Memorandum

To: Board of Directors
   Council Officers

From: Chad Darling, MD, FACEP
       Subcommittee Chair for Medical Malpractice Research

       Vik Bebarta, MD, FACEP
       Co-Chair, Research Committee

       Alan Jones, MD, FACEP
       Co-Chair, Research Committee

       Hans House, MD, FACEP
       Board Liaison

Date: December 31, 2013

Subj: Research on Cost of Medical Liability for Emergency Medicine

A Research Committee objective was to develop a strategy for research assessing the cost of medical liability as it relates to defensive medicine in Emergency Medicine (EM).

In October 2011, the Board approved the Research Committee’s recommendation to convene a group of content experts to determine the feasibility, funding, design, and potential partners for a study to assess the impact of medical liability/defensive medicine on emergency medicine (Attachment A).

After convening a group of content experts via a conference call, the group determined that we would be able to address the questions adequately by e-mails and conference calls. Attachment B provides background information elicited from the content experts regarding emergency medicine malpractice/defensive medicine, including recommendations.

In April 2012, the Board concluded that the original proposed study (with a potential cost of $200,000) to determine the cost of defensive medicine was unnecessary. However, the Board believed this issue was still important to members and directed the Research Committee and Medical- Legal Committee to look at the following:

- Of the $25M in the Affordable Care Act (ACA) for defensive medicine pilot projects, are emergency medicine issues currently in any of these projects?
- The Board believes that changing physician behavior, particularly in terms of ordering tests, was critical. What research is necessary to determine the key liability reform and other factors/elements that will change physician behavior?
- In relation to research or studies, could the Emergency Medicine Foundation (EMF) or the Emergency Medicine Action Fund (EMAF) help in the funding of key research initiatives?
Members of the Research Committee and Medical-Legal Committee as well as EMF concluded that a reasonable next step in addressing defensive medicine would be to examine the efficacy of various tort reforms to see what impact they have had on the practice of medicine and specifically emergency medicine.

**Proposed Recommendations**

1. Members of the Research and Medical-Legal Committees continue to collaborate by examining the current literature and writing a paper detailing the various tort reforms that have been enacted. Specifically the efficacy of these reforms will be studied as they relate to cost of malpractice premiums, access to specialists, and defensive medicine practices and where possible, the impact of these reforms on emergency medicine will be highlighted.

2. The information from the paper will be provided to the ACEP Board for review and the Research and Medical-Legal Committees can use this information as a guideline to potentially inform research projects in this area of specific interest to emergency medicine. This research could potentially be supported through the involvement of the EMF.

In September 2012, the Board approved the development of a paper and to use this information as a guideline (Attachment C). The Research Committee’s paper (Attachment D) addresses:

- First generation tort reforms to assess their impact on the medical-legal climate;
- Second generation innovative approaches to medical liability;
- The Affordable Care Act funds for defensive medicine projects in emergency medicine; and
- Research necessary to determine key liability reform and other factors that will change physician behavior.

The Medical-Legal Committee’s comments on the paper are included in Attachment E. These comments will be integrated into the Research Committee’s paper, but are kept separate as additional informational items for the purpose of the Board’s review. Based on the information in the paper, potential areas where ACEP might consider supporting research in medical liability or provide education about medical legal issues for ACEP members are listed below.

**Some Considerations for the ACEP Board of Directors**

- **Improve and organize the medical-legal section on the ACEP website.** The current medical legal information on the ACEP website is limited and provides little education for members. For instance, there are many excellent reviews that summarize both first and second generation reforms that could be provided on the website. It might also be helpful for members to have access to an up-to-date list of malpractice law summaries for all states (e.g., statute of limitations, limits on attorney’s fees, caps on damages, etc.). Such summaries are already available and could be kept current by the Medical - Legal Committee. In particular, if ACEP members are better educated about innovative reforms they may be more likely to encourage these strategies in their own healthcare systems.

