



**Medical Malpractice Reforms  
Report and Proposal of the Secretary of Administration  
Pursuant to Act No.48 of 2011, section 2(a)(7)**

*Submitted to the*

**Senate Committee on Health and Welfare  
Senate Committee on Judiciary  
House Committee on Health Care  
House Committee on Judiciary**

January 30, 2012

# Medical Malpractice Reforms

## Report and Proposal of the Secretary of Administration Pursuant to Act No. 48

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### I. Introduction

#### a. Legislative Charge

The Legislature has charged the administration as follows:

No later than January 15, 2012, the secretary of administration or designee shall submit to the house committees on health care and on judiciary and the senate committees on health and welfare and on judiciary a proposal for potential improvement or reforms to the medical malpractice system for Vermont. The proposal shall be designed to address any findings of defensive medicine, reduce health care costs and medical errors, and protect patients' rights, and shall include the secretary's or designee's consideration of a no-fault system and of confidential pre-suit mediation. In designing the proposal, the secretary or designee shall consider the findings and recommendations contained in the majority and minority reports of the medical malpractice study committee established by Sec. 292 of No. 122 of the Acts of the 2003 Adj. Sess. (2004).

Act No. 48 of the 2011 Session, section 2(a)(7).

#### b. Health Care Reform and Medical Malpractice

A central goal of health care reform in Vermont is to target our limited resources as efficiently as possible, focusing on expenditures that optimize patient health, and, wherever we can, minimizing expenditures that don't contribute to better patient outcomes and healthier Vermonters. In addition to excising the unwieldy administrative costs associated with our current system, we are evaluating the practice of medicine itself, with an eye toward continuing to develop relevant data to support sound evidence-based medicine and eliminating systemic pressures or incentives to misallocate medical resources.

In our effort to find savings that don't unreasonably compromise patient care wherever we can, we should consider all aspects of the health care system—including the medical malpractice system whereby the law identifies and requires compensation for some patients injured as a result of reasonably avoidable medical errors.

Our medical malpractice system potentially affects health care costs in two main related but distinct ways. First, it may affect medical malpractice premiums paid by health care providers, in turn impacting health care costs overall. Second, it may affect the way health care providers practice medicine, with a consequent impact on health care costs. The former concern is decidedly beyond the scope of this analysis and accompanying recommendations. In 2005, at the direction of the Vermont General Assembly, the Vermont Medical Malpractice Study Committee (“VMMSC”) produced an extensive report analyzing the connection between medical malpractice premiums and medical malpractice laws, and responding to a litany of specific questions posed by the General Assembly with respect to potential changes to insurance and/or medical malpractice laws.<sup>1</sup> Although the data is not current, we have no evidence that the underlying market dynamics described in that report have changed considerably.

The goal of these recommendations is to consider potential changes to Vermont’s medical malpractice system in a manner that addresses “any findings of defensive medicine,” reduces health care costs and medical errors, and protects patients’ rights. To the extent that this analysis overlaps with the VMMSC analysis, we hope to build on its work.

c. Vermont Medical Malpractice Law

In general, a person is legally liable to another if he or she has a legal duty to that other person, he or she breaches that duty; the breach is the “proximate cause” of harm to the other; and the other suffers actual loss or damage. O’Connell v. Killington, Ltd., 164 Vt. 73, 76 (1995). This longstanding historical rule of general legal responsibility is subject to more specific rules in particular settings.

In the context of medical negligence, or “malpractice,” a plaintiff in Vermont has the legal burden of proving:

- (1) The degree of knowledge or skill possessed or the degree of care ordinarily exercised by a reasonably skillful, careful, and prudent health care professional engaged in a similar practice under the same or similar circumstances whether or not within the state of Vermont.
- (2) That the defendant either lacked this degree of knowledge or skill or failed to exercise this degree of care; and
- (3) That as a proximate result of this lack of knowledge or skill or the failure to exercise this degree of care the plaintiff suffered injuries that would not otherwise have been incurred.

12 V.S.A. §1908. A plaintiff must generally prove these elements using expert testimony. Begin v. Richmond, 150 Vt. 517, 520 (1988).

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<sup>1</sup> Vermont Medical Malpractice Study Committee (VMMSC), *Medical Malpractice Liability Insurance in Vermont* (December 15, 2005).

The Vermont Supreme Court has made it clear that in Vermont, a physician “is not required to be infallible.” Utzler v. Medical Center Hospital of Vermont, 149 Vt. 126, 127 (1987). Moreover, A plaintiff cannot prove a breach of the standard of care solely on the basis of a bad medical result. Lockwood v. Lord, 163 Vt. 210, 213 (1994).

These above standards reflect the burden of proof a plaintiff must satisfy in order to *win* a medical malpractice case. If the plaintiff fails to disclose sufficiently reliable expert testimony within the court’s deadlines, the judge may enter judgment in favor of the defendant. In addition, once a plaintiff discloses proposed expert testimony or after the expert’s deposition, the defendant may challenge the experts’ qualifications and the basis for the expert’s opinions. The judge may rule that such testimony is inadmissible if it does not meet the requirements set out in the Rules of Evidence and the case law. If the plaintiff fails to meet his burden of proof at trial by adducing the appropriate expert testimony, the judge may also grant a verdict in favor of the defendant and not permit the jury render to a verdict.

The Administration takes no position regarding Vermont’s existing arbitration “screening panel” program for medical malpractice claims. Feedback solicited from the judiciary, trial lawyers, and doctors was that the arbitration procedures set forth in 12 V.S.A. §§ 7001 - 7009 are rarely if ever used. The Administration also takes no position regarding the “contingent amendment” contained in Sec. 48 of No. 160 of the Acts of 1991 (Adj. Sess.) that makes medical malpractice arbitration mandatory in the event the State achieves universal health care.

#### d. Constitutional Requirements

Medical malpractice reforms must be carefully tailored to comply with constitutional requirements of access to courts, access to a jury trial, equal protection, and separation of powers. Many types of medical malpractice reforms—including expert witness qualifications, certificate of merit requirements, and arbitration screening panel programs—have been struck on constitutional grounds. *See, e.g., Broussard v. St. Edward Mercy Health Sys., Inc.*, \_\_\_ S.W. 3d \_\_\_, 2012 Ark. 14 (Jan. 19, 2012) (striking statute requiring expert witness to be of same specialty as defendant on separation-of-powers grounds); *Seisinger v. Siebel*, 203 P.3d 483 (Ariz. 2009) (upholding statute creating expert witness qualifications that conflicted with rule of evidence on separation-of-powers grounds by concluding that expert witness qualifications were “substantive” and not “procedural”); *Putman v. Wenatchee Valley Medical Center, P.S.*, 216 P.3d 374 (Wash. 2009) (finding certificate of merit requirement involving written, signed opinion of expert unconstitutional on access-to-courts and separation-of-powers grounds); *Zeier v. Zimmer, Inc.*, 152 P.3d 861 (Okla. 2006) (finding certificate of merit requirement involving written, signed opinion of expert unconstitutional on equal protection and access-to-courts grounds). *See also, e.g., Eaton v. Fleet*, No. 2008-cv-074, (NH Superior Court, Nov. 3, 2009), appeal pending at New Hampshire Supreme Court (finding medical malpractice arbitration screening panel program unconstitutional on separation-of-powers grounds); *Waples v. Yi*, 234 P.3d 187 (Wash. 2010) (striking medical malpractice pre-suit notice requirement as

unconstitutional on separation-of-powers grounds); *Irish v. Gimbel*, 691 A.2d 664 (Me. 1997) (upholding medical malpractice arbitration screening panel program as constitutional); *Hoem v. State*, 756 P.2d 780 (Wyo. 1988) (striking medical malpractice arbitration screening program on equal protection grounds due to lack of sufficient evidence of state medical malpractice problem).

In light of these cases, the Administration’s proposal seeks to balance the constitutional rights of medical malpractice plaintiffs and defendants, as well as separation of powers requirements, with procedures that will (a) help address concerns surrounding the practice of defensive medicine and associated costs, and (b) encourage parties to resolve their claims in an efficient and cost-effective manner.

#### e. Vermont’s Medical Malpractice Experience

Malpractice payouts in Vermont are among the lowest in the country. The VMMSC found that Vermont’s mean payout in medical malpractice claims from 1996-2003 was decidedly less than the national mean—less than half in most years.<sup>2</sup> In 2003, the median payment in Vermont was 50% of the national median payment, and the mean payment was 46% of the national average.<sup>3</sup> Vermont’s median payment in malpractice claims ranked 48<sup>th</sup> nationwide.<sup>4</sup> In 2004, Vermont’s total medical malpractice liability insurance premiums paid were \$25.6 million, representing less than 1 percent of total health expenditures.<sup>5</sup> More recent data ranked Vermont in 2006 as 51<sup>st</sup> in the United States, including D.C., in mean payments for malpractice claims.<sup>6</sup>

The number of malpractice claims in Vermont is likewise low. Per the National Practitioner Data Bank, the total number of claims paid in Vermont between 1996 and 2003 ranged from 19 in the lowest year to 49 in the highest; the average annual number of claims paid out was 30.<sup>7</sup>

Finally, malpractice insurance premiums in Vermont are extremely low in relative terms. The Vermont Medical Malpractice Study Committee (“VMMSC”) found that in 2003 Vermont’s premiums were the lowest in New England.<sup>8</sup>

## II. **Defensive Medicine**

### a. Defining “Defensive Medicine”

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<sup>2</sup> VMMSC, *Medical Malpractice Liability Insurance in Vermont*, Table 1.2, page 28.

<sup>3</sup> VMMSC, *Medical Malpractice Liability Insurance in Vermont*, Table 1.3, page 28.

<sup>4</sup> VMMSC, *Medical Malpractice Liability Insurance in Vermont*, Table 1.3, page 28.

<sup>5</sup> VMMSC, *Medical Malpractice Liability Insurance in Vermont*, Table 1.3, page 28.

<sup>6</sup> National Practitioner Data Bank Annual Report 2006.

<sup>7</sup> VMMSC, *Medical Malpractice Liability Insurance in Vermont*, Table 1.2, page 28.

<sup>8</sup> VMMSC, *Medical Malpractice Liability Insurance in Vermont*, Table C, p. 25, citing Medical Liability Monitor, October, 2004.

Researchers and commentators do not all use the term “defensive medicine” in the same way, and studies evaluating health care expenditures as they relate to the malpractice system don’t all purport to measure the same thing.

