."<sup>20</sup>

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<sup>20</sup> Rothberg MB, Class J, Bishop TF, Friderici J, Kleppel R, Lindenauer PK. The Cost of Defensive Medicine on 3 Hospital Medicine Services. *JAMA Intern Med*. Published online September 15, 2014.