- **First generation reforms, including caps on damages, have only improved the medical legal climate for physicians to a limited extent. ACEP could consider publicizing and supporting efforts that look at innovative reforms such as early error disclosure/apology and safe harbor projects.**
- The Texas reforms have had a considerable impact on the medical legal climate in that state. **ACEP could consider partnering with Texas ACEP or the Texas Medical Association to study liability reform efficacy as it relates specifically to emergency medicine in that state.**

- The Emergency Medicine Foundation (EMF) currently accepts grant applications studying medical liability research through their Health Policy and Career Development grants. **ACEP could consider discussing with EMF leadership whether it is worth soliciting applications that directly address patient safety and medical liability** (e.g., innovative procedures for tracking patient safety incidents in emergency departments).

Please review Attachment D and Attachment E and submit your comments to staff liaison Marjorie Geist, RN, PhD, CAE, by Friday, February 7, 2014. The paper will be available in sections of ACEP’s Web site covering medical legal, advocacy, and research topics.
Memorandum

To: Board of Directors
   Council Officers

From: Chad Darling, MD, FACEP
      Subcommittee Chair, Research on Medical Liability

Edward C. Jauch, MD, FACEP
Chair, Research Committee

Date: September 29, 2011

Subj: Research Strategy for Assessing the Cost of Medical Liability

Recommendation

That the Board of Directors approve the proposed research strategy of convening a group of interested parties and content experts to determine the feasibility, funding, design and potential partners for a study to assess the impact of medical liability/defensive medicine on emergency medicine.

Background

An objective of the Research Committee was to work with the Medical-Legal Committee to develop a strategy for research assessing the cost of medical liability.

To ensure that resulting projects yield maximum benefit to the ACEP membership and advance patient care, the consensus of the Medical-Legal Committee was that additional data were required before developing specific research on the cost of medical liability. Their rationale/concerns included:

- There is no simple way to estimate/quantify the costs of defensive medicine due to the number of variables and lack of rigid science;
- If ACEP could establish reasonable data it would not be sufficient to move the needle toward more effective medical liability reform or meaningfully influence policy decisions, resulting in less than optimal impact;
- Only if there is a radical change in marrying access to care with liability reform would there be substantive change in physician behavior;
- Being in a state with a cap on non-economic damages or a standard of liability greater than “more likely than not” will not change physicians’ practice patterns of diagnostic testing, evaluation, consultation or admission decisions---if it won’t change physician behavior it won’t lower health care costs:
  - Behavior changes when there is no liability (legal, professional or social).
  - As long as a near zero miss rate is essential to avoid litigation, physicians will feel compelled to consider every test as a way of protecting themselves from the grief and cost of the liability system.

The Academic Affairs Committee identified the following barriers to medical liability research:
Research Strategy for Assessing the Cost of Medical Liability
Page 2

- Long-life cycle of medical liability cases;
- Under reporting of incidents; and
- Lack of standard definitions/measures.

The Research Committee recommends that a group of interested parties (including ACEP members from the Medical-Legal Committee and Research Committee) and content experts be convened to:

1. Identify an optimal research strategy focusing on medical legal risk and defensive medicine in EM.
2. Determine the feasibility and costs of conducting either a study related to defensive medicine costs or a more focused project in this domain.
3. Identify partners who may assist with the development and/or implementation of such a study.

This meeting would be convened pending funding from either ACEP or another funding agency or organization. See Attachment A for an overview, key questions, recommendations to convene a group, and reference citations.

**Prior Board Action**

None

**Fiscal Impact**

The cost of funding a 1.5 day meeting at ACEP headquarters would range from $7,795 to $12,445 (excluding staffing hours/benefits and overhead).

<table>
<thead>
<tr>
<th>ACEP Members (6 committee members and 1 BOD Liaison)</th>
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<tbody>
<tr>
<td>Airfare: $475 x 7 = $3,325</td>
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<td>Per Diem: $75 x 7 x 2 days = $1,050</td>
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<td>Hotel: $150 x 7 x 1 night = $1,050</td>
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<th>Catering</th>
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<td>Lunch $14 x 15 x 2 days = $420</td>
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<td>Breakfast $10 x 15 x 1 day = $150</td>
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<td>Snacks/Beverages x 2 days = $400</td>
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<td>Dinner $70 x 20 = $1,400</td>
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**Subtotal = $7,795**

If paying for other attendees (6 content experts):

| Airfare: $475 x 6 = $2,850 |
| Per Diem: $75 x 6 x 2 days = $900 |
| Hotel: $150 x 6 x 1 night = $900 |

**Subtotal = $4,650**

**TOTAL = $12,445**
Background

Estimates of defensive medicine costs nationally range from $45.6 billion\(^1\) to 10% of total healthcare costs ($200 billion) annually. There are no estimates specific to EM.