One common definition, originated by the now-defunct U.S. Congress Office of Technology Assessment (OTA), holds that defensive medicine occurs when “doctors order tests, procedures, or visits, or avoid high-risk patients or procedures, primarily (but not necessarily solely) to reduce their exposure to malpractice liability.”<sup>9</sup> But, as noted by one prominent researcher, “This definition says nothing about the benefits—potentially substantial—to patients that may arise from greater use of medical services—or, for that matter, about the damages that patients could incur from excess or unnecessary care.”<sup>10</sup>

For that reason, studies that document an association between medical malpractice costs and health care spending without also tracking the associated patient outcomes don’t necessarily tell us about the *desirability* of those costs from a patient-care perspective. A finding that a more robust (and by inference higher cost) medical malpractice system is associated with more intensive medical treatment and higher health care costs (or avoidance of higher-risk patients or procedures) could signal that pressures flowing from the medical malpractice system are distorting health care decisions and causing providers to provide more expensive care than optimal to many patients, and less care than optimal to others. The same finding could signal that the medical malpractice system is working exactly as it’s supposed to—incentivizing providers to provide an optimal level of care to promote patient health, and to avoid unreasonable risks in treating patients.<sup>11</sup> As one British researcher has noted with reference to increased diagnostic testing, “One doctor’s defensive medicine may be another doctor’s good practice.”<sup>12</sup> The Dartmouth Institute, however, has done extensive research on the variation in ordering certain types of procedures for the Medicare population. Their research has shown a correlation between higher utilization, higher costs, but lower quality. For more detailed information, see the Dartmouth Atlas at <http://www.dartmouthatlas.org/>

On the other hand, in defining “defensive medicine,” some scholars—most commonly economists—consider not simply whether a medical expenditure is influenced by fear of malpractice liability, but also whether the particular expenditure is undesirable. Thus, for example, Kessler and McClellan define defensive medicine as “administer[ing] precautionary

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<sup>9</sup> OTA Defensive Medicine and Medical Malpractice, July 1994. See also Mello, Chandra, Gawande, and Studdert, *Health Affairs*, Vol 29:9 p. 1572 (September 2010).

<sup>10</sup> Mello et al, above, at 1572.

<sup>11</sup> See, for example, Katherine Baicker, Elliott S. Fisher, and Amitabh Chandra, Malpractice Liability Costs and the Practice of Medicine in the Medicare Program, *Health Aff (Millwood)* 2007 26(3):841-852 (documenting an association between a 10% increase in medical malpractice payments per physician within a state and a 2.2% increase in imaging services for Medicare patients, but noting that the data do not imply that any increased spending was necessarily “defensive medicine” since the additional procedures might have been protective of patient health).

<sup>12</sup> Nicholas Summerton, *Positive and Negative Factors in Defensive Medicine: a Questionnaire Study of General Practitioners* *BMJ* vol. 310, p. 27 January 7, 1995.

treatments with minimal expected medical benefit out of fear of legal liability.”<sup>13</sup> Such treatments lead to a “socially excessive level of care due to malpractice liability pressures.” This kind of “defensive medicine” is the “bad” kind—the kind we would like to minimize or eliminate to the extent reasonably possible.

b. Empirical Studies As To Existence and Prevalence Of “Bad” Defensive Medicine

The extent of this “bad” kind of defensive medicine (and hereafter unqualified references to “defensive medicine” will connote the “bad” kind) is difficult to ascertain and quantify, and research to date has yielded mixed results. Various studies have attempted to quantify the link between defensive medicine and health care costs by analyzing the relationship between medical malpractice premiums, medical malpractice risk, or the structure of a jurisdiction’s medical malpractice system on the one hand, and health care expenditures on the other.

An early and influential study along this line was conducted in 1996 by two economists. Kessler and McClellan analyzed data concerning all elderly Medicare beneficiaries treated for acute myocardial infarctions (heart attacks) or ischemic heart disease in 1984, 1987, and 1990 throughout the country with reference to the evolving malpractice laws in the various states throughout that time period. They considered the changes in the relevant hospital expenditures over time in each state in light of presence of various kinds of changes to that state’s medical malpractice laws. By doing so, they were able to obtain comparisons across states with different medical malpractice laws and through time as a given state’s laws changed. At the same time, they considered mortality and morbidity data and compared patient outcomes across the same array of states, time periods, and medical malpractice regimes. They concluded that in connection with the specific conditions they studied that malpractice liability law changes that directly limited malpractice awards did lead to substantial reductions in the growth of medical expenditures in those states that had adopted such changes, without significant negative impact on the morbidity and mortality measures they tracked.<sup>14</sup>

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<sup>13</sup> Daniel Kessler and Mark McClellan, *Do Doctors Practice Defensive Medicine?*, Quarterly Journal of Economics, May 1996, p. 345.

<sup>14</sup> The significance of Kessler and McClellan’s conclusions may be limited. First, the authors themselves cautioned that their conclusions were necessarily short-term, and that their study was not long enough to allow them to reach “equally certain conclusions about the long-term effects of malpractice reforms on medical expenditure growth and trends in health outcomes.” Kessler and McClellan, above, at 387. Moreover, their study was limited to a narrow class of cases and patients—Medicare patients seeking cardiac care—and the results do not necessarily extend to other types of patients and conditions. Among other things, “treatment intensity for other conditions may be less subject to physician discretion than cardiac care.” Mello et al, above, at 1573. See also F.A. Sloan, J.H. Shadle, *Is there empirical evidence for “Defensive Medicine”? A reassessment*, Journal of Health Economics, Vol. 28 (2009) p. 483 (noting that Kessler-McClellan study was potentially not generalizable insofar as it focused on a narrow class of conditions and a narrow class of patients.) Finally, their study was limited to hospital care, when most policy discussions of defensive medicine refer to care rendered by physicians. Sloan and Shadle, above, at 483.

On the other hand, more recently Sloan and Shadle undertook a similar analysis. Rather than focusing just on hospital expenditures, they extended their study to physician expenditures. They analyzed data over a longer period than Kessler and McClellan—15 years rather than six—but covered a smaller sample of patients (60,000). They studied cases involving hospital admission for *any* diagnosis (as opposed to just the two cardiac diagnoses studied by Kessler and McClellan), and they separately studied primary diagnoses of acute myocardial infarction (AMI), stroke, breast cancer and diabetes, controlling for additional variables not controlled in the Kessler-McClellan study. Sloan and Shadle did not purport to measure the marginal benefit of any extra care attributable to tort reforms as compared to the costs of those reforms, but did measure survival as a measure of benefit. Sloan and Shadle concluded that “direct tort reforms” did not significantly influence medical expenditures (although the impact of the reforms in the AMI context approached significance). They did identify impacts—both on survival and expenditures—associated with “indirect tort reforms,” but for various reasons that they set forth, they were reluctant to draw conclusions based on these findings, both with respect to survival and reduced expenditures associated with “indirect reforms.”<sup>15</sup>

The Kessler-McClellan study and the Sloan-Shadle study are two of the most comprehensive and rigorous empirical studies to date that were designed to identify and quantify the relationship between medical malpractice laws and process and medical expenditures. And they seem to point in opposite directions.<sup>16</sup>

Still other studies document *some* association between medical malpractice laws or expenditures and medical expenditures, but the magnitude of the association is far less than supposed. For example, drawing on extensive nationwide insurance databases and analyzing the gamut of practice areas and types of medical expenditures, Thomas, Ziller and Thayer concluded that savings associated with a 10 percent premium reduction in medical malpractice premiums would be just .132 percent.<sup>17</sup>

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<sup>15</sup> Sloan and Shadle, above, at 481-491.

<sup>16</sup> For other examples of conflicting studies, see A. Russell Localio, Ann G. Lawthers, Joan M. Bengston, Liesi E. Hebert, Susan L. Weaver, Troyen A. Brennan, J. Richard Landis, *Relationship Between Malpractice Claims and Cesarean Delivery*, JAMA, Vol. 269, No. 3 (January 20, 1993), p. 366 (finding a positive statistical association between malpractice risk as measured at the regional or hospital level and the odds of cesarean section); but see Laura-Mae Baldwin, L. Gary Hart, Michael Lloyd, Meredith Fordyce, Roger A. Rosenblatt, *Defensive Medicine and Obstetrics*, JAMA, Vol. 274, No. 20 (November 22/29, 1995) p. 1606 (study did not support an association between the malpractice experience or exposure of individual physicians and an increase in the use of prenatal resources or cesarean deliveries for the care of low-risk obstetric patients). Sloan and Shadle have cataloged a larger set of studies reaching conflicting conclusions. See F.A. Sloan, J.H. Shadle, *Is there empirical evidence for “Defensive Medicine”? A reassessment*, Journal of Health Economics, Vol. 28 (2009) p. 482 et seq. See also J. William Thomas, Erika C. Ziller and Deborah A. Thayer, Health Affairs Vol. 29, No. 9 (2010), pp. 1579-1580, notes 16-22 (listing studies that find relationships between changes to medical malpractice laws and studies that find only weak relationships or no relationships at all between malpractice premiums or malpractice laws and health care costs).

<sup>17</sup> J. William Thomas, Erika C. Ziller, and Deborah A. Thayer, *Low Costs of Defensive Medicine, Small Savings From Tort Reform*, Health Affairs, Vol. 29 No. 9 (September 2010) pp 1578-1574. The Congressional Budget Report of Secretary of Administration

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On a basis of a review of the empirical studies relating to medical malpractice laws or premiums on the one hand, and health care expenditures on the other, we cannot conclude that defensive medicine motivated by fear of medical malpractice claims leads to substantial unwarranted health care costs; nor can we confidently rule out the possibility.

c. Physicians' Self-Reports

Some researchers rely on physicians' self-reports to ascertain the extent and impact of defensive medicine. For example, a study published in 2010 found that 91% of physicians responding to the study believed that physicians order more tests and procedures than needed in order to protect themselves from malpractice suits, and a comparable percentage believed that protections against unwarranted malpractice suits are needed to decrease the unnecessary use of diagnostic tests.<sup>18</sup> The authors of these various studies did not measure actual practice patterns to corroborate physicians' perceptions, and acknowledged that the survey data might overstate the actual role of defensive medicine in practice as contrasted with physicians' perceptions.<sup>19</sup> In at least one study, physicians' reports of their own defensive medicine practices proved to be particularly striking among high risk specialist physicians in an exceptionally volatile malpractice environment.<sup>20</sup>

The Vermont Medical Society conducted a survey in 2005. Consistent with the national data, most physicians reported practicing defensive medicine due to concerns about malpractice liability. In particular, respondents answered the following four questions in these proportions:

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Office has likewise concluded that certain changes in medical malpractice laws would likely lead to a reduction in health care expenditures, but the package of changes upon which their conclusion was premised includes a host of very substantial limitations on the ability of a patient injured by medical negligence to recover damages, and the overall savings they projected from such restrictions would be .3 percent of medical spending. Congressional Budget Office, Letter from Director Douglas W. Elmendorf to Orrin G. Hatch, October 9, 2009. See also *Limiting Tort Liability for Medical Malpractice*, Congressional Budget Office Economic and Budget Issue Brief (January 8, 2004) p. 6 ("On the basis of existing studies and its own research, CBO believes that savings [associated with changes to the malpractice system] from reducing defensive medicine would be very small.")

<sup>18</sup> Tara F. Bishop, Alex D. Federman and Salomeh Keyhani *Physicians' Views on Defensive Medicine: A National Survey*, Archives of Internal Medicine, vol 170, no. 12 at 1081 (June 28, 2010).

<sup>19</sup> See Bishop et al., note 9 above, at 1082.

<sup>20</sup> David M. Studdert, Michelle M. Mello, William M. Sage, Catherine M. DesRoches, Jordon Peugh, Kinga Zapert, Troyen A. Brennan, *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, Journal of the American Medical Association, Vol. 293, No. 21 (2005).

| Questions   | Yes       | No        |
|---|-----------|-----------|
| Due to concerns about malpractice liability, do you order more tests than you would, if based only on professional judgment of what is medically needed?  | 46<br>75% | 15<br>25% |
| Due to concern about malpractice liability, do you refer patients to specialists more often than you would, if based only on your professional judgment of what is needed?  | 41<br>67% | 20<br>33% |
| Due to concerns about malpractice liability, do you prescribe more medications such as antibiotics than you would, if based only on your professional judgment of what is medically needed?                                 | 18<br>30% | 43<br>70% |
| Due to concerns about malpractice liability, do you suggest invasive procedures such as a biopsies to confirm diagnoses more often than you would, if baswed only on your professional judgment of what is actually needed? | 23<br>38% | 37<br>62% |

Vermont Medical Society, *Prevalence of “Defensive Medicine” in Vermont, Preliminary Results*, April 21, 2005. (The emphasis on defensive medicine in the context of diagnostic tests as opposed to therapeutic measures is consistent with responses to national surveys.)

