

**Oregon Health Policy Board  
Medical Liability Task Force**

**Wednesday, October 6, 2010  
1:00 - 3:00 pm**

**Wilsonville Training Center, Room 112  
29353 Town Center Loop East, Wilsonville, OR**

**DRAFT AGENDA**

Time	Item	Lead	Action Item
1:00 pm	Call to Order	J. Michael Alexander	
1:00 pm	Review and Draft Summary for September Meeting	J. Michael Alexander	x
1:10 90 min	Discussion of Draft Recommendations: <ul style="list-style-type: none"> <li>➤ Early Disclosure and Offer</li> <li>➤ Evidence-Based Guidelines as Safe Harbor</li> <li>➤ Administrative System for Compensating Patient Injuries</li> </ul>	Lynn-Marie Crider J. Michael Alexander	x
1:40 15 min	Outline of Full Committee Report  Process for Finalizing Presentation to the Board and Committee Report	Lynn-Marie Crider	
1:55 5 minutes	Next meeting	J. Michael Alexander	
4:00	Adjourn	J. Michael Alexander	x

**Exhibit Materials:**

01. Agenda
02. Meeting #4 Draft Summary
03. Draft recommendation on early disclosure and offer
04. Draft recommendation on evidence-based guidelines safe harbor
05. Draft recommendation on an administrative system for compensating patient injuries
06. Draft outline of committee report include schematics

**Medical Liability Task Force  
Meeting #4 Summary**

Wednesday, September 8, 2010  
1:00-4:00 pm

Work Group Members in Attendance

Michael Alexander, Co-Chair  
Joseph Siemieniczuk MD, Co-Chair  
Rick Bennett  
Peter Bernardo MD  
Jeffrey Bildstein  
Janet Billups  
Jim Dameron  
Jodie Mooney  
Mark Stevenson

Work Group Members Absent

Craig Fausel MD  
Scott Gallant  
Robert Holland MD  
Laura Potter  
Christoffer Poulson MD  
Lawrence Wobbrock

OHPR Staff in Attendance

Jeanene Smith  
Lynn-Marie Crider  
Carrie Parrish

OHFB Liaison Representative in Attendance

Chuck Hofmann MD (by phone)

Meeting Summary (actions in bold)

*The meeting was called to order shortly after 1 pm.*

*Review of meeting summary*

**The meeting summary for the August 4 meeting was approved.**

*Presentation of Straw Recommendation on Health Courts and Discussion*

Lynn-Marie Crider discussed three alternatives for Task Force recommendations on health courts. She recommended alternative #1: To take no action to establish a health court system on a “full-out” or “pilot” basis until evidence supports a finding that at least two of the task force’s objectives for reform would be accomplished by establishing health courts. At such time as the evidence supports that finding, consideration should be given to establishing a mandatory administrative system for handling all claims. She explained that a pilot was doomed to failure because the positive changes that are the hoped-for results of health courts could not be achieved in the short-term or without across-the-board adoption of the system.

She also presented two alternatives for pilots or carve-outs for specific conditions.

Co-chair Mic Alexander noted that a fourth alternative might be considered. It would be “the full monty now”—that is, establishment of a mandatory administrative system for handling all claims with a changed standard of compensability such as “no fault” or “avoidability.”

After discussion, Task Force members agreed that:

- They are very enthusiastic about the potential of an administrative system to produce better results than the existing system on the dimensions that serve as the framework for the Task Force’s work.
- They are not interested in establishing a parallel court system for addressing cases involving medical liability or medical errors, but they are interested in the potential for establishing an administrative system for adjudication with a lowered standard for recovery and a schedule of damages.
- They do not believe a carve-out or pilot is feasible.
- They believe a feasibility study should be undertaken to help an advisory group such as the Task Force determine if an administrative system should be recommended. The study should be funded so that it can be high-quality, thorough, and data-driven. The concept should be well-described and the legislature should be requested to fund it.
- Meantime, the state should actively monitor state-level experiments.

Lynn-Marie will prepare a draft recommendation. Jodie Mooney, Janet Billups, and Jim Dameron offered to review it before the next meeting.

### *Discussion of other issues*

There was some discussion of whether the Task Force might wish to make a recommendation on error reporting, the nature of required disclosures.

This issue will be revisited at the Task Force’s next meeting.