Like other specialties EM appears to practice defensive medicine at a high degree. A 2010 survey conducted by the ACEP Medical-Legal Committee found that almost 90% of respondents reported they practiced defensive medicine, and half felt that it influenced their management more than 25% of the time. This same survey indicated that medical legal issues are of significant interest to the ACEP membership.

A survey published in *JAMA* of a mixed group of Pennsylvania physicians found that 93% of physicians practiced some form of defensive medicine. In that same survey 70% of emergency physicians admitted they *often* ordered tests that were not medically indicated as a result of defensive medicine\(^2\).

Defensive medicine influences diagnosis more than treatment\(^3\), and the fear of malpractice has been associated with increased diagnostic testing and higher hospitalization rates of low-risk acute coronary syndrome patients\(^4\). Defensive medicine fears in EM may also be greater than actual medical-legal risk\(^5\).

It is unclear what effect tort reform would have (or has had) on medical-legal and defensive medicine costs\(^6,7\). For instance, Florida has seen no reduction in costs since tort reform passed, but reform may have resulted in improved physician supply\(^8\).

The content expert group addressed the following issues regarding conducting medical malpractice/defensive medicine research:

A. **Study Feasibility:** Obtaining an estimate of the cost of defensive medicine in EM on a national scale would be feasible. However, there was debate about the utility of obtaining such a cost estimate. The official position of ACEP’s Medical Legal Committee is that such a number may not be useful in influencing the tort-reform debate whereas others believe that it would serve as an invaluable first step in stimulating research in this area.

B. **Potential Design:** The likely overall design of this study would be to combine estimates of the prevalence of defensive medicine practices in each state with administrative (claims) data detailing the utilization (cost) of medical services for emergency care. There are obvious limitations to the reliability of this estimate as utilization of services occurs for many reasons other than defensive medicine.

C. **Estimated Cost:** The most significant factor that would drive the cost of such a study would be the cost of acquiring the claims data. The cost would be further increased if the study is conducted through a university which is required to cover overhead. In this case we estimate this would cost 200K to carry out over a 1-2 year period. A potential more cost-effective way to get this research done would be to partner with a health policy researcher(s) with an established infrastructure who would act as a consultant (not through a university).

D. **Identifying the partner:** There are several content experts that may be able to carry out this research. These potential research partner(s) could be chosen by the Research Committee or alternatively the Emergency Medicine Foundation (EMF) could issue a onetime request for applications (RFA) to solicit applications, review them, and select the partner (EMF currently supports a 50K Health Policy Research grant).
Recommendations/Comments

1. Obtaining an estimate of the cost of defensive medicine that is specific to EM is feasible. The utility of this measurement is debatable. The Board may be better positioned to judge the merits of such a measurement as it relates to tort reform efforts.

2. The costs to fund such a study would be significant and need to be considered by the Board when assessing feasibility.

3. If the decision is to fund this research then the EMF would likely be the best choice to direct this effort.

References

5. Carrier ER, Reschovsky JD, Mello MM, Mayrell RC, Katz D. Physicians' fears of malpractice lawsuits are not assuaged by tort reforms. Health Aff (Millwood);29:1585-92.
Memorandum

To: Board of Directors
   Council Officers

From: Chad Darling, MD, FACEP
       Subcommittee Chair for Medical Malpractice Research
       Edward C. Jauch, MD, FACEP
       Co-Chair, Research Committee
       Alan Jones, MD, FACEP
       Co-Chair, Research Committee

Date: September 25, 2012

Subj: Research on Cost of Medical Liability for Emergency Medicine

Recommendations

1. That the Board of Directors approve development of a paper addressing the efficacy of state tort reforms based on literature review.