A group of researchers attempted to drill down a level by analyzing the variation in physicians’ perceptions that they engage in defensive medicine as a result of concerns about exposure to malpractice claims across specialties and different legal environments.<sup>21</sup> In the survey-style study, a substantial majority of physicians (60-78%) endorsed all five measures of “malpractice concern,” including statements that the physicians “order some tests or consultations simply to avoid the appearance of malpractice,” “ask for consultant opinions primarily to reduce [the] risk of getting sued.,” and believe that “relying on clinical judgment rather than on technology to make a diagnosis is becoming risky because of the threat of malpractice suits.”

The physicians’ self-reports varied among specialties in ways that corresponded with the perceived relative risk of malpractice claims associated with those practice areas. So, for example, emergency physicians and ob/gyns expressed greater malpractice concern than psychiatrists and general pediatricians.<sup>22</sup>

But the state-to-state variation in physicians’ levels of malpractice concern and self-reported defensive medicine practices was marginal compared to the dramatic differences in the actual malpractice risk in different states. The average malpractice risk in the one-third of states with the highest malpractice risk is more than three times that found in the third of states with the lowest values, but the difference between the malpractice concern figures among those sub-groups is modest (63.5% versus 67.8%). Using other measures, the researchers found that

<sup>21</sup> Emily R. Carrier, James D. Reschovsky, Michelle M. Mello, Ralph C. Mayrell, and David Katz, *Physicians’ Fears of Malpractice Lawsuits Are Not Assuaged By Tort Reforms*, *Health Affairs*, 29:9 at 1585 (September, 2010).

<sup>22</sup> *Id.* at 1587-88.

physicians with twice the objective measure of malpractice risk had levels of concern that were only 2.9% and 2.5% higher than those of their peers at lower risk. The researchers assessed the impact of a host of individual malpractice system modifications or limitations on physicians' perceptions and concluded that "Overall, physicians' malpractice concerns appear to be relatively insensitive to their states' malpractice reforms, including caps on noneconomic and punitive damages."<sup>23</sup>

The researchers opined that "the level of liability concern reported by physicians is arguably out of step with the actual risk of experiencing a malpractice claim" and described the high level of malpractice concern even among physicians practicing in relatively low-risk environments, as "striking."<sup>24</sup> They hypothesized that malpractice claims are a "dread risk" for physicians, triggering a statistically irrational level of risk aversion akin to members of the general public's documented higher levels of fear of dying in an airplane crash than in a car accident, even though the latter fate is far more likely.<sup>25</sup> The researchers left the door open to the possibility that broad-based liability reform could have an impact on physicians' perceptions, and noted the recently-funded federal demonstration projects testing innovative approaches to liability reform. However, their study does suggest to the extent that physicians in Vermont do engage in defensive medicine out of fear of malpractice exposure, changes to the malpractice liability system may not significantly change such behaviors.

The physician-survey studies provide helpful insights into the perspective of practicing physicians. However, like any research method, our ability to draw conclusions from the physician surveys may be limited. The authors of a prominent article reporting their own survey results acknowledged a significant limitation:

[M]easurement and self-identification of defensive medicine are difficult because distinctions between inappropriate and appropriate care are not clear in many clinical situations. . . . Moreover, it can be difficult to disentangle liability-related motivators from other factors that influence clinical decision making, such as physicians' general desire to meet patients' expectations, preserve trust, and avoid conflict. . . . To the extent that physicians unconsciously practice defensive medicine [such survey] results will underestimate defensive medicine; to the extent that physicians attribute liability motivations to decisions driven primarily by other considerations, [such surveys'] findings will be exaggerated.<sup>26</sup>

The upshot of these surveys is that the usefulness of physician survey data in predicting the impact, if any, of changes to the medical malpractice system is limited.

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<sup>23</sup> *Id.* at 1588-1589.

<sup>24</sup> *Id.* at 1590-91.

<sup>25</sup> *Id.* at 1591.

<sup>26</sup> David M. Studdert et al, *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, above, at 2616-17.

That said, we do not view the data as irrelevant to our broader goals. First, the data suggest that certain classes of medical expenditures, such as diagnostic tests, offer real opportunities for “bending the curve.” Second, the data offer important insights into the experiences and perceptions of physicians practicing in Vermont and beyond. Physician satisfaction is important to maintaining Vermont’s health care workforce and to the extent we can identify reforms that address physicians’ concerns without compromising patient care or legal rights, we should explore those reforms. We have seen, both through anecdotal experience as well as the data above (as well as other studies) that a) physician concern and anxiety about exposure to legal malpractice claims and liability is significant and real and b) this concern impacts the job satisfaction and quality of life of physicians in Vermont and beyond.

### **III. Recommendation #1: Certificate of Merit**

Anecdotally, the top concern we have heard doctors express is a fear of being the subject of a frivolous lawsuit. Although the legal system is set up to filter out cases in which a plaintiff has no evidence to support his or her case, that process can take time. And from the perspective of many physicians, eventual dismissal of a case that has no merit is an inadequate remedy for the stress of being named in a malpractice case in the first place. In order to avoid subjecting physicians to lawsuits by plaintiffs who have no evidence to support their cases, many states have passed laws requiring that plaintiffs filing malpractice claims file “certificates of merit” or “affidavits of merit” at the outset of litigation. Approximately 25 states have some sort of requirement that fits under this general heading.<sup>27</sup>

These state statutes share common elements, but vary widely with respect to specifics. The common element to the various statutes is some sort of requirement that, at the beginning of a malpractice case, the plaintiff certify that a qualified expert has offered an opinion that the case has merit. The variables include:

- 1) the exact timeline for filing the affidavit or certification;
- 2) whether the plaintiff is required to produce certification from counsel or an expert’s opinion itself;
- 3) the specific standard to be applied by the expert;
- 4) the required qualifications for the expert;
- 5) whether the requirement is reciprocal such that defendants are required to provide comparable certifications if they deny claims;

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<sup>27</sup> Fred J. Hellinger and William E. Encinosa, Agency for Healthcare Research and Quality, *Review of Reforms to Our Medical Liability System* (12/31/09) Section II, citing Amy Lynn Sorrel, “New Jersey Upholds Certificate-of-Merit Rule,” *American Medical News*, American Medical Association (Chicago, 2/5/09) and Catherine T. Struve, *Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options*, Pew Project on Medical Liability (2003).

- 6) whether the requirement applies to a range of professional negligence cases or is limited to medical malpractice claims; and
- 7) what exceptions to the general rule, if any, may apply.

The goal of such statutes is to screen out meritless malpractice claims at the outset by requiring consultation with a qualified expert at the beginning of a lawsuit. This requirement is not likely to significantly impact the practice of experienced plaintiffs' attorneys who focus on medical malpractice matters, as they routinely solicit expert evaluations before filing suit.<sup>28</sup> It may, however, ensure that less experienced plaintiffs' attorneys vet their cases with appropriate experts before filing suit.

A "certificate of merit" requirement is not without peril. First, as one commentator has noted, at the outset of litigation, the plaintiff may not have access to all the information necessary to fully assess the case—including most particularly the defendant's own explanation.<sup>29</sup>

Second, it could drive up the cost of bringing a medical malpractice claim—especially if the requirement is structured in a way that leads plaintiffs' attorneys to hire a separate expert for pre-suit review.<sup>30</sup> A certificate of merit requirement should be designed to meet the underlying goals while minimizing these potential adverse consequences.

Third, as discussed previously, there has been recent litigation in other states regarding the certificate of merit, which have struck written, signed certificate of merit requirements on constitutional grounds. *See, e.g., Putman v. Wenatchee Valley Medical Center, P.S.*, 216 P.3d 374 (Wash. 2009) (finding certificate of merit requirement involving written, signed opinion of expert unconstitutional on access-to-courts and separation-of-powers grounds); *Zeier v. Zimmer, Inc.*, 152 P.3d 861 (Okla. 2006) (finding certificate of merit requirement involving written, signed opinion of expert unconstitutional on equal protection and access-to-courts grounds).

For these reasons, the administration recommends a certificate of merit requirement that:

- 1) Requires the certification simultaneous with filing a malpractice claim, rather than after, so that the "screening" of unsupported claims occurs before a plaintiff actually files a case against a physician;
- 2) Requires that *counsel* certify to receiving information from a qualified expert meeting the requisite standard;
- 3) Requires that the expert meet the standards of expertise set forth below (see Recommendation #2, regarding expert qualifications); and
- 4) Is limited to the medical malpractice context.

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<sup>28</sup> Struve, *Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options*, above, at 51.

<sup>29</sup> *Id.* at 51-52.

<sup>30</sup> *Id.* at 52-53.

These considerations are reflected in the draft legislation attached as Appendix A.

#### **IV. Recommendation #2: Expert Witness Qualifications**

A related fear expressed by some physicians is that their conduct will be evaluated on the basis of opinions offered by unqualified expert witnesses. Some medical associations have their own standards governing expert witness testimony. In Vermont, the qualifications of a proposed expert witness are determined by courts pursuant to standards established through Vermont Rule of Evidence 702 and case law.

A bill regarding expert witness qualifications should assure that prospective witnesses are qualified in the area about which they seek to testify without (a) creating undue burdens or costs in the litigation process, and (a) respecting the doctrine of separation of powers and the proper role of the judiciary in establishing court procedures. *See, e.g., Broussard v. St. Edward Mercy Health Sys., Inc.*, \_\_ S.W. 3d \_\_, 2012 Ark. 14 (Jan. 19, 2012) (striking statute requiring expert witness to be of same specialty as defendant on separation-of-powers grounds); *Seisinger v. Siebel*, 203 P.3d 483 (Ariz. 2009) (upholding statute creating expert witness qualifications that conflicted with rule of evidence on separation-of-powers grounds by concluding that expert witness qualifications were “substantive” and not procedural).

Such a proposal should be crafted after consultation with the judiciary and may be most appropriate in the form of an amendment to the existing rules of evidence. The Administration therefore recommends that the Advisory Committee on Vermont’s Rules of Evidence may wish to consider the following with respect to expert witness qualifications in medical malpractice cases: that the expert possess a current, valid and unrestricted license to practice medicine—or have had a valid and unrestricted license within a reasonable period so that recently retired physicians who have special expertise in the area are not excluded as an expert solely by virtue of their relatively recent retirement. Further, the physician expert witness should be qualified in the area of medical practice involved in the case. And, when the physician is testifying as to standard of care, he or she should be familiar with the standard of care provided at the time of the alleged occurrence.

Specific language the Advisory Committee on Vermont’s Rules of Evidence may wish to consider as an amendment to V.R.E. 702 or otherwise is below.

(a) Except as provided for in subsection (c) of this section, no person shall be permitted to serve as a physician expert witness unless the person has a current, valid, and unrestricted license to practice medicine in the state in which he or she practices, and is currently practicing.

(b) The physician expert witness shall:

(1) be qualified by experience or demonstrated competence in the area of medical practice involved in the case; and

(2) if the witness testifies regarding compliance with the standard of care, be familiar with the standard of care provided at the time of the alleged occurrence.