### *Staff presentation on evidence-based guidelines*

Jeanene Smith and David Pass, Director of the Health Resources Commission (HRC), made a powerpoint presentation on the way evidence-based reviews are done of medical treatments and technologies and how they inform development of evidence-based guidelines.

Co-chair Joe Siemienczuk asked if Dr. Smith was recommending that the HRC develop guidelines for use as a safe harbor. She said that the HRC was one body that might be assigned that function. There was discussion of the resource-intensive nature of guideline development. Dr. Smith noted that the HRC could review and adopt rather than develop guidelines from scratch.

There was discussion of the changed role for guidelines in the safe harbor world in that going outside the guidelines jeopardizes the safe harbor.

Varying opinions were expressed about the value of guidelines in the liability system.

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At 3 pm a number of members of the Task Force had to leave. The remainder stayed for an informal discussion with Dr. Allen Kachalia, who is trained in both law and medicine, is Medical Director for Quality and Safety for Brigham & Women's Hospital, holds an appointment at the Harvard School of Public Health, and does research related to patient safety and medical liability issues.

### *Conversation with Dr. Kachalia*

Dr. Kachalia answered questions about his recently published study demonstrating that an early disclosure and offer program at the University of Michigan Health System reduced liability costs.

The University investigates adverse events, discloses errors, apologizes, and tells patients what it is changing to prevent similar events. Risk managers get involved. The cases that go to trial tend to be about the amount of recovery rather than liability. Staff is free to talk about pending cases.

It would be harder to conduct an early disclosure program in a system that is not a staff-model, closed system. Kachalia suggested that insurers should make arrangements in advance about how they will handle these events.

Institutions with early offer and disclosure programs cannot really know if they are disclosing a high percentage of errors because there is not culture of reporting. To know, a medical records review would have to be done.

Some possible steps to encourage disclosure and offer were discussed:

- State could offer reinsurance to reduce fears of increased cost.
- Institutions can take responsibility for errors to alleviate physician fears of reporting to the National Practitioner Data Bank. This may, however, be contrary to the reporting rules.
- Notice of intent to file requirements, although they may violate the state constitution.

Seven states have mandatory disclosure laws. He will provide the Task Force with a list of them.

Kachalia's view is that the primary value of written disclosures to patients is to memorialize a conversation and allow measurement. People want to talk.

Kachalia said he didn't know if a safe harbor approach would work but that it might drive adherence to protocols—which would be in the interest of patient safety and quality care, and efficiency and hence have value even if it doesn't reduce medical liability costs.

Kachalia is “a fan of health courts.” He believes that de-coupling compensation from fault is important. It could induce physicians to assist patients to file claims and support better reporting of errors. The first step in a health court system could be to require the institution to disclose errors.

Joe asked if he had any concern that patients would be taken advantage of if cases were settled without a patient lawyer. Kachalia said that University of Michigan encourages patients to get a lawyer.

The Task Force adjourned at 4 pm.

The next committee meeting is scheduled for October 6, 2010 from 1-3 pm in Wilsonville.

**Early Disclosure and Offer  
Draft Recommendation 10/6/2010**

The Task Force concludes that formal, voluntary policies requiring early disclosure of medical errors by health care facilities and professionals coupled with offers of compensation contribute to achievement of the three objectives for medical liability system reform.

- The medical liability system becomes a more effective tool for improving patient safety because, in order to identify medical errors, health care facilities and professionals must conduct root cause analyses of adverse events, which are the foundation of system improvement.
- The medical liability system more effectively compensates individuals who are injured as a result of medical errors because compensation is likely to be made more quickly, it relieves patients injured by adverse events of responsibility for extracting information about why they were injured, it increases the likelihood that deserving patients will be compensated, and it should increase the share of resources available for compensation that actually go to patients.
- The collateral costs associated with the medical liability system (including costs associated with insurance administration, litigation, and defensive medicine) are reduced because litigation is avoided by early settlement.

To encourage widespread adoption of early disclosure and offer policies, the Task Force makes the following recommendations to policymakers:

**1. To encourage full disclosure**

- **Remove insurance concerns as a barrier to full disclosure:** Enact a statute explicitly providing that a health care facility or provider's duty to cooperate with an insurer does not preclude disclosure of an adverse event or the reasons underlying it to a patient or the patient's family and that such disclosure may not be the grounds for refusal to defend or for cancellation or nonrenewal of coverage.
- **Encourage comprehensive disclosure:** The Oregon Patient Safety Commission should work with facilities to experiment with disclosure protocols that include disclosure of root cause analyses with patients or their representatives.