2. That the Board of Directors approve the use of this information as a guideline to potentially inform research projects in this area of specific interest to emergency medicine.

Background

A Research Committee objective was to develop a strategy for research assessing the cost of medical liability as it relates to defensive medicine in emergency medicine (EM).

Over the last year and a half, the Research Committee, with input from members of the Medical-Legal Committee and content experts, has been examining a variety of strategies by which ACEP might address defensive medicine from a research perspective.

In October 2011, the Board approved the Research Committee’s recommendation to convene a group of content experts to determine the feasibility, funding, design, and potential partners for a study to assess the impact of medical liability/defensive medicine on emergency medicine (Attachment A).

After convening a group of content experts by conference call, the group determined that we would be able to address the questions adequately through e-mails and conference calls. Attachment B provides background information elicited from the content experts regarding emergency medicine malpractice/defensive medicine, including recommendations.

Based on discussion by the Board in April 2012 (Attachment C), the Board concluded that the original proposed study (with a potential funding cost of $200,000) to determine the cost of defensive medicine was unnecessary.
However, the Board believed this issue was important to members and directed the Research Committee and Medical-Legal Committee to look at the following:

- Of the $25 million in the Affordable Care Act (ACA) for defensive medicine pilot projects, are emergency medicine issues currently in any of these projects?
- The Board believes that changing physician behavior, particularly in terms of ordering tests, was the key. What research is necessary to determine the key liability reform and other factors/elements that will change physician behavior?
- In relation to research or studies, could the Emergency Medicine Foundation (EMF) or the Emergency Medicine Action Fund (EMAF) help in the funding of key research initiatives?

A 2010 survey conducted by the ACEP Medical-Legal Committee found that almost 90% of respondents reported that they practiced defensive medicine, and half believed that it influenced their management more than 25% of the time. This same survey indicated that medical legal issues in general are of significant interest to the ACEP membership.

Members of the Research Committee and Medical-Legal Committee, as well as EMF, concluded that a reasonable next step in addressing defensive medicine would be to examine the efficacy of various tort reforms to see what impact they have had on the practice of medicine and specifically emergency medicine.

**Proposed Recommendations**

1. Members of the Research and Medical-Legal Committees continue to collaborate by examining the current literature and writing a paper detailing the various tort reforms that have been enacted. Specifically, the efficacy of these reforms will be studied as they relate to cost of malpractice premiums, access to specialists, and defensive medicine practices and where possible, the impact of these reforms on emergency medicine will be highlighted.

2. The information from the paper will be provided to the ACEP Board for review and the Research and Medical-Legal Committees can use this information as a guideline to potentially inform research projects in this area of specific interest to emergency medicine. This research could potentially be supported through the involvement of EMF.

**Prior Board Action**

October 2011, approved convening a group of content experts to determine the feasibility, funding, design, and potential partners for a study to assess the impact of medical liability/defensive medicine on emergency medicine.

**Fiscal Impact**

None beyond budgeted committee and staff time.
Tort Reform and Medical Liability in Emergency Medicine

PURPOSE:
For a number of years there have been calls for medical liability reform from the medical community that views the current medical liability system as being dysfunctional. Some reforms, such as monetary caps on damages, have been enacted, and some ‘innovative’ reforms have been proposed. The 2010 survey data from ACEP’s Medical-Legal Committee supports the notion that medical liability issues are important to ACEP members. The purpose of this report is to:

1. Examine various ‘first-generation’ tort reforms to see what impact they have had on the medical-legal climate.
2. Highlight some innovative (second-generation) approaches to medical liability.
3. Determine if the $25M in the Affordable Care Act (ACA) funds for defensive medicine pilot projects involved emergency medicine in any specific way.
4. Discuss the following point: ACEP believes that changing physician behavior, particularly in terms of ordering tests (defensive medicine), was important. What research is necessary to determine the key liability reform and other factors/elements that will change physician behavior?