(c) A retired physician may serve as a physician expert witness if, within the past three years, the physician held an unrestricted license and is engaged in medical research or teaching medicine at an academic institution, provided the research or teaching is in the same or similar field as the defendant's and provided it addressed a relevant issue in the case.

(d) The physician expert testimony shall state the basis of his or her testimony or opinion.

(e) No physician expert may accept fees wholly or partially contingent upon the outcome of the matter in which medical testimony is offered.

## V. Recommendation #3: Revitalize Protected Early Disclosure and Resolution Options

### a. The Benefits of Early Full Disclosure and Resolution

An important factor in a patient's decision to pursue a medical malpractice claim against a physician is the patient's experience of his or her relationship with the doctor. For example, researchers in the early 1990s interviewed and reviewed questionnaires completed by 127 families of infants who had experienced permanent injuries or deaths and had closed malpractice claims during a three year period.<sup>31</sup> They found that a significant portion (24%) of the patients identified as a significant factor in their decision to pursue a claim their perception that the physician had failed to be completely honest with them about what happened, allowed them to believe things that were not true, or intentionally misled them.<sup>32</sup> Twenty percent indicated that they did so in part because they thought the courtroom was the only forum in which they could find out what happened from the physicians who provided care.<sup>33</sup> "Of all families interviewed, 32% believed that their physicians would not talk or answer questions, 13% that their physicians would not listen, 48% that their physicians had misled them, and 70% that no one involved in providing medical care during the perinatal period ever told them that their infants might have permanent medical problems or die."<sup>34</sup>

This study is not an outlier. Through a variety of methodologies, researchers have consistently found that effective communication with patients, including candid disclosure of medical errors, reduces the risk of litigation.<sup>35</sup> As one group of researchers noted, in reviewing the literature,

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<sup>31</sup> Gerald B. Hickson, Ellen Wright Clayton, Penny B. Githens, Frank A. Sloan, *Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, JAMA 267(10): 1359-1363 (1992).

<sup>32</sup> *Id.* at 1361.

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

<sup>35</sup> See, for example, Kathleen M. Mazor, George W. Reed, Robert A Yood, Melissa A Fischer, Joann Baril, and Jerry H. Gurwitz, *Disclosure of Medical Errors – What Factors Influence How Patients Respond?*, J. Gen. Intern. Med 21:704-710 (2006) (relying on simulated scenarios to test simulated patients' responses to different approaches to disclosure, and concluding that disclosure of medical error does not increase the likelihood, and in some cases decreases the likelihood, that a patient will seek legal counsel following an adverse event); Wendy Levinson, Debra

“When faced with a bad outcome, patients and families are more likely to sue a physician if they feel the physician was not caring and compassionate.”<sup>36</sup> The specific information patients consistently say they want to know in the context of medical errors is 1) what happened, 2) the implications of the error for their health, 3) why it happened, 4) how the problem will be corrected, and 5) how future errors will be prevented.<sup>37</sup> For many patients, an apology, rather than a mere expression of regret, is important.<sup>38</sup>

The data on this subject is not just based on subjective self-report and focus-group responses to hypotheticals; we can evaluate the real-life experience of programs that have implemented aggressive early disclosure and apology (and resolution) programs. In 2001, the University of Michigan Health System launched “a comprehensive claims management model with disclosure as its centerpiece.”<sup>39</sup> Pursuant to that model, UMHS’ approach is “Apologize and learn when we’re wrong, explain and vigorously defend when we’re right, and view court as a last resort.”<sup>40</sup> In particular, UMHS says that when a patient complains, or a staff person realizes that a “mishap or near miss has occurred,” it takes the following steps:

1. We follow our institutional policy of communicating openly and directly with the patient or his/her medical representative in the aftermath of the situation or complaint.
2. We review the incident or complaint thoroughly and impartially, to assess what happened. This includes a peer review involving professionals in relevant fields. We also note any opportunities for improvement that might prevent similar situations in the future.
3. If the patient has engaged legal counsel, we offer to meet with both of them to review the care and answer their questions, whether or not they have sent us a notice of intent to sue.
4. If we have concluded that our care was unreasonable, we say so – and we apologize. If our care caused an injury, we work with the patient and his/her counsel to reach mutual

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L. Roter, John P. Mullooly, Valerie T. Dull, and Richard M. Frankel, *Physician-Patient Communication – The Relationship With Malpractice Claims Among Primary Care Physicians and Surgeons*, *Journal of the American Medical Association* 277:553-559 (1997) (identifying through observation distinctions in patient-communication behaviors between primary care physicians who had malpractice claims and those who did not).

<sup>36</sup> Levinson et al, above, *JAMA* 277:553. See also Hillary Rodham Clinton and Barack Obama, *Making Patient Safety the Centerpiece of Medical Liability Reform*, *New England Journal of Medicine* 354:2205-2208 (2006).

<sup>37</sup> Thomas H. Gallagher, MD, Amy D. Waterman, PhD, Alison G. Ebers, Victoria J. Fraser, M.D., Wendy Levinson, M.D., *Patients’ and Physicians’ Attitudes Regarding the Disclosure of Medical Errors*, *Journal of the American Medical Association (JAMA)* 289(8): 1001, 1004 (2003).

<sup>38</sup> See Carol B. Liebman and Chris Stern Hyman, *A Mediation Skills Model to Manage Disclosure of Errors and Adverse Events To Patients*, *Health Affairs* 23(4):22-32 (2004). In fact, the *character* of the apology—“I’m sorry this happened to you” versus “I’m sorry we did this to you”) can make a difference. Id. at 27-28.

<sup>39</sup> Allen Kachalia, MD, JD, Samuel R. Kaufman, MA, Richard Boothman, JD, Susan Anderson, MBA, MSN, Kathleen Welch, MS, MPH, Sanjay Saint, MD, MPH, and Mary A.M. Rogers, PhD, *Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program*, *Ann Intern Med.* 2010;153:213-221. See also Richard C. Boothman, Amy C. Blackwell, Darrell A. Campbell, Jr., Elaine Commiskey, and Susan Anderson, *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, *J. Health & Life Sci. L.*, January 2009, at 125.

<sup>40</sup> University of Michigan Health System Newsroom, *Medical Malpractice and Patient Safety at UMHS*, [www.med.umich.edu/news/newsroom/mm.htm](http://www.med.umich.edu/news/newsroom/mm.htm) (11/9/11).

agreement about a resolution. This doesn't always mean a settlement, but if it does, we compensate quickly and fairly.

5. If our investigation convinces us that the care was medically appropriate, we still offer to meet with the patient and his/her counsel to discuss our findings. Often, a medical staff member involved in the patient's care will participate in this discussion. Many patients are satisfied with full explanations, and may even drop their complaint or suit. One important thing we have learned is that patients want an explanation of their care, and when they don't get it, they frequently feel they were not treated appropriately.
6. If a patient persists in a suit over care that we think was medically appropriate, or declines to participate in a dialogue with us, we will vigorously defend our staff with the finest legal team we can assemble.
7. No matter what happens: We will seek to learn from the experience, educate our staff, and make changes to the systems and processes that were involved in the care that prompted the complaint. Even if our analysis convinces us that we provided medically appropriate care, the patient's complaint teaches us that something has clouded his or her perception of our care. If we can do something to keep that from happening with another patient, we will.<sup>41</sup>

UMHS has integrated its disclosure program into its peer review, quality improvement, and patient safety efforts.<sup>42</sup> The results of UMHS' groundbreaking shift in approach have been noteworthy:

- The monthly rate of lawsuits against UMHS dropped from 2.13 per 100,000 patient encounters before the program was implemented to .75 per 100,000 patient encounters after the program was implemented—or from 38.7 lawsuits per year to 17 lawsuits per year after program implementation.<sup>43</sup>
- The time from claim to ultimate resolution dropped from more than 20 months in 2001 to about 10 months a decade later.<sup>44</sup>
- The severity of UMHS's claims is rising far less rapidly than the national average. In particular, the severity of UMHS claims is rising by about 2.6 percent each year, in contrast to the predicted rise of more than 10% per year on a national basis.<sup>45</sup>
- UMHS' total liability costs have dropped dramatically. The average monthly liability cost after implementation was 41% of the average monthly liability cost before implementation. (The mean monthly liability costs per \$1,000 operating revenue

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<sup>41</sup> Id.

<sup>42</sup> Kachalia et al, *Liability Claims and Costs*, above, at 214.

<sup>43</sup> Kachalia et al, *Liability Claims and Costs*, above, at 215-217.

<sup>44</sup> University of Michigan Health System Newsroom, *Medical Malpractice and Patient Safety at UMHS*; see also Kachalia et al, *Liability Claims and Costs*, above, at 217 (median time to claim resolution dropped from 1.36 years to .95 year after resolution).

<sup>45</sup> University of Michigan Health System Newsroom, *Medical Malpractice and Patient Safety at UMHS*.

dropped from 18.91 before implementation to 7.78 after implementation.) This drop represents substantial drops in *both* patient compensation *and* legal costs.<sup>46</sup>

- The number of reported incidents has increased tremendously, allowing for more effective safety improvements and delivery of safe and high quality care.<sup>47</sup>
- In contrast to state and national trends, UMHS' malpractice premiums (the system is self-insured) have remained practically level, despite increases in its clinical business.<sup>48</sup>

This data is not without its limitations. During the relevant period, the number of reported malpractice claims declined in Michigan more generally, suggesting that the entirety of the savings noted above cannot be attributed to the early disclosure and settlement program. However, the UMHS data compares favorably to the Michigan-wide data during that period.<sup>49</sup> And UMHS itself has become a wholehearted proponent of its approach.<sup>50</sup>

The other early disclosure and resolution program that has attracted some national attention is that of the Department of Veterans Affairs. In the late 1980s, in the wake of two substantial malpractice judgments, the Veterans Affairs Medical Center in Lexington, Kentucky, adopted a proactive policy of identifying and investigating apparent accidents and incidents of medical negligence, and notifying the patient of the committee's findings. Even though this policy led to significant settlements in some cases that never would have come to light in the absence of the facility's own investigation, overall the financial implications of the policy of full disclosure were "moderate."<sup>51</sup> In 1995, the Department of Veterans Affairs as a whole rewrote its policy manual to require medical centers to make broad and early disclosure of patient injury caused by accidents or negligence.

A final program, discussed more fully below, couples early disclosure and settlement with mandatory pre-suit mediation. That program in Florida has yielded savings similar to Michigan.<sup>52</sup>

Although these programs are relatively new, and we can't necessarily extrapolate from a handful of programs to the entire country with certainty, they are promising. They offer the hope of a

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<sup>46</sup> Kachalia et al, *Liability Claims and Costs, above*, at 217. See also University of Michigan Health System Newsroom, *Medical Malpractice and Patient Safety at UMHS* (average legal expense per case down by more than 50% since 1997).

<sup>47</sup> Kachalia et al, *Claims and Costs, above*, at 220.

<sup>48</sup> See also University of Michigan Health System Newsroom, *Medical Malpractice and Patient Safety at UMHS*.

<sup>49</sup> Kachalia et al, *Liability Claims and Costs, above*, at 220.

<sup>50</sup> See, for example, University of Michigan Health System Newsroom, *Medical Malpractice and Patient Safety at UMHS, above*.