**2. Expand reporting and disclosure programs**

- **Expand the Patient Safety Commission's voluntary reporting and disclosure program to clinic and other ambulatory settings:** Amend Oregon's patient safety law to allow ambulatory physician practices to participate in the reporting program of the Oregon Patient Safety Commission.

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### Policy Option Considered but Not Recommended

Other policy options on disclosure and offer have been identified by experts or proposed in literature consulted by the Task Force that are not included in the Task Force's recommendations. They are:

- Create a state reinsurance or excess liability fund for providers and facilities that implement model early disclosure and offer programs.<sup>1</sup>
- Offer broad statutory protection from admissibility for statements made in a disclosure to the patient or his or her family, representative or friend in lawsuits against institutions as well as physicians (by amending ORS 677.082 to more clearly define what is inadmissible as an “expression of regret or apology” and to clearly preclude an apology’s admissibility in a suit against a facility as well as a provider).<sup>2</sup>
- Require disclosure of all unanticipated outcomes and written disclosure of serious ones and spell out the components of the disclosure—either in administrative rule or statute.<sup>3</sup>
- Require mandatory reporting of some or all adverse events.<sup>4</sup>

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<sup>1</sup> Identified as an option by Dr. Allen Kachalia in a conversation with the Task Force on September 8, 2010.

<sup>2</sup> The general concept of offering broad protection appears in Anna C. Mastroianni et al, “The Flaws in State ‘Apology’ and ‘Disclosure’ Laws Dilute Their Intended Impact on Malpractice Suits,” *Health Affairs* 29, no. 9 (2010), pages 1611-1619. Current Oregon law reads as follows:

**ORS 677.082 Expression of regret or apology by licensee.** (1) For the purposes of any civil action against a person licensed by the Oregon Medical Board, any expression of regret or apology made by or on behalf of the person, including an expression of regret or apology that is made in writing, orally or by conduct, does not constitute an admission of liability for any purpose.

(2) A person who is licensed by the Oregon Medical Board, or any other person who makes an expression of regret or apology on behalf of a person who is licensed by the Oregon Medical Board, may not be examined by deposition or otherwise in any civil or administrative proceeding, including any arbitration or mediation proceeding, with respect to an expression of regret or apology made by or on behalf of the person, including expressions of regret or apology that are made in writing, orally or by conduct.

<sup>3</sup> The general concept of requiring disclosure of all unanticipated outcomes and written disclosure of serious ones appears in Anna C. Mastroianni et al, “The Flaws in State ‘Apology’ and ‘Disclosure’ Laws Dilute Their Intended Impact on Malpractice Suits,” *Health Affairs* 29, no. 9 (2010), pages 1611-1619. Current Oregon law does not require disclosure of unanticipated outcomes; to the extent a facility opts into a voluntary reporting program, the facility must disclose serious adverse events that are reportable under the program’s rules. See ORS 442.819 et seq and applicable administrative rules.

<sup>4</sup> Current Oregon law does not require reporting of adverse events; rather, facilities may opt into a voluntary reporting program. See ORS 442.819.

### **Evidence-based Guideline Safe Harbor Draft Recommendation 10/6/2010**

In light of the medical liability reform planning grant awarded to the State of Oregon by the Agency for Healthcare Research and Quality, the Task Force concludes that exploring how evidence-based guidelines might serve as a legal standard of care may contribute to achievement of two of the Task Force's three objectives for medical liability system reform.

- The medical liability system could become a more effective tool for improving patient safety because (1) the legal protection provided to physicians may increase the use of evidence-based guidelines, which should reduce the number of patient injuries, and (2) guidelines may give physicians greater clarity about the standard of care expected of them.
- The collateral costs associated with the medical liability system (including costs associated with insurance administration, litigation, and defensive medicine) are reduced because (1) the protection afforded by the guidelines may reduce the costs of defensive medicine because physicians will not feel the need to order unnecessary tests or do unnecessary procedures to protect themselves against claims; (2) clarity regarding the standard of care may reduce the number of claims filed and promote the settlement of claims, and (3) the litigation process may be simplified by reducing the need for expert testimony.