SUMMARY

1. Impact of First-Generation Tort Reforms (See Section C below)

First-generation medical liability reforms include measures such as caps on damages, collateral source rule reform, limits on attorney’s fees, periodic payment of damages, pre-trial screening panels, and statute of limitation reforms among others. Despite the fact that many states have enacted many of these reforms, only caps on damages (usually non-economic damages) have clearly demonstrable effects. Most notably they have decreased premiums; they may decrease defensive medicine in some areas, and appear to increase physician supply. Other reforms are often ‘packaged’ with some form of damage caps and therefore are difficult to study in isolation. Moreover, there is no substantial evidence that the current medical liability system (with or without reforms) has increased patient safety or the quality of care provided. It is also unclear what effect tort reform would have (or has had) on medical-legal and defensive medicine costs overall. Florida has seen no reduction in costs since tort reform passed. However, one estimate of the savings that would result from tort reform are $54 billion nationally, and others have estimated that tort reform may decrease state healthcare expenses by 3-4%, and has been shown to influence the rate of neurologic imaging in the ED for head injury.

From the physician’s perspective, Texas, which passed liability reform in 2003, deserves special mention as an example where liability reform appears to be having a particularly demonstrable effect. The constitutionality of these reforms has been challenged in court and has been ruled to be constitutional. The cornerstone of the Texas reforms is a cap of $250,000 dollars on non-economic damages. Since that time, the Texas Medical Association has reported a number of positive developments including: 1) A record number of new physician licensures in 2012; 2) physician growth that has outpaced population growth for every year since 2007; 3) a 46% average reduction in insurance premiums since 2003; and 4) $100 million dollars of savings each year by Texas hospitals due to reduced insurance premiums.

However, the overall effect of first-generation reforms remains limited in scope. At least one study has demonstrated that physicians have an ongoing fear of malpractice regardless of the medical liability climate of the state in which they live. Moreover, medical liability reforms remain politically difficult to enact and several states have recently determined that caps on damages are unconstitutional.

2. Innovative Approaches to Medical Liability (See Section D below)

There are many innovative ideas that have been proposed to change the manner in which cases of medical error and liability are handled. Some of these approaches do not represent true reforms of the current system, but rather propose new strategies that would significantly reduce the need to access the traditional medical liability system altogether. Some examples include administrative compensation systems, the creation of victims’ compensation funds, ‘apology’ laws/early error disclosure and compensation systems, and safe harbor
Tort Reform and Medical Liability in Emergency Medicine

statutes. These strategies have many advantages over traditional reforms as they may improve the quality of care
(safe harbor), decrease the time and expense it takes for a plaintiff to receive compensation, and improve patient-
provider communication around a particular adverse event. These approaches may also be somewhat more
politically acceptable whereas many traditional reforms are intensely debated.

3. Agency for Healthcare Research and Quality (AHRQ) and Affordable Care Act Pilot Projects (See
Appendix 1)
http://www.ahrq.gov/qual/liability/

- AHRQ administered several grants to states and/or health systems
- $25 million allocated in 2010 to support these projects- None of these projects have specifically targeted
emergency medicine
- Funding earmarked for projects that improve patient safety, decrease defensive medicine, and address liability
reform
- 7 planning grants and 13 demonstration grants were made in 2010 to investigate patient safety and a range of
innovative reforms
- The health reform bill authorized an additional $50 million dollars for demonstration projects but these appear
to not have been funded to date.

4. Strategies to Change Physician Behavior and Reduce Defensive Medicine

First-generation reforms such as caps on damages have had a very modest, if any, impact on reducing the practice
of defensive medicine. Strategies to reduce defensive medicine might include broader reaching liability reform,
greater acceptance of safe harbor rules, and better ways to embed evidence-based medicine decision support into
clinical practice, among others. This latter idea has been demonstrated by research that studied the effectiveness
of decision rules embedded into electronic order entry systems in the ED. Moreover, a recent study of a safe
harbor demonstration project in Oregon found that greater adherence to evidence based medicine reduced
healthcare expenditures by impacting physician ordering practices. This type of information should be widely
available to ACEP members so they may participate in, and support, efforts such as these in their own states and
medical centers.