<sup>51</sup> Steve S. Kraman, MD, and Ginny Hamm, JD, *Risk Management: Extreme Honesty May Be the Best Policy*, Ann Intern Med. 1999;131:963-967 at 964. Data on the financial ramifications of this policy are less thorough than the data from the UMHS experience, but from 1990-1996, the Lexington facility fell in the lowest quartile of malpractice payments relative to similar Veteran's facilities.

<sup>52</sup> Randall C. Jenkins, JD, Linday A. Wraen, JD, and Nicolaus Gravenstein, MD, *Mandatory pre-suit mediation: Local malpractice reform benefiting patients and healthcare providers*, American Society for Healthcare Risk Management 30(2):27-32 (2010).

reform that reduces the costs associated with our malpractice system without limiting patients' legal remedies. Moreover, full disclosure programs can promote patient safety by providing a mechanism for reporting and amalgamating information about medical errors. Scholars who studied various types of full disclosure models noted that "[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."<sup>53</sup>

Early disclosure and apology practices offer real benefits for physicians as well. No doctor wants to make a medical error. The anxiety engendered by the ever-present possibility of making an error and unintentionally harming a patient, as well as the wrenching emotions doctors feel when they make medical errors, is substantial.<sup>54</sup> Most physicians want to apologize, but worry that an expression of regret might be construed as an admission of legal liability.<sup>55</sup> As one doctor explained,

You would love to be just straightforward. "Gosh, I wish I had checked that potassium yesterday. I was busy, I made a mistake, I should have checked that. I can't believe I wouldn't do that. I will learn from my mistake and I will do better next time, because this is how we learn as people." But if you say that to a patient, which you would like to be able to say, honestly, as just another human being, is that we have this whole thing, the wait to cash in [through a lawsuit].<sup>56</sup>

In short, early disclosure, apology and resolution programs have the potential to a) reduce the costs of malpractice claims; b) increase patient satisfaction; c) improve patient safety by generating data about medical errors; and d) improve quality of life for physicians.

#### b. Obstacles to Full Disclosure

The move toward more proactive and thorough disclosure in connection with medical errors has taken hold throughout the United States and abroad.<sup>57</sup> As one group of commentators explained:

A transformation in how the medical profession communicates with patients about harmful medical errors has begun. Within a decade, full and frank disclosure of these events to patients is likely to be the norm rather than the exception.<sup>58</sup>

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<sup>53</sup> Michelle M. Mello, JD, PhD and Thomas H. Gallagher, MD, *Malpractice Reform- Opportunities for Leadership by Health Care Institutions and Liability Insurers*, New England Journal of Medicine 2010; 362:1353-1356.

<sup>54</sup> Gallagher et al, *Disclosure of Medical Errors*, JAMA 289:1005.

<sup>55</sup> *Id.*, Gallagher et al, *Disclosure of Medical Errors*, JAMA 289:1005.

<sup>56</sup> *Id.* See also, Albert W. Wu, MD, MPH, Thomas A. Cavanaugh, PhD, Stephen J. McPhee, MD, Bernard Lo, MD, Guy P. Micco, MD, *To Tell the Truth, Ethical and Practical Issues in Disclosing Medical Mistakes to Patients*, Journal of General Internal Medicine, 12:770-775 (1997) (cataloging potential benefits and downsides to physicians of broad disclosure of medical error, and citing studies).

<sup>57</sup> Thomas H. Gallagher, MD, David Studdert, LLB, ScD, MPH, and Wendy Levinson, MD, *Disclosing Harmful Medical Errors to Patients*, New England Journal of Medicine 356:2713-2719 (2007) (documenting the trend toward more complete institutional disclosures policies in the United States, as well as Australia's and the United Kingdom's ambitious efforts to expand disclosure).

In general, institutions that implement voluntary programs, rather than legal reform are driving this transformation.<sup>59</sup> That's a good thing insofar as voluntary institutional reform optimizes buy-in from clinical and risk-management staff and does not impair the legal remedies of patients; instead, institutions can tailor their approaches to their own circumstances.<sup>60</sup>

Although voluntary adoption and implementation of full disclosure programs does not require state action, the state *can* optimize the climate for these programs to thrive. Despite the counterintuitive evidence that full disclosure can *reduce* malpractice exposure, the fear of litigation still leads many physicians to choose their words very carefully when talking with patients about error, and can lead to less-than-full disclosure, especially when patients don't proactively ask.<sup>61</sup> The challenge is to figure out how to structure the legal environment so that patients' legal remedies are not limited, but providers are incentivized to pursue full disclosure (and early settlement) practices.

In addition, medical practices that are insured through the commercial market, rather than self-insured, may face impediments in adopting a full-blown early disclosure, apology and settlement program because their insurers may not concur in settlement decisions.

### c. Vermont Law on Disclosure and Reporting

Although physicians in Vermont, like physicians everywhere, have an ethical obligation of disclosure,<sup>62</sup> Vermont does not statutorily mandate that doctors disclose medical errors to patients.<sup>63</sup> The hospital report card on the Department of Banking, Insurance, Securities, and Health Care Administration's website provides information to the general public on infection rates, outcomes for certain health conditions, volume and mortality rates for certain surgeries, nurse staffing, and patient satisfaction. In addition the board of medical practice places disciplinary actions and licensee profiles online.<sup>64</sup> Physician profiles include information on

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<sup>58</sup> *Id.* These considerations led then-Senators Hillary Rodham Clinton and Barack Obama to propose a national Medical Error Disclosure and Compensation bill to promote early confidential disclosure to patients of medical errors along with offers to resolve claims. See Clinton and Obama, above, N. Engl. J. Med 354:2205-2208.

<sup>59</sup> Michelle M. Mello, JD, PhD and Thomas H. Gallagher, MD, *Malpractice Reform—Opportunities for Leadership by Health Care Institutions and Liability Insurers*, New England Journal of Medicine 2010; 362:1353-1356.

<sup>60</sup> *Id.*

<sup>61</sup> Gallagher et al, *Disclosure of Medical Errors*, JAMA 289: 1004-1005

<sup>62</sup> AMA Code of Medical Ethics 8.121 (d)(3)(2003) (“When patient harm has been caused by an error, physicians should offer a general explanation regarding the nature of the error and the measures being taken to prevent similar occurrences in the future.”); American College of Physicians Ethics Manual, 5<sup>th</sup> edition (2005) (“[P]hysicians should disclose to patients information about procedural or judgment errors made in the course of care if such information is material to the patient’s well-being.”)

<sup>63</sup> Several states do. See, for example, 29 Fla. Stat. § 395.1051 (requiring health care facilities to inform patients about adverse incidents that result in serious harm to the patient, and providing that such notification does not constitute an acknowledgment or admission of liability and cannot be introduced as evidence); 40 Pa. Stat. § 1303.308 (“A medical facility . . . shall provide written notification to a patient affected by a serious event . . . within seven days of the occurrence or discovery of a serious event.”). Nev. Rev. State. § 439.855 (same).

<sup>64</sup> [http://www.healthvermont.gov/hc/med\\_board/bmp.aspx](http://www.healthvermont.gov/hc/med_board/bmp.aspx) on the menu to the right, click on board actions and physician profiles

malpractice court judgments, arbitration awards, or settlements for the past 10 years. Physicians must report judgments, awards, and settlements on their initial licensing and renewal applications.

The patient safety surveillance and improvement system, 18 V.S.A. chapter 43a, establishes a system for regulating hospitals “for the purpose of improving patient safety, eliminating adverse events in Vermont hospitals, and supporting and facilitating quality improvement efforts by hospitals.” 18 V.S.A. 1913(a). The Department is required to:

- (1) collect data concerning the occurrence of reportable adverse events;
- (2) aggregate and analyze data for the purpose of developing and implementing strategies to target and eliminate specific adverse events;
- (3) verify that hospitals are in compliance with all the requirements of this chapter and regulations adopted hereunder;
- (4) for reportable adverse events, verify that hospitals are conducting causal analyses and developing corrective action plans consistent with standards set by the department, current patient safety science, and relevant clinical standards;
- (5) provide technical assistance or assist hospitals in locating technical assistance resources for analyzing adverse events and near misses and developing and implementing corrective action plans; and
- (6) encourage hospitals to utilize anonymous in-hospital reporting when possible.

The statute provides that the information regarding adverse events reported to the Department of Health remain confidential and privileged and exempt from the public records act. The purpose behind this provision was to ensure that hospitals conduct causal analyses and develop corrective action plans whenever a reportable adverse event occurs in the facility. The information provided to the Department may include information protected by the patient privilege and also confidential peer review materials. 18 V.S.A. §§ 1915(4) and (5). In addition, the information provided to the Department may not be disclosed under the federal Health Insurance Portability and Accountability Act (HIPAA) if there are so few events reported that the information could readily be tracked back to an individual patient. This is a common problem in small populations where the incidence of a particular event is small.

The Department of Health has actively been reviewing whether the data it has obtained for adverse events has reached numbers that would allow the department to report the data without violating the statute or HIPAA. To ensure that aggregated data could be reported, a statutory change could be made specifying that this type of data is reportable. This is included as a recommendation in Appendix A.

In addition, Vermont law does provide a safe harbor for expressions of regret, apologies, and explanations of how medical errors occurred so that such communications, if made within 30 days of when the provider or facility knew or should have known of the consequences of the error, cannot be used in deposition, trial, or other legal proceedings relating to the medical error. This protection should create a mechanism to encourage and facilitate early disclosure, apology (where appropriate) and resolution.

The Vermont Medical Malpractice Study Committee considered early disclosure and apology programs in its 2005 study, and passed a motion strongly urging the Legislature to continue to explore the issue of safe apologies, including excluding physician apologies from evidence (a measure adopted by the Legislature) and exploring the concept of a voluntary pilot program based on the concepts of apology and disclosure.<sup>65</sup> In 2006, the Legislature created a pilot program to encourage broader adoption of early disclosure, apology, and settlement practices by hospitals. The Sorry Works! Pilot program established a framework for early disclosure and settlement by participating hospitals, provided for tolling of the applicable statute of limitations pending negotiations, and provided that BISHCA would use all methods at its disposal to gain the participation of insurers to enable hospitals to participate in the program. The program also included data-gathering so that policymakers in Vermont could assess the effectiveness of the program. The pilot program sunsetted on June 30, 2009, without any actual participation.

Although no hospitals formally participated, anecdotally we understand that more hospitals are, in selected cases, engaging in early and frank discussions and case resolutions. But we have no data on this, and cannot quantify the shift.

A recommendation to reenact the SorryWorks! Program is incorporated into the draft legislation attached as Appendix A. In addition, the merits of the program should be discussed and promoted to hospitals and physicians in order to generate interest.

#### VI. **Recommendation #4: Confidential Pre-Suit Mediation**

On the basis of the rationales underlying the University of Michigan's aggressive early disclosure and settlement program, the University of Florida Health Science Center went a step further, implementing a mandatory confidential pre-suit mediation program known as the Florida Patient Safety and Pre-Suit Mediation Program ("FLPSMP").<sup>66</sup> Mediation is "[a] method of nonbinding dispute resolution involving a neutral third party who tries to help the disputing parties reach a mutually agreeable solution."<sup>67</sup> Mediation can provide an opportunity for the disclosures, explanations, and apologies (when appropriate) that have proven so successful in the University of Michigan program. It also provides a mechanism to facilitate resolution of a case, where direct

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<sup>65</sup> VMMSC, above, at 83-87.

<sup>66</sup> Jenkins et al, above, *Mandatory pre-suit mediation*, American Society for Healthcare Risk Management 30(2):27-32.