To explore the potential value of using evidence-based guidelines as the legal standard of care, the Task Force recommends that policymakers support the continuation and completion of the Medical Liability Planning Grant.

As the grant project moves forward, the Task Force recommends that a broadly representative set of individuals be included in the planning process. In addition, the Task Force recommends exploration of the following questions:

- Are there collections of similar adverse events that could be prevented if a single evidence-based guideline was consistently followed? Have those adverse events historically resulted in significant malpractice cost?
- How and by whom should guidelines be selected for special status in the medical liability system? Based on what criteria?
- Do the guidelines supplant the traditional community standard of care (serving as both a sword and a shield) or are they simply a defense to a claim based on deviation from the traditional standard of care (serving as a shield only)?
- Would guidelines used for safe harbors need to be protocols in order to play the role of safe harbor in the legal system?
- How can it be assured that the guidelines will remain up to date and not hold up desirable innovation?

If the year-long exploration produces a clear indication that this approach is feasible and has broad-based support, the Task Force supports the development of implementation legislation.

DRAFT  
**Recommendation to Study an Administrative System  
 for Compensating Patient Injuries**

**Background**

In Oregon and around the country, critics of the medical liability system are proposing to replace the tort system for compensating victims of medical negligence and the medical liability insurance system with what some call “health courts.” Most “health courts” proposals would create an administrative system for compensating injuries to patients from some or all unanticipated adverse outcomes of medical care—not just medical negligence.

Enthusiasts believe implementing an administrative system will dramatically improve the collection of data on unanticipated adverse outcomes thereby supporting safety improvement programs; foster development of consensus around best practices for avoiding patient injury; increase the number of individuals compensated by lowering the bar for recovery to something less than negligence; reduce the legal costs incurred by patients to establish their claims; result in speedier resolution of claims; produce more consistent decisions and awards; reduce administrative costs, including defense costs; and reduce overutilization of medical procedures driven by the practice of defensive medicine.<sup>1</sup> They further believe that the changes in our nation’s health care insurance system occasioned by passage of the Patient Protection and Accountable Care Act can be leveraged to improve the liability system and reduce costs.

Skeptics share the enthusiasts’ desire to improve patient safety programs, improve access to compensation for victims of medical errors, and reduce collateral costs, including insurance-related costs and the costs of defensive medicine; but they doubt that an administrative compensation system will result in the hoped-for improvements. They believe that estimates of defensive medicine are greatly exaggerated. They point out that both deeply rooted medical culture and powerful fee-for-service payment incentives drive overutilization of medical procedures, confounding efforts to measure the effect of fear of lawsuits on utilization. In addition, they are concerned that administrative decision-makers may display pro-physician bias and that benefits available in an administrative system may be inadequate.<sup>2</sup>

The magnitude of the benefits envisioned by advocates for replacing the existing system are great and warrant giving the concept a hard look. But the anticipated benefits are not certain. The design issues are many and complex. And the potential pitfalls are serious. The proposed change is not something that can be tested through pilot projects or half-way measures. Replacing the medical liability system with an administrative system to compensate patient injuries is something that must be done wholeheartedly or not at all.

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<sup>1</sup> Citations.....

<sup>2</sup> Citations.....

## **Recommendation**

The Task Force concludes that it would be worthwhile for the Legislature to undertake a study to determine whether or not an administrative system could be designed that would achieve the reform objectives the Task Force has enunciated and if so, whether implementation is financially, legally, and politically feasible.

The study should be overseen by an unbiased entity that has not taken a position for or against the health courts concept. It should be conducted by a well-qualified team with knowledge of the existing medical liability system, knowledge of administrative compensation systems in the United States and elsewhere, skill in economic and social research and modeling, legal and actuarial expertise, and funding sufficient to do a thorough job.

### **Scope of the recommended study**

The study should assume that an administrative compensation system would include the following basic features:

- The administrative system would be the exclusive remedy for events that are compensable under the administrative scheme. Individuals injured as a result of medical negligence could no longer bring a suit for negligence in court.
- Compensable events would embrace a defined class of patient injuries broader than the class of injuries caused by medical negligence. While it may be unlikely that a pure “no-fault” system is economically feasible, a “low-fault” threshold could make more people eligible for benefits. Compensable events might include a very broad class of events arising out of encounters with medical professionals or facilities such as “treatment injuries” (as in New Zealand), “undesired” or “unexpected” outcomes,” or “avoidable” injuries (as in Sweden).
- The system would compensate victims for both economic damages and non-economic damages caused by the injury.