Medical Liability

A. INTRODUCTION: EMERGENCY MEDICINE AND MEDICAL LEGAL RISK

Emergency medicine (EM) has been identified as a high risk medical specialty with regard to medical liability. There
are several reasons for this including the high acuity of patients, lack of an established provider-patient relationship,
frequent handoffs, hospital/ED crowding, and the fact that diagnosis and treatment is often difficult due to limited
clinical information. This risk is illustrated by the fact that by the age of 65 at least 75% of EM physicians will have
faced a claim.

The 2010 ACEP Medical-Legal Committee survey found that nearly 90% of respondents reported they practiced
defensive medicine, and half believed that it influenced their management more than 25% of the time. Moreover, a
survey published in JAMA found that 70% of EM physicians admitted they often ordered tests that were not medically
indicated as a result of defensive medicine. The fact so many providers feel a need to practice defensive medicine in
response to real or perceived medical legal risk likely explains why EM practitioners have a negative perception of the
medical liability system. It follows that many would welcome meaningful tort reform. Currently ACEP endorses
federal laws, state legislation, or constitutional amendments to implement tort legal reforms, including but not limited
to the following:
B. THE CALL FOR MEDICAL LIABILITY REFORM

Webster’s dictionary defines a tort as a ‘wrongful act that injures another and for which the law permits a civil (noncriminal) action to be brought. The rationale for why a tort system should exist are to: 1) provide reasonable and prompt monetary compensation for injury; and 2) deter negligent or substandard conduct. However, with regard to medical liability the tort system is a contentious topic with medical providers, insurance groups, patients, and those in the legal community often at odds as to how to address shortcomings in the current system.

Physicians’ groups and insurers have several complaints regarding the medical legal environment including that: 1) the current system encourages costly defensive medicine practices (over-ordering of tests or avoidance of high risk patients/procedures in order to avoid a lawsuit); 2) it may decrease physician supply as a result of providers moving to avoid an adverse medical-legal climate and high premiums; 3) malpractice cases without merit may go to trial; 4) jury awards are unpredictable and can be exceptionally large; 5) the system may lead to adversarial physician-patient relationships; and 6) it has not led to improved patient safety or quality of care. Lastly, the medical liability system has also been criticized for adding cost to healthcare. One estimate of the cost of the entire medical liability system in 2008 dollars was $55.6 Billion. However, this estimate may be low as some have estimated the cost as high as 10% of the healthcare system or $200 Billion (Price Waterhouse 2006).

Patient advocates and the legal community also have concerns about the current system, including: 1) it is much too difficult for patients to gain prompt access to the legal system; 2) patients may not be told of medical errors out of fear of lawsuits (lack of transparency); 3) legal outcomes of medical legal cases are unpredictable; 4) the system does not award damages efficiently (five years on average); and 5) traditional tort reform efforts, such as limitations on pain and suffering awards, may adversely impact victims of medical errors.

Medical liability reform efforts have been categorized into two broad categories termed first-generation reforms and second-generation reforms. First-generation reforms were initially enacted in the 1970’s (and later) in response to insurer and provider concerns to reduce the severity and frequency of claims. A notable example of a first-generation reform includes California’s Medical Injury Compensation Reform Act (MICRA) statute that capped noneconomic damages. In contrast, second-generation innovations are aimed at modifying and improving the procedures by which medical injuries are disclosed, disputed, and resolved. Examples of second-generation innovations include apology laws, disclosure and offer systems, and health courts.

C. FIRST-GENERATION MEDICAL LIABILITY REFORM EFFORTS

1. Caps on damages

Monetary caps on damages are the most common and widely discussed type of tort reform. There are 3 main categories of potential damages related to medical malpractice cases. The first is noneconomic damages which include...
awards related to pain and suffering. The second type of damage a patient may have are economic losses that relate to medical expenses and/or lost income from work. Lastly, punitive damages may be awarded in cases where providers are judged to have acted negligently or recklessly. Nearly 30 states have passed some measure of liability reform(s), with the most common reform being a cap on non-economic damages.