<sup>67</sup> *Id.* at 28 (citing Black's Law Dictionary).

negotiations may or may not accomplish that goal. When the parties are unable to reach a mediated result, the patient is free to file a lawsuit and to pursue his or her traditional legal remedies.

In the FLPSMP program, as part of the informed consent process, patients were asked to sign a form that included a specific agreement to participate in non-binding, confidential pre-suit mediation prior to filing a claim against a provider/facility. The program has been in effect since January 1, 2008. In the first two years of the program, the University of Florida realized the following benefits:

- **Dramatic reduction in timeline to resolution of claims.** Prior to the FLPSMP, the average time from claim to resolution was 33.8 months. Pursuant to the FLPSMP, claims were resolved, on average, in 6.2 months.<sup>68</sup> In addition to benefiting all parties, this accelerated timetable allows “the system” to identify and assimilate the lessons from a particular incident more quickly.<sup>69</sup>
- **Dramatic reduction in litigation costs.** Prior to the FLPSMP, the cost per healthcare provider for litigation costs (lawyers, experts, courts) was \$63,128. After implementation of the FLPSMP, the allocated per provider cost was \$6,446—about 10% of the pre-program costs. The average litigation costs *per claim* pursuant to the FLPSMP was less than one-third of the litigation costs per claim prior to the program.<sup>70</sup>
- **Fair compensation for meritorious claims.** The cost-savings within the FLPSMP do not come at the expense of patients with meritorious claims. The average compensation to patients to resolve claims was actually slightly higher under the FLPSMP than prior to the program, and the *net* to patients was substantially higher due to the substantial reduction in the patients’ attorneys fees and litigation costs.<sup>71</sup>
- **Dramatic reduction in system malpractice-related costs.** Prior to the FLPSMP, the average malpractice-related cost per bed (for legal expenses plus compensation paid to patients) was \$3,459. In 2008 and 2009, the average mediated expense per bed was \$1,287—*less than 40% of the pre-program costs.*<sup>72</sup>

Like the University of Michigan program, mandatory, confidential, non-binding pre-suit mediation offers the possibility of a win-win-win. Providers and patients win because meritorious claims can be identified and resolved before reaching litigation. Everyone benefits from dramatic reductions in systemic malpractice-related costs. And nobody is required to forfeit legal rights or remedies. Instead, the savings to the system and the benefits to the participants derive from the administrative costs excised from the process— attorney fees, expert costs, court costs, etc. This kind of reform—offering a realistic and very substantial reduction in

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<sup>68</sup> *Id.* at 29.

<sup>69</sup> *Id.* at 29.

<sup>70</sup> *Id.* at 29-30.

<sup>71</sup> *Id.* at 30-32.

<sup>72</sup> *Id.* at 32.

malpractice liability-related costs *without* compromising anyone’s legal rights and remedies (the patient’s right to seek redress in court, and the provider’s right to deny and defend a claim) dovetails comfortably with the overall spirit of Vermont’s health care reform—designed to deliver better care while controlling costs.

Some might argue that Vermont law *already* provides for mandatory mediation in the litigation process, so a mandatory, confidential pre-suit mediation requirement is unnecessary. Prior to the FLPSMP, Florida law likewise provided for mediations—typically undertaken shortly before trial, after extensive discovery and substantial administrative costs. The advantage to *pre-suit* mediation is that it provides a mechanism for resolving claims *before suit is filed*—before the administrative costs drive up the costs of managing the claim—in some cases to a level that could make settlement much more difficult, before parties have hunkered down and positions have hardened, at a time when candid explanation and apology, if appropriate, are most likely to effectively reduce the drive to litigation, and before the physician has actually been sued. For these reasons, mandatory, confidential pre-suit mediation would advance our collective goals more effectively than that mediation during litigation.

Unfortunately, as noted earlier in this report, many types of medical malpractice reform have been subject to constitutional challenges. *See, e.g., Eaton v. Fleet*, No. 2008-cv-074, (NH Superior Court, Nov. 3, 2009), appeal pending at New Hampshire Supreme Court (finding medical malpractice arbitration screening panel program unconstitutional on separation-of-powers grounds); *Waples v. Yi*, 234 P.3d 187 (Wash. 2010) (striking medical malpractice pre-suit notice requirement as unconstitutional on separation-of-powers grounds); *Irish v. Gimbel*, 691 A.2d 664 (Me. 1997) (upholding medical malpractice arbitration screening panel program as constitutional); *Hoem v. State*, 756 P.2d 780 (Wyo. 1988) (striking medical malpractice arbitration screening program on equal protection grounds due to lack of sufficient evidence of state medical malpractice problem). In addition, the constitutional issues were not applicable to the University of Michigan and the University of Florida programs, because it was not the state requiring participation in pre-suit mediation. Because of the potential constitutional issues related to mandating mediation prior to filing, the mediation program should be voluntary.

A voluntary program could be helpful, however. We hear anecdotally that providers are increasingly engaging in pre-suit mediation in Vermont. But pre-suit mediation, and the early disclosure and open communication implicit therein, does represent a culture shift. Both the University of Michigan and the University of Florida saw 60% drops in their malpractice-related expenses after they adopted their respective programs. Even if Vermont only realized *half* that amount in malpractice-related savings, that would represent a 30% drop in Vermont’s malpractice-liability related costs.

For these reasons, the administration recommends a program of voluntary pre-suit mediation. 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. As a practical matter, both parties will find that it is to their advantage to cooperate in broader pre-suit exchange of information in order to maximize the chances of a successful mediation program.

A recommendation for a voluntary, pre-suit mediation program is incorporated into the draft legislation attached as Appendix A.

## **VII. Consideration of a No-Fault System**

### **a. Background**

Some advocates have urged a complete restructuring of the medical liability system away from the negligence-based approach described in section I.c., above, and toward a “no-fault” system. The Vermont Medical Malpractice Study Committee spent time on this issue in 2005, and the committee’s report includes three pages of discussion of the subject. The committee voted 6-1 against the concept of a fixed compensation system for medical malpractice cases, with the Vermont Medical Society representative providing the sole vote in favor of such an approach. The administration has reviewed and considered the committee’s report in connection with its own analysis. The relevant section of the VMMSC is appended as Appendix B.

### **b. What is a “no-fault” system?**

The concept of a “no-fault” system in connection with medical liability is that patients who suffer injuries as a result of medical treatment are eligible for compensation regardless of whether the medical provider was negligent. As long as the patient can establish that the injury was caused by medical treatment, he or she is eligible to recover for that injury. However, any given patient’s right to recover is limited in some way. In other words, in theory, in a no-fault system, more patients would be expected to recover for injuries sustained during medical treatment but the maximum recovery, even for those injured as a result of medical error, would be severely limited relative to a traditional tort-system, negligence-based recovery.

### **c. Experiences From Other Jurisdictions**

Proponents point to New Zealand’s system as a potential prototype for an American state-based no-fault system.<sup>73</sup> New Zealand’s system is not narrowly tailored to the specifics of medical malpractice; rather, New Zealand has adopted a broad government-funded system for

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<sup>73</sup> See, for example, Willilam C. Hsiao, PhD, FSA, Steven Kappel, MPA, and Jonathan Gruber, PhD, *Act 128 Health System Reform Design* at 60-62 (February 17, 2011) (pointing to the New Zealand system as a model).

compensating people with personal injuries, including medical treatment injuries.<sup>74</sup> This system is managed by a central agency, the Accident Compensation Corporation (“ACC”), and claims are handled administratively, rather than through courts.<sup>75</sup> The ACC is financed through general taxes and an employer levy.<sup>76</sup>

About 40% of claims are accepted by the ACC, although dissatisfied claimants can request review of the decision and ultimately a court appeal.<sup>77</sup> Benefits to successful claimants are fixed and limited, and consist of the following:

1. *Treatment and rehabilitation* includes the cost of pharmaceuticals, disability aids, child care, home modifications, and vocational retraining. Most treatment costs are already covered by New Zealand’s universal health care system.
2. *Compensation for loss of earnings* includes weekly compensation of 80 percent of the claimant’s earnings at the time of injury, up to a set maximum. . . .
3. *Lump-sum compensation* – a one-time payment of up to US \$70,000 to compensate for permanent impairment resulting from an injury—is paid in addition to any other ACC entitlements.
4. *Support for dependents* takes the form of a funeral grant and a survivor’s grant paid to the surviving spouses and children under age eighteen.

The New Zealand system has been in place for decades, although it has undergone some tweaks in recent years with respect to medical treatment injuries. It appears to be generally well accepted in New Zealand.

#### d. Pros and Cons

##### i. Physician Quality-Of-Life

One potential advantage of a no-fault system is that it may mitigate the dread of malpractice claims that many physicians experience within our current system, as well as the increased stigma many physicians associate with malpractice claims. In a system in which *causation* but not *fault* is the central issue in legal adjudication following injuries sustained in medical treatment, physicians may experience greater job satisfaction and quality of life.<sup>78</sup> On the other hand, depending on the design of a no-fault system, there could be increased processing of claims that otherwise would not have entered into the medical malpractice system.

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<sup>74</sup> Marie Bismark and Ron Paterson, *No-Fault Compensation in New Zealand: Harmonizing Injury Compensation, Provider Accountability, and Patient Safety*, Health Affairs 25(1):278-283 ( January/February 2006).

<sup>75</sup> *Id.* at 278-80.

<sup>76</sup> *Id.* at 280.

<sup>77</sup> *Id.*

<sup>78</sup> See Thomas May and Mark P. Aulisio, *Medical Malpractice, Mistake Prevention, and Compensation*, Kennedy Institute of Ethics Journal Vol. 11, No. 2, 135-146 (2001) (describing the climate of fear among physicians engendered by the malpractice system and advocating adoption of a no-fault style system that would remove “the stigma of implied ‘failure to care’ that lies at the foundation of the current malpractice system.”)

## ii. Breadth of Coverage for Injuries From Medical Treatment

A second advantage of a no-fault system is that it could provide broader claims coverage than the traditional tort system.<sup>79</sup> In our current tort system, only claimants who can establish that their injuries resulted from medical negligence can recover. In addition, even patients who can demonstrate medical negligence often cannot practically pursue a claim because the costs of litigation outweigh the potential damages. A no-fault system could create a mechanism whereby these classes of injured patients who cannot recover anything in our current system could recover.

Although the structure of a no-fault system would seem to allow for a higher number of successful claims, in the context of medical treatment injuries the impact of eliminating the requirement that a claimant prove medical negligence is tempered by the remaining requirement that the claimant prove *causation*. The central issue in many traditional medical malpractice cases is, in fact, causation rather than negligence: Was the harm suffered by the plaintiff the result of the defendant's negligence, or would the plaintiff have suffered that harm even if the defendant provider had adhered to the standard of care? This may explain why, even under its no-fault system, the ACC in New Zealand has historically only accepted around 40% of claims.<sup>80</sup>

## iii. Administrative Efficiency

The New Zealand model is viewed as more efficient than a traditional tort litigation model in terms of the speed and ease of the process.<sup>81</sup> Moreover, the administrative costs of New Zealand's system, accounting for 10% of the overall expenditures of the ACC, are substantially lower than the administrative costs of our tort system.<sup>82</sup>

We would likely see some administrative savings relative to our traditional litigation model with a no-fault system. However, we should not exaggerate the savings. The closest analog we have in Vermont is the workers' compensation administrative claims process. That process—which provides for limited benefits to injured workers on a no-fault basis in lieu of traditional tort liability—can be relatively efficient in some cases. However, insofar as causation remains an issue in workers' compensation cases—as it would in a no-fault medical liability system—many cases still require litigation, and the process can still stretch over months or years.