A host of other issues would need to be considered, among them the relationship between the health insurance system and the new compensation system and the role if any for medical liability insurance. (For a list of some of the design issues that should be studied, see Exhibit 1.)

The study should address, first and foremost, the impact of each design choice on the value of the administrative system for achieving the goals for system improvement identified by the Task Force at the outset of its work.

In addition, the study should address the specific issues listed below relating to patient safety, access to compensation, the cost of health care, relation to state and federal law, and financial and political feasibility:

- Patient Safety
  - What is the likely effect of replacing the medical liability system with an administrative compensation system on patient safety?
  - Will it create more or less incentive for health care providers and facilities to invest in prevention of medical errors?
  - Will the effect on safety incentives depend on how the system is financed?
  - Will the proposed change support the safety improvement infrastructure more or less effectively?
  - Will some administrative system designs support patient safety improvement more effectively than others?
  
- Access to and adequacy of payment
  - What is its likely effect on access to and amounts of compensation for patient injury?
  - How would the choice of compensability standard and other design choices affect numbers of injured individuals compensated or amounts of recovery?
  - Who will suffer as a consequence of any payment reductions?
  
- Cost of health care
  - How will an administrative program affect health insurance costs?
  - How will it affect the practice of defensive medicine?
  
- Federal issues
  - Is ERISA implicated by an administrative program?
  - How would federal payers interact with it?
  - Would they have liens against recoveries?
  
- State constitutional issues (right to jury trial and right to remedy)
  - Can an administrative program be implemented to replace the tort system without statutory or constitutional changes?
  - If not, what changes are necessary?
  - Will some system designs pass constitutional muster and others not?
  
- Financial feasibility
  - What are the anticipated total costs of the program?
  
- Political feasibility
  - Who can be expected to support or oppose the concept?<sup>3</sup>

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<sup>3</sup> [Note: One of the co-chairs has requested including language something like this in the document to make it clear that trial lawyers are unlikely to support the concept to be studied.] Replacing the current system with an administrative one would both eliminate jury trials and limit damages to the extent that compensation is scheduled in some way. Although the ultimate reaction of any group to the results of a study cannot be predicted with certainty, it can be anticipated that trial lawyers who represent injured Oregonians and other groups who

**Timing of the study**

For years, Oregonians have discussed the merits and demerits of the medical liability system in the context of proposed legislation and proposed ballot measures to change the system. It is critically important to ground this discussion in fact. A professional study of the feasibility of establishing an administrative compensation system and the effectiveness of such a system as compared with the existing one for improving patient safety, improving access to compensation for injured patients, and reducing collateral costs of the medical liability system will be challenging but, if well done, it will serve the state well. The study should be funded without delay.

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have opposed previous efforts to impose caps on damages may view an administrative substitute for the right to a jury trial for negligence as an assault on fundamental rights and vigorously oppose it.

## Exhibit 1

The feasibility study should address the following design issues, among others. It should identify alternative design choices and evaluate their impact on objectives identified in the Task Force's framework for medical liability reform:

- **Compensability standard:** What options are there for defining the injuries to be covered by the system?
- **Filing of claims:** Should claims be considered only if filed by the injured patient or her representative or family? Should providers be required to affirmatively advise the patient of any medical event that meets the threshold for a claim for benefits and direct her to the agency that processes claims as in other systems? Should providers be required to file such claims on behalf of the injured patient as in the workers compensation system?
- **Economic Losses:** What losses will be reimbursed?
  - **Medical Costs:** Will compensable losses include medical costs as they do in the workers' compensation system or should all financial responsibility for medical costs related to the injury be borne by the health insurer and/or the injured patient? If medical costs are compensable, how will responsibility for those costs be apportioned and determined? Should responsibility be apportioned in the administrative proceeding, with the collateral source rule abolished? Or should it be the responsibility of the fund to collect from a health insurer without involving the injured patient?
  - **Death benefits:** Should death benefits be payable? Is the workers compensation system a good model?
  - **Lump sum payment or ongoing responsibility for losses:** Will losses—such as predicted costs of medical care, non-medical care such as home care or skilled nursing care, and lost wages—be paid in a lump sum or will losses be paid by the administrative system on an on-going basis? If on an ongoing basis, who will decide what needs are related to the injury and determine what services are necessary and what will be paid for them? Will expenses be reimbursed to the patient or paid directly by the system?
- **Non-economic Losses:** Should non-economic damages be paid according to a schedule? How will schedules be established and updated?
- **Responsibility:** How will the administrative system interface with the tort system in cases in which someone other than a professional or a healthcare institution bears some responsibility for the injury (e.g., defective medical device)?
- **Administration:** Will there still be insurance carriers that accept or deny and pay claims? Will there be a single state fund out of which claims are paid?