Of first-generation reforms, caps on damages are the most widely studied with respect to their impact on the medical legal climate. For instance, several studies have found that caps on award amounts result in modest increases (2-12%) in physician supply in specialties with the highest risk. Moreover, since Texas passed Proposition 12 in 2003, 40 counties that did not have an ED physician now have one. Several studies have demonstrated that caps reduce insurance premiums and result in lower insurance company losses compared to states without caps. However, it has been argued that caps result in an excessive burden for injured patients such as the elderly who would not have significant economic losses as a results of a medical injury.

### 2. Limits on attorney’s fees

Over 25 states limit, or reserve the right to review, what fees an attorney may receive in the setting of a malpractice case. In theory, statutory limits on attorney’s fees should decrease the incentive that attorneys have for pursuing medical legal cases. The way in which fees are limited varies from state to state. For instance, in Tennessee the fee may not exceed one third of the overall award. In California, a sliding scale percentage fee exists that decreases as the damages awarded increases. Lastly, some states allow or require the court to determine if attorney fees are reasonable.

It is difficult to know what effect fee limits have had on the number of cases brought forward. These fee limitations often do not exist alone but rather are incorporated into other medical legal legislation such as in the case with California’s MICRA laws. Currently the available evidence would suggest that limits on fees have not resulted in significantly decreasing the number of claims filed, decreased premiums, or an increase in physician supply.

### 3. Joint and several liability reform

**Joint liability** refers to the situation where all defendants are equally responsible for damages up to the full amount requested by the plaintiff. **Several liability** refers to the situation where each defendant is only obligated to pay for damages as they relate to their actual responsibility in the case in question. In a situation where joint and several liability (JSL) exists a plaintiff may pursue all damages from any one defendant and it is up to the defendants to sort out the proportion of responsibility. This may lead to situations where a plaintiff may seek damages from the plaintiff with the most financial resources regardless of fault. States differ on how JSL is handled in tort cases. Most states have either modified or abolished JSL. There is mixed evidence as to whether or not these reforms have decreased the number of claims filed, and it does not appear that JSL reform increases physician supply or quality of care.

### 4. Certificate of merit

Many states require that when filing a case of medical malpractice the plaintiff’s attorney must have had the medical facts reviewed by a medical expert who believes that the case has sufficient merit to move forward in the legal process. As with many other reforms, the hope is that meritless cases would be less likely to move forward if a certificate of merit process is in place. Currently, over 30 states have some form of required pre-trial screening process in place. There is little to no evidence regarding what effect certificate of merit reform has had on frequency of claims, physician supply, quality of medical care, or lower medical liability insurance premiums.

### 5. Collateral source rule reform

**Collateral source rule (CSR)** reform would address the situation where a plaintiff would attempt to obtain damages that have already been paid by another source. For instance, if an individual has suffered from a medical related injury and a portion of their damages have been paid by insurance, then under CSR reform the injured individual would not be able to ask for duplicate payment of those damages as a result of their lawsuit against the medical providers. Some have argued this may be unfair because it punishes people who had the foresight and means to obtain insurance;
6. Periodic payment of damages

Periodic payment of damages allow for payment of damages to a plaintiff to be done over a court defined period of time (years) rather than in a lump sum. Spacing out payments protects the defendant from paying large lump sum amounts for damages that account for future losses such as medical costs, lost earnings, and inflation. Periodic payments would prevent plaintiffs from benefiting from large sum inheritances if the injured patient died prematurely. It would also prevent large fluctuations in insurance company expenses and reduce costs. Periodic payment of damages has been enacted in 30 states. Some states provide this as an option for medical liability cases that either party can request; other states require periodic payments for all cases. The minimal amount of damages required for periodic payments to be enacted vary from state to state with amounts ranging from $50,000 to $250,000. Some states do not have set values and will instead require periodic payments based on the assessment of the courts.

There have been few studies examining the efficacy of periodic payments on changing the costs of healthcare. A few studies have looked at the effect of periodic payments on claim payments and have found no significant reduction in payment amounts. Moreover, there is no conclusive evidence that it reduces claim frequency. There have been only two studies that have looked at the effects of periodic payments on decreasing liability insurance