Moreover, for our purposes the most relevant comparison is not between the traditional tort system and the New Zealand administrative process, but is between a no-fault administrative

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<sup>79</sup> Bismark and Paterson, *No Fault Compensation in New Zealand* at 281.

<sup>80</sup> Bismark and Paterson, *No Fault Compensation in New Zealand* at 280.

<sup>81</sup> Bismark and Paterson, *No Fault Compensation in New Zealand* at 280 (“The ACC system is one of the simplest in the world for patients to navigate.”)

<sup>82</sup> Bismark and Paterson, *No Fault Compensation in New Zealand* at 281 (comparing 10% administrative costs in New Zealand to 50-60% administrative costs among malpractice systems in other countries).

process and a program of early disclosure, apology (when appropriate), and settlement as outlined above.

#### iv. Fair Compensation

The greatest challenge in a no-fault system would be to provide fair compensation to patients injured as a result of medical error. Because a no-fault system potentially provides benefits to a much broader class of patients, it must necessarily limit the available benefits in order to be sustainable. The New Zealand model provides an example. In New Zealand, an injured patient who can show that the injury resulted from medical treatment can claim weekly compensation of 80% of the patient's lost earnings up to a set maximum. Under our tort system, a patient injured as a result of medical negligence is entitled to damages accounting for the entirety of his or reasonable lost earnings (subject to an obligation to try to replace those earnings). The difference between 80% of a person's lost earnings—subject to a cap, and 100% of the lost earnings he or she can prove through competent evidence is not insubstantial, and the elimination of a full lost earnings remedy for medical malpractice claimant's would raise serious moral, policy and even constitutional issues.<sup>83</sup>

Likewise, the restriction of non-economic damages to scheduled injuries subject to a \$70,000 limit could lead to manifest injustice. If a health care provider negligently amputated the wrong leg, we would certainly expect a jury within our current system to award the injured patient more than \$70,000. And if a health care provider negligently prescribed a medication to which a patient had a known serious allergy, resulting in the patient being bedridden and experiencing severe nausea for months or years, the patient's expectation of some compensation for the loss of the ability to fully engage in and enjoy life for those months or years would not be unreasonable.

Vermont would not necessarily be constrained to follow New Zealand's lead in establishing the level of benefits available to a claimant who could demonstrate medical treatment injury, but the more the fixed benefits approach the potential tort-system damages available to the claimant, the less likely the system to be financially sustainable.

#### v. Total Cost

The cost savings or increase incident to a no-fault system would depend entirely on the level of benefits. The lower the benefits, the greater the potential for cost savings. For that reason, the better a prospective no-fault system scores on the "fair compensation" measure, the worse it will score on a "cost" assessment.

Moreover, it's difficult to meaningfully compare the total costs of medical liability in the New Zealand system with the costs here because New Zealand has a universal health care system. There simply is no New Zealand analog to the "medical expenses" element of damages in our

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<sup>83</sup> See, for example, Amy Widman, *Why Health Courts Are Unconstitutional*, 27 Pace Law Review 55 (2006).

tort system. Accordingly, any comparisons of malpractice-liability costs per claim, or per provider, or per patient here versus New Zealand are necessarily apples-to-oranges comparisons.

Finally, we know from the data above that early disclosure and settlement models offer demonstrated cost savings *without* compromising the goal of fair compensation to patients. In the no-fault context, by contrast, the goals of cost-reduction and fair compensation are at odds with one another.

#### vi. Patient Safety

Advocates on both sides invoke patient safety as a factor supporting their respective views. Proponents of no-fault systems argue that no-fault systems encourage more timely and comprehensive identification and reporting of medical errors by providers, thereby allowing for more effective systemic reform.<sup>84</sup> Opponents of no-fault systems argue that removing the threat of fault-based litigation reduces hospitals' incentives to develop safer systems.<sup>85</sup> The limited data suggest that neither is right (or wrong). As two New Zealand commentators noted:

After thirty years of the ACC and nine years of independent complaint resolution, New Zealand hospitals appear no safer (or more dangerous) than those in other Western countries. The adverse-event rate of 12.9 percent stands midway between the levels recorded in two countries with shared medical traditions in training and practice: Australia (16.6 percent) and the United Kingdom (10.8 percent).<sup>86</sup>

A six-country survey of patients' experiences found that patient-reported (perceived) medical and medication errors in New Zealand were squarely in the same range as the United States, Australia, Canada, Germany, and United Kingdom.<sup>87</sup> New Zealand doctors were somewhat more likely than those in the other countries to tell patients about the medication or medical error—but even in New Zealand 60% of patients reported that they were *not* told by doctors involved in their care about the mistake.<sup>88</sup>

We cannot conclude that the goal of patient safety clearly favors either a traditional tort model or a no-fault model.

#### vii. Other Considerations

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<sup>84</sup> See, for example, May and Aulisio, *Medical Malpractice, Mistake Prevention, and Compensation*, Kennedy Institute of Ethics Journal, above, (arguing that a no-fault system would encourage more thorough reporting of medical errors).

<sup>85</sup> See, for example, George J. Annas, JD, MPH, *The Patient's Right to Safety—Improving the Quality of Care through Litigation against Hospitals*, N Engl J Med 354;19:2063-2066.

<sup>86</sup> Bismark and Paterson, *No Fault Compensation in New Zealand* at 282.

<sup>87</sup> Cathy Schoen, Robin Osborn, Phuong Trang Huynh, Michelle Doty, Kinga Zapert, Jordon Peugh, and Karen Davis, *Taking the Pulse of Health Care Systems: Experiences of Patients With Health Problems In Six Countries*, Health Affairs Web Exclusive (2005), Exhibit 3 and accompanying text.

<sup>88</sup> Id.

As noted above, New Zealand does not single out medical injuries for special administrative treatment relative to other kinds of personal injuries; New Zealand has abolished a traditional tort system in favor of a government-run administrative compensation system for *all* personal injuries. Viewed in that light, New Zealand’s medical malpractice liability system is unremarkable; it’s part and parcel of that country’s system for dealing with personal injuries *writ large*, just as our current medical malpractice system fits within our overall tort system. To separate out injuries due to medical negligence from injuries due to other kinds of negligence could create odd inequities in the context of our overall system. A passenger who loses a leg in a car accident due to another driver’s negligence would be entitled to substantially greater compensation than the same passenger who lost the same leg to an improper amputation in the hospital because the hospital negligently tracked the unconscious patient’s medical needs.

Moreover, because the New Zealand ACC processes all claims for personal injuries, the infrastructure for processing no-fault medical injury claims is already part and parcel of New Zealand government. Implementation of a no-fault system for medical injury claims would require creation of a new government agency to absorb the new duties associated with such a system.

Finally, the New Zealand system operates in the context of a different social safety net and different community values, limiting the ability to generalize the New Zealand experience.<sup>89</sup>

e. Conclusion

The administration has reviewed the concept of a no-fault system for medical liability. On balance, we conclude it is not the best direction for reform. A no-fault system could improve the quality of life for some doctors—a benefit that is not insubstantial, and could allow for compensation to a broader pool of injured patients than our existing system. However, on balance, we conclude that the disadvantages to a no-fault system outweigh these benefits. The disadvantages of unfair compensation to patients injured by medical negligence, increased systemic costs, or both, are quite substantial. Moreover, the New Zealand model (like the Swedish model and others identified by proponents of a no-fault system) exists in a very different legal, social, and economic milieu. The more limited social safety net in the United States as compared with some of these other countries exacerbates the potential inequity of adopting a New Zealand style system.

We conclude that the above proposals for early disclosure and settlement of claims offer even greater administrative and overall systemic savings, the possibility of improved quality-of-life for physicians, and the prospect of greater patient satisfaction *without* compromising the legal remedies available in our current system, and without creating a new government agency.

## **VIII. Summary and Recommended Legislation**

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<sup>89</sup> Bismark and Paterson, *No Fault Compensation in New Zealand* at 278.

In conclusion, the administration provides a four part recommendation for medical malpractice reform, which should alleviate concerns of health care providers, provides a balance approach to this issue, and would minimize potential litigation against the state.

## Appendix A.

Sec. 1. 12 V.S.A. § 1040 is added to read:

### §1040. Certificate of Merit

(a) No civil action shall be filed to recover damages resulting from personal injury or wrongful death occurring on or after July 1, 2012, in which it is alleged that such injury or death resulted from the negligence of a health care provider, unless the attorney or party filing the action files a certificate of merit simultaneous with the filing of the complaint. In the certificate of merit, the attorney or plaintiff shall certify that he or she has consulted with a health care provider qualified pursuant to the requirements of Vermont Rule of Evidence 702 and any other applicable standard, and that, based on the information reasonably available at the time the opinion is rendered, the health care provider has:

(1) Described the applicable standard of care;

(2) Indicated that based on reasonably available evidence, there is a reasonable likelihood that the plaintiff will be able to show that defendant failed to meet that standard of care; and

(3) Indicated that there is a reasonable likelihood that the plaintiff will be able to show that the defendant's failure to meet the standard of care caused plaintiff's injury.

(b) A plaintiff may satisfy this requirement through multiple consultations that collectively meet the requirements of subsection (a) of this section.

(c) A plaintiff must certify to having consulted with a health care provider as set forth in subsection (a) of this section with respect to each defendant identified in the complaint.

(d) Upon petition to the clerk of the court where the civil action will be filed, an automatic ninety-day extension of the statute of limitations shall be granted to allow the reasonable inquiry required by this section.

(e) The failure to file the certificate of merit as required by this section shall be grounds for dismissal of the action without prejudice, except in the rare instances in which a court determines that expert testimony is not required to establish a case for medical malpractice.

(f) The requirements set forth in this section shall not apply to claims where the sole allegation against the health care provider is failure to obtain informed consent.

## Sec. 2. SORRY WORKS! PILOT PROGRAM

(a) For purposes of this section:

(1) "Commissioner" means the commissioner of banking, insurance, securities, and health care administration.

(2) "Department" means the department of banking, insurance, securities, and health care administration.

(b) The Sorry Works! pilot program is established under the oversight of the commissioner. Any hospital that voluntarily chooses to participate shall be eligible for the program beginning on January 1, 2013. Hospitals may participate only with the approval of the hospital administration and the hospital's medical staff.

(c)(1) Under the program, participating hospitals and physicians shall promptly acknowledge and apologize for mistakes in patient care that result in harm and promptly offer fair settlements. If a settlement is accepted, further litigation with respect to the mistake shall be prohibited.

(2) Participating hospitals shall provide to the patient written notification of the patient's right to legal counsel. The notification shall include an affirmative declaration that no action was taken to dissuade a patient from using counsel for the negotiations.

(3) A communication between parties engaged in negotiation pursuant to this program is privileged and is not subject to discovery or admissible in evidence in any civil or administrative proceeding. Evidence or information

that is otherwise admissible or subject to discovery does not become inadmissible or protected from discovery solely by reason of its disclosure or use in negotiations pursuant to this program.

(4) Participation in Sorry Works! shall toll the applicable statute of limitations in cases where such negotiations are unsuccessful. The commissioner shall establish guidelines for determining when negotiations under the Sorry Works! program begin and end for purposes of tolling the statute of limitations.