- Financing: Who will pay for the administrative/adjudicative apparatus? Who will pay for the cost of claims?
- Attorney fees: How will injured patients' lawyers be paid? (By the system? Out of the injured patients' recovery?)
- Appeals: Who may appeal an adverse determination by the administrative adjudicator? Should the appeal be taken to the court of appeals in the same manner and reviewed under the same standard as decisions in contested cases? Who should pay costs on appeal?

DRAFT  
Outline of Medical Liability Task Force Report

Cover Page

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Task Force Membership and Staff

Executive Summary

I. Charge to the Task Force

II. Framework for Deliberations

A. The Task Force chose to focus on recommending changes that have the following impact:

1. The medical liability system becomes a more effective tool for improving patient safety;
2. The medical liability system more effectively compensates individuals who are injured as a result of medical errors;
3. The collateral costs associated with the medical liability system (including costs associated with insurance administration, litigation, and defensive medicine) are reduced.

B. The Task Force identified five questions that should be asked about any reform concept studied. They were:

1. What is the likely effect of the proposal on patient safety?
2. What is the likely effect of the proposal and access to compensation for patient injury?
3. What is the likely effect of the proposal on health care costs?
4. Is the proposal feasible?
5. Can the proposal be implemented without statutory or constitutional changes? If not, what changes are necessary?

C. The Task Force prioritized three concepts for study. They were disclosure and offer programs; evidence-based guideline safe harbors; and health courts. The Task Force chose not to study other concepts. (fn concepts identified not to study)

D. The task force chose not to pursue other on other issues flagged in the charter or by TF participants for the following reasons:

1. Caps on non-economic damage awards: Not doable without constitutional amendment and voters have rejected; some evidence that caps on damages reduce defensive medicine—but not by much.
  2. Other traditional tort reforms: Premiums are relatively low cost state compared with other states and frequency of claims is essentially flat. The real problem for Oregon providers is not the absolute cost of the medical liability system but rather the volatility of costs and uneven distribution of risk — which appear to be a function of the insurance system and hence are not amenable to fix through traditional tort reforms.
  3. Rural practitioner issues: Task Force decided to defer to the Legislative work group that is studying the issue.
  4. Excess liability fund: The Task Force concluded that this concept would not serve the objectives for system improvement identified by the Task Force.
- E. The Task Force chose not to seek an answer to elusive factual questions like the cost of defensive medicine as a percentage of health care spending or seek an answer to such contentious value questions as whether the costs associated with the medical liability system are out of proportion to its benefits.
- III. Background [Paint picture of where Oregon is on patient safety/medical errors; access to compensation; and collateral costs.]

A. Patient Safety

The seminal authority on the issue remains the 1999 Institute of Medicine's landmark report entitled "To Err Is Human". Relying on the Harvard Medical Practice Study's review of a random sample of hospital records in New York State,<sup>1</sup> the IOM estimated that as many as 98,000 Americans die every year from preventable medical errors in hospitals. Reliable estimates have not been made of deaths and other serious injuries occurring in non-hospital settings. However, in a study commissioned by the Society of Actuaries and published in 2010, the Milliman firm estimated conservatively, using claims data, that 7% of hospitalizations result in "medical injury". They further consulted that some 6.3 million medial injuries occurred in the United States in 2008—1.5 million associated with medical error. They estimated the cost to the economy of in the form of increased medical and

