VIEWPOINT

Another Medical Malpractice Crisis?
Try Something Different

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With hospitalizations related to coronavirus disease 2019 (COVID-19) soaring, revenue from elective procedures plummeting, and health professionals experiencing unprecedented stress, the pandemic is challenging the US health care system in unimaginable ways. Will there be further consequences? Another medical malpractice crisis is a growing possibility.

Physicians, hospitals, and nursing homes, along with manufacturers of vaccines and therapeutics, are apprehensive about potential liability during the pandemic.[1] Some health care organizations are asking patients to acknowledge and explicitly assume COVID-19 risks before receiving care; others have requested and sometimes have obtained legal immunity from tort liability through state legislation or executive order.[1]

The history of medical malpractice suggests that a much larger medical liability problem may be on the horizon, if shifts in global insurance markets compound financial stresses among purchasers of malpractice coverage. Insurance issues are often overlooked in malpractice policy,[2] but the waves of tort reform laws enacted during previous malpractice crises all had as their primary objective to maintain the availability and affordability of liability insurance coverage.

For example, the most recent medical malpractice insurance crisis occurred in the early 2000s. Medical malpractice is a long-tail line of property and casualty insurance, meaning that it can take many years to identify and resolve a claim involving serious injury, subjecting the premiums charged physicians for coverage to a high degree of uncertainty. During the 1990s, physicians under cost pressure from managed care had switched insurance carriers frequently in search of lower prices, reducing the stability of coverage for high-risk specialties (eg, obstetrics or neurosurgery) and forcing premiums sharply upwards when actuarial projections turned conservative because of declining investment returns, increases in the frequency or severity of losses, and regulatory changes unfavorable to insurers. A "hard market" for physician malpractice coverage emerged in 2001, which was characterized by higher premiums, stricter underwriting of risk, and less willingness among insurers to negotiate terms with prospective policy holders. Markets for excess coverage or reinsurance to protect hospitals against rare but catastrophic losses (eg, a $50-million to $100-million malpractice judgment) hardened even more quickly because global insurance capacity declined precipitously, especially following the September 11, 2001, terrorist attacks. As a result, most hospital systems faced large, recurring premium increases for professional liability. However, insurance markets stabilized by 2005.

Signs of worsening insurance market conditions began to appear in 2019. A Milliman industry report on medical professional liability (MPL) insurance showed that premiums paid by policy holders increased by 74% between 2001 and 2006, declined by 21% between 2006 and 2017, and then entered a new period of growth (5.4% in 2018 and 1.2% in 2019) (R. Lord, Milliman, unpublished report "The National Medical Professional Liability Insurance Market," 2020).

Another industry analysis[3] projects a hard market emerging and persisting for the next 3 to 5 years, noting that the industry has consolidated and remains strongly capitalized but expressing concern over increases in direct written premium and decreases in profitability in 2019, with more frequent high-dollar losses.

As a result of financial and structural integration, many (although not all) physicians are better insulated as individuals from rising premiums and uncertain coverage now than in past malpractice insurance crises. Institutional risk management, particularly the cost and availability of excess coverage, may be the greater concern. Hospitals now employ approximately 40% of US physicians, which is far more than during the malpractice crisis of the early 2000s. Liability coverage and risk management have shifted in parallel, with large health systems, captive carriers (ie, insurance companies owned by the businesses they insure), risk retention groups (entities that are owned by and insure policy holders with a common business need), and international companies now competing with companies selling conventional malpractice insurance to individual physicians.

Managers and trustees of major hospitals seeking to protect their institutions against the unlikely event of an extremely high-damage award may again find excess coverage unavailable or offered only at many times the accustomed price. Physician group practices are particularly vulnerable because they have less experience self-funding potential claims than do hospitals and because they tend to invest less capital in their businesses overall. However, even hospitals may again be forced to assemble their desired level of overall coverage from smaller monetary layers that insurers, which have begun to exercise disciplined underwriting for the first time in more than a decade, are currently willing to offer.