(d) Participating hospitals shall report to the department their total costs for medical malpractice verdicts, settlements, and defense litigation for the preceding five years to enable the department to determine average costs for that hospital during that period. The department shall develop standards and protocols to compare costs for cases handled by traditional means and cases handled under the Sorry Works! program for purposes of reporting to the general assembly as to the financial impact of the program.

(e) The commissioner shall establish criteria for the program, including the criteria under which hospitals shall be selected to participate. A program participant may withdraw from the program by notifying the commissioner. Any mistakes in patient care that result in harm that occurred prior to the program participant notifying the commissioner shall continue to be subject to this section and the terms of the program.

(f) In consultation with hospitals, providers, and other interested parties, the department shall adopt rules to implement the pilot program no later than October 1, 2012.

(g) The department shall initiate a dialogue with insurers and encourage them to participate in the Sorry Works! pilot program with any hospital that is willing to commit to the program.

Sec. 3. 12 V.S.A. chapter 215, subchapter 2 is added to read:

#### Subchapter 2. MEDIATION PRIOR TO FILING A COMPLAINT OF MALPRACTICE

##### § 7011. PURPOSE

The purpose of mediation prior to filing a medical malpractice case is to identify and resolve meritorious claims and reduce areas of dispute prior to litigation, which will reduce the litigation costs, reduce the time necessary to resolve claims, provide fair compensation for meritorious claims, and reduce malpractice-related costs throughout the system.

##### § 7012. PRE-SUIT MEDIATION; SERVICE

(a) A potential plaintiff may serve upon each known potential defendant a request to participate in pre-suit mediation prior to filing a civil action in tort or in contract alleging that an injury or death resulted from the negligence of a health care provider and to recover damages resulting from the personal injury or wrongful death.

(b) Service of the request required in subsection (a) of this section shall be in letter form and shall be served on all known potential defendants by certified mail. The date of mailing such request shall toll all applicable statute of limitations.

(c) The request to participate in pre-suit mediation shall name all known potential defendants, contain a brief statement of the facts that the potential plaintiff believes are grounds for relief, be accompanied by a certificate of merit in accordance with 12 V.S.A. § 1040, and may include other documents or information supporting the potential plaintiff's claim.

(d) Nothing in this chapter precludes potential plaintiffs and defendants from pre-suit negotiation or other pre-suit dispute resolution to settle potential claims.

### § 7013. MEDIATION RESPONSE

(A) Within 60 days of service of the request to participate in pre-suit mediation, each potential defendant shall accept or reject the potential plaintiff's request for pre-suit mediation by mailing a certified letter to counsel or if the party is unrepresented to the potential plaintiff.

(b) If the potential defendant agrees to participate, within 60 days of the service of the request to participate in pre-suit mediation, each potential defendant shall serve a responsive certificate on the potential plaintiff by mailing a certified letter indicating that they or counsel have consulted with a qualified expert within the meaning of 1643a of this title and that expert is of the opinion that there are reasonable grounds to defend the potential plaintiff's claims of medical negligence. Notwithstanding the potential defendant's acceptance of the request to participate, if the potential defendant does not serve such a responsive certificate within the 60 day period then the potential plaintiff need not participate in the pre-suit mediation under this title and may file suit. If the potential defendant is willing to participate, pre-suit mediation may take place without a responsive certificate of merit from the potential defendant at the plaintiff's election.

### § 7014. PROCESS; TIMEFRAMES

(a) The mediation shall take place within 60 days of the service of all potential defendants' acceptance of the request to participate in pre-suit mediation. The parties may agree to an extension of time. If in good faith the mediation cannot be scheduled within the 60 day time period, the potential plaintiff need not participate and may proceed to file suit.

(b) If pre-suit mediation is not agreed to, the mediator certifies that mediation is not appropriate, or mediation is unsuccessful, the potential plaintiff may initiate a civil action as provided for in the Vermont Rules of Civil Procedure. The action shall be filed:

(1) within 90 days of the potential plaintiff's receipt of either the potential defendant's letter refusing mediation, the failure of the potential defendant to file a responsive certificate of merit with the specified time period, or the mediator's signed letter certifying that mediation was not appropriate or that the process was complete; or

(2) prior to the expiration of the applicable statute of limitations, whichever is later.

(c) If pre-suit mediation is attempted unsuccessfully, the parties shall not be required to participate in mandatory mediation under Vermont Rule of Civil Procedure 16.3.

### § 7015. CONFIDENTIALITY

All written and oral communications made in connection with or during the mediation process set forth in this chapter shall be confidential. The mediation process shall be treated as a settlement negotiation under Rule 408 of the Vermont Rules of Evidence.

#### Sec. 4. SUNSET

12 V.S.A. chapter 215, subchapter 2 shall sunset on June 30, 2014.

#### Sec. 5. 18 V.S.A. § 1919 is amended to read:

The commissioner shall consult with the commissioner of banking, insurance, securities, and health care administration, and with patient safety experts, hospitals, health care professionals, and members of the public and shall make recommendations to the commissioner of banking, insurance, securities, and health care administration concerning which data should be included in the hospital community reports required by section 9405b of this title. Beginning in 2013, the community reports shall include at a minimum data from all Vermont hospitals of reportable adverse events aggregated in a manner that protects the privacy of the patients involved and does not identify the individual hospitals in which an event occurred together with analysis and explanatory comments about the

information contained in the report to facilitate the public's understanding of the data. ~~The commissioner shall make such recommendations no more than 18 months after data collection is initiated.~~

Sec. 6. EFFECTIVE DATES

This act shall take effect upon passage.

**VII. Is it feasible to create a fixed compensation system for medical malpractice cases based on pre-set payment amounts for particular types of injuries?**

**A. General Discussion**

Section 292(c)(7) of the Act directed the Committee to consider “whether it would be feasible to create a fixed compensation system for medical malpractice cases based on pre-set payment amounts for particular types of injuries, including how such a system would operate and whether it would have an impact on medical malpractice insurance costs”. This issue was considered by the Committee on September 29, 2004 and October 27, 2004. Relevant materials are attached as *Exhibits 31 – 33, 42 and 43*. Additionally, Harvey Yorke, President and CEO of Southwestern Vermont Health Care presented his proposal on a fixed compensation system at the October 27, 2004 meeting. An outline of Mr. Yorke’s proposal is attached as *Exhibit 36*.

A fixed compensation system is a term typically used to describe a system which provides compensation to injured parties without regard to fault or negligence and in lieu of access to the court system. No fault fixed compensation systems are used for workers compensation claims in the U.S. and are used to resolve medical malpractice claims in Australia, New Zealand and Sweden.  
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Opponents of fixed compensation systems argue that they deprive injured parties of their right to a jury trial and fail to deter medical errors. Proponents of fixed compensation systems argue such systems actually help to prevent medical errors because they can be devised to promote the critical examination of adverse events and, further, that the traditional tort system is highly inefficient in providing compensation for those harmed by medical error.<sup>50</sup>

In the United States, there are some examples of this type of system being used for specific types of catastrophic medical injuries on a limited basis. By removing these large claims from the system, it is hoped that insurance costs can be stabilized. However, evidence that such systems have stabilized insurance rates is lacking.

In the 1980’s, Virginia established the Birth-Related Neurological Injury Compensation Fund (the “Birth Injury Fund”) to increase malpractice liability insurance availability for obstetricians, and in turn, to encourage obstetricians to continue practicing, particularly in rural areas.<sup>51</sup> Families of qualifying infants receive lifetime compensation for medically reasonable and necessary expenses

relating to the injury, but do not have the right to sue the obstetrician involved in the birth.

The Birth Injury Fund provides compensation only for medical injuries of infants who suffer severe neurological damage due to oxygen deprivation or mechanical injury to the brain or spinal cord during birth, provided the doctor is a participant in the program.<sup>52</sup> Compensation from the fund is determined on a nofault basis, meaning that a finding of fault is not necessary to qualify for compensation. If the doctor or hospital do not participate in the program, or the child's injuries do not qualify for the program, a traditional medical malpractice lawsuit is still an option.

The Birth Injury Fund pays for only "medically necessary and reasonable expenses" and is provided on a reimbursement basis, after collateral sources are used. Funding is provided by assessments on hospitals, doctors and the insurance industry. It also provides payments (in regular installments) for loss of earnings from age 18 to 65 and reimbursement of reasonable expenses incurred in connection with filing a claim.<sup>53</sup> Physician participation in the program is voluntary. Claims for compensation are made to, and awarded by, the Virginia Workers' Compensation Fund.

Although premiums for Virginia obstetricians fell after the implementation of the fund, it is difficult to quantify the impact the creation of the Birth Injury Fund had on premium rates because Virginia also employs other tort reform measures, such as caps on damages.<sup>54</sup> The Virginia Joint Legislative Audit and Review Committee concluded that the Fund had a positive impact on insurance availability, but has had mixed success in meeting some of its objectives. For example, although the limited data available suggests that premiums have been

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stabilized, it is not clear that the Birth Injury Fund's existence has had a significant impact on the availability of obstetric services in the state or that, when coupled with the assessments necessary for funding, much money has been saved by health care providers.<sup>55</sup>

Similar to Virginia, in 1988 Florida established the Birth-Related Neurological Injury Compensation Association. Unlike the voluntary nature of the Virginia program, hospital participation in the Florida program is mandatory. The Florida program is funded through assessments on hospitals.<sup>56</sup>

Another example of a no fault system in use in the United states, is the National Vaccine Injury Compensation Program (VICP), established by the federal government and designed to compensate individuals and their families for injuries resulting from childhood vaccines. The legislative intent was to "ensure an adequate supply of vaccines, stabilize vaccine costs, and to establish and maintain an accessible and efficient forum for individuals thought to be injured by childhood vaccines."<sup>57</sup> The program is mandatory, but injured patients can file

suit if their claim is rejected or they disagree with the outcome. Under VICP, initially the number of lawsuits dropped, but over time more claims were rejected and lawsuits rose again.

In addition to no fault, fixed compensation systems, some parties are advocating for “health courts” which would require a finding of fault in order for compensation to be granted, but would use a set schedule of payments for injury compensation rather than allow a jury to award damages. Common Good, a legal reform coalition, and the Harvard School of Public Health are developing a prototype for a medical injury compensation system that would include specialized administrative courts and will include study of the New Zealand and Swedish systems.<sup>58</sup> In 2005, U.S. Representative Mac Thornberry of Texas introduced legislation to create such courts on a pilot project basis.<sup>59</sup>

As presently envisioned, the “health court” concept would include dedicated judges to hear medical malpractice cases, independent medical experts, no jury trials, a set schedule of benefits and limited appeal rights for both claimants and defendants.<sup>60</sup> Proponents claim that such a system would provide for much swifter resolution of cases, allow people with smaller claims access to compensation, reduce administrative costs associated with a claim and allow health care providers to improve patient safety by creating a coherent body of decisions regarding the appropriate standard of care and facilitating critical analysis of medical errors. Opponents claim that such a system would favor defendants and deprive claimants of the constitutional right to a jury trial.<sup>61</sup>

While adoption of a fixed compensation system for medical malpractice is possible, it is mostly untested in the U.S. When contemplating such a system, the following related issues should be considered: 1) whether there are constitutional or moral limitations on depriving a claimant a right to a jury trial; 2) the parameters of coverage offered by such a system; 3) how compensation schedules would be established and maintained; 4) how to avoid complicated and potentially biased relationships among those involved with the system (a particularly tricky problem in a state as small as Vermont); and 5) ways to integrate the system into an effective patient safety system. Some of these issues are intended to be addressed by the Harvard project.