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<sup>1</sup> Adverse event is defined as "an injury that was caused by medical management (rather than the underlying disease) and that prolonged the hospitalization, produced a disability at the time of discharge, or both" (p 145). Brennan TA, Leape LL, Laird NM, Hebert L, Localio AR, Lawthers AG, Newhouse JP, Weiler PC, Hiatt HH. Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice Study I. *N Engl J Med* 1991 324:370-6.

short-term disability of about \$19.5 million.<sup>2</sup> Earlier studies made much higher estimates of the economic burden of medical errors.<sup>3</sup>

There are no comprehensive records of medical errors occurring in Oregon. The Oregon Patient Safety Commission's reporting programs are voluntary. While 56 of 58 have committed to reporting, only half of nursing homes participate in the program. Ambulatory surgery facilities may participate, but physician practices may not. Nevertheless, in 2009, Oregon hospitals reported 127 adverse events, 32 of which resulted in death.<sup>4</sup> Relying on data from Pennsylvania, where a more mature hospital error reporting system is in place, Oregon's Public Health Officer estimated that 1600 serious events resulting in patient harm occurred in Oregon hospitals alone in 2008.<sup>5</sup>

Many of these injuries can and should be prevented.

#### B. Access to Compensation

Our current tort system, as it applies to medical claims, is fault-based, meaning that compensation may only be awarded if the medical provider is shown to have rendered unreasonable care. The principal purpose of the tort system is to provide compensation to victims of medical negligence. Because there is no comprehensive data on the numbers of negligent medical errors occurring in Oregon each year, it is impossible to calculate the degree to which the tort system accomplishes its goal.

There is no question, however, that many people who are harmed by medical negligence do not receive compensation through the tort system. Studies designed to examine hospital records to identify adverse events caused by medical negligence and mapping those against malpractice claims have found that 97-98% of patients so injured did not file claims.<sup>6</sup>

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<sup>2</sup> "Medical injuries are any adverse events which occur due to medical intervention, but not all injuries are necessarily errors. A medical error is defined as an injury which results from inappropriate medical care" (p 5). Shreve J, Van Den Bos J, Gray T, Halford M, Rustagi K, Ziemkiewicz E. *The Economic Measurement of Medical Errors*. Milliman June 2010.

<sup>3</sup> Thomas EJ, Studdert DM, Newhouse JP, et al. Costs of Medical Injuries in Utah and Colorado. *Inquiry*. 36:255–264, 1999. Johnson WG, Brennan TA, Newhouse JP, et al. The Economic Consequences of Medical Injuries. *JAMA*. 267:2487–2492, 1992.

<sup>4</sup> "Hospital Report," Oregon Patient Safety Commission (August 2010)

<sup>5</sup> "Public Health Officer Certification Report 2008 – Oregon Patient Safety Commission Adverse Event Reporting Programs" (August 2009).

<sup>6</sup> Localio, AR, et al, "Relation Between Malpractice Claims and Adverse Events Due to Negligence" *New England Journal of Medicine*. 325:245-251 ( ) (1.53%); Studdert DM, Thomas EJ, Burstin HR, Zbar BIW, Orav EJ, Brennan TA. Negligent Care and Malpractice Claiming Behavior in Utah and Colorado. *Med Care* 2000 38(3):250-60.

This suggests that the system as it now functions is a less-than-perfect vehicle for compensating victims of medical negligence and probably an even less satisfactory vehicle for compensation victims of medical errors that could have been prevented had best practices been followed. The reasons why so few are compensated, however, is a problem requiring further study.

C. Collateral Costs

1. Total system costs

The costs of the medical liability system (as opposed to economic burden of the treatment-related injuries themselves) include compensation paid for injury and collateral costs—primarily the costs of insurance administration and litigation and costs associated with diagnostic and treatment activities taken primarily to avoid malpractice liability or claims (that is, “defensive medicine”).

Three recent estimates of total system costs have been published. The estimates range from .46% of total health care spending (Public Citizen, relying on estimates of malpractice premiums alone)<sup>7</sup> to 2.4% of health care spending (Mello et al, who attempt to include the costs of defensive medicine).<sup>8</sup> The Congressional Budget Office estimated total costs at 2% of health care spending.<sup>9</sup> [Add footnotes.] With national health care spending at \_\_\_\_\_, the range of dollar cost estimates run from \_\_\_ to \_\_\_\_.