If history is any guide, the tendency within the health care industry—should malpractice insurance again become unaffordable or inaccessible—will be to blame the legal system, support antilawsuit candidates for office, and lobby for additional legislative change. However, most states enacted tort reforms years ago that made malpractice claims more difficult to bring and less lucrative to pursue, leaving little room for such maneuvers. There are also significant downsides to tort reform. Even emergency legal immunity adopted during COVID-19 will add to the burdens on injured

patients, including potentially substantial bills for health care services rendered, and may allow unsafe conditions to persist in poorly designed or operated clinical environments.

There is a better path. Beginning in 2002, the University of Michigan Health System was able to forgo excess coverage entirely, substantially alleviating financial pressure on the institution. Buoyed by solid investment returns, the university's well-managed captive carrier transformed the organization's claims management strategy. Rather than waiting for complaints and lawsuits, the health system's risk management department put in place a quick-response system for addressing unfavorable patient outcomes. Seizing control over the timing addressed persistent concerns about delayed claims among both risk managers and clinicians, reduced financial uncertainty by promptly resolving most well-founded claims without litigation, and shifted the basis of claims management from "legal defensibility" to patient safety. This resulted in quicker resolution of claims and decreases in lawsuits and costs, the latter driven in large part by a reduction in the high-dollar settlements that obligate most hospitals to maintain excess coverage.[4] These early favorable outcomes reinforced organizational confidence in the Michigan model, and it has proved durable for nearly 2 decades since the last malpractice insurance crisis ended.

The Michigan model was a precursor to modern communication and resolution programs (CRPs).[5] According to the Collaborative for Accountability and Improvement at the University of Washington, launching a CRP requires delivering on several commitments by health care organizations and their clinicians: (1) ensuring transparency with patients around risks and adverse events; (2) developing and implementing action plans designed to prevent recurrences of adverse events caused by system failure or human error; (3) supporting the emotional needs of the patient, family, and care team; (4) proactively and promptly offering financial and nonfinancial resolution to patients when adverse events were caused by unreasonable care; (5) educating patients or their families about their right to seek legal representation; (6) working collaboratively with other health care organizations and professional liability insurers; and (7) assessing the program's effectiveness using accepted, validated metrics. Several hundred health care organizations continue to develop and implement communication and resolution programs, and the model has been formally endorsed by major medical professional groups.[6]

The US may be in the lull before an approaching storm of medical liability, which may include unexpected patient injuries, novel legal claims, rising insurance premiums, and insurers withdrawing from malpractice markets. COVID-19 involves severely ill patients, poorly understood patterns of infection, changing standards of care, hospitals operating at or near capacity, workforces under stress, and the potential for explicit or tacit rationing of scarce resources. Whether the US enters another true crisis of availability or affordability of malpractice insurance cannot yet be known. Also because of COVID-19, fewer patients are receiving routine medical care, temporarily keeping projected future malpractice claims below both hospitals' institutional reserves and insurers' estimates of financial exposure. Many state courts remain closed for civil claims such as medical malpractice, which further reduces the pressure to resolve existing cases.

This presents an opportunity to head off the worst consequences of a hardening insurance market through clinical engagement involving physicians, health systems, and patients. Applying communication and resolution program principles during the pandemic could both improve quality of care and avert high-dollar claims, which in turn could potentially reduce medical malpractice insurance costs. Structured communication, including via telehealth, could convey the uncertainty clinicians face in determining what care might and what care should not be deferred during the pandemic, as well as the potential consequences of delay. When outcomes related to COVID-19 are less than desirable, transparency helps temper the unrealistic expectations that contribute to malpractice claims and substitutes compassion and shared purpose. These applications also demonstrate the critical connection between pretreatment patient-physician communication (informed consent), a universally accepted ethical obligation, and communication following unanticipated care outcomes. Should the combination of COVID-19–related claims and global economic contraction significantly reduce insurance capacity, preparing for a pandemic-induced malpractice crisis by embracing these principles could confer more durable benefits on hospitals, physicians, and patients than merely demanding greater protection from litigation.

ARTICLE INFORMATION

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