The problem with all of these estimates is that they include both compensation and collateral cost, so while they are a good measure of the burden of the system on health care practitioners, they are not particularly useful in identifying the collateral costs that the Task Force seeks to reduce. Therefore, we turn to studies that seek to parse these costs.

2. Costs of insurance administration and litigation

Mello et al estimated the total national cost of insurance administration and defendant legal expenses at \$4.13 billion in 2008—with an additional \$2.0 billion in legal costs borne by injured patients out of their recoveries. The total of these costs estimates for indemnity payments of \$5.72 billion.<sup>10</sup>

Oregon estimates [in process]

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<sup>7</sup> *Medical Malpractice Payments Fall Again*, Public Citizen ( March 3, 2010) at 5.

<sup>8</sup> Mello MM, Chandra A, Gawande AA, Studdert DM. National Costs of the Medical Liability System. *Health Affairs* 2010 29(9):1569-77.

<sup>9</sup> Congressional Budget Office Letter, October 9, 2009.

<sup>10</sup> See footnote 8.

3. Defensive Medicine

The costs of defensive medicine are notoriously difficult to measure. For that reason, the Task Force has not attempted to agree on its prevalence.

In a 2006 paper published by the Robert Wood Johnson Foundation, Michelle Mello, wrote:

“There are no reliable estimates of the national costs of defensive medicine. Many analysts have attempted to estimate these costs; all have failed to do so reliably. All of the available measurement methodologies have serious shortcomings (10, 18). For example, some national estimates are based on the incremental cost increases associated with just two or three medical procedures or diagnoses. It is simply not possible to extrapolate so widely to other procedures, because some are more amenable to defensive medical practice than others. The Office of Technology Assessment conducted a comprehensive review of the evidence about defensive medicine costs in 1994 and concluded that none of available estimates were reliable (32). Much additional research has been conducted since then, but the conclusion remains the same.”<sup>11</sup>

Nevertheless, in 2010 Mello and colleagues attempted to estimate the cost of defensive medicine as part of a broader effort to quantify the cost of the medical liability system. They warned that “Although our figure was based on methodologically strong studies, because the hospital spending estimates were derived from a narrow range of diagnoses, the quality of evidence supporting our system-wide estimate is best characterized as low.” This “low quality” national estimate for defensive medicine costs for hospitals and the physicians was \$45.49 Billion, or about 1.97% of total health care costs.

IV. Early offer and disclosure programs

A. Describe key elements of these programs in a paragraph

B. TF believes it is the right thing to do:

- Disclosure is right – patients should know what happened to them
- Disclosure promotes prevention of recurrence
- Early disclosure and offer reduces transaction costs
- Early disclosure and offer saves money (UMich and Ky VA studies)

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<sup>11</sup> Mello, Understanding Malpractice Insurance: A Primer, Robert Wood Johnson Foundation (2006).

- C. Prevalence of programs in Oregon: Many facilities claim to have early offer programs, but it is impossible to measure the accuracy of the claim.
- D. Barriers to programs in Oregon:
  - Insurers discourage disclosure
  - Providers fear that insurers will not defend if there is disclosure
  - Many incidents arise in the ambulatory context where patient safety and risk management programs are less likely to be in effect than in hospitals
  - CMS and Joint Commission disclosure requirements and Oregon’s voluntary reporting and disclosure programs extend only to facilities, not providers; so such programs have not served to encourage a culture of disclosure in much of the delivery system.
  - Split coverage situations: Many claims, particularly those arising out of incidents occurring in a hospital, involve claims against multiple parties. If they are separately insured, it is more difficult to settle early.
- E. Recommendations (see straw proposal for discussion 10/6/2010)

VI. Administrative Systems for Compensating Victims Medical Errors

- A. Describe the key elements of the programs in place in a number of countries for compensation of medical errors
- B. Administrative remedy to drive improvement on the dimensions identified in our framework for system improvement
- C. Recommendation (See draft recommendations in meeting materials)

VII. Evidence-based guidelines safe harbor

- A. The concept and how it ties to the principles
- B. Grant project description
- C. Recommendation (See draft recommendations in meeting materials)

Next Steps

- Legislation

Appendices

- Charter
- List of references and individuals consulted
- List of medical liability strategies identified but not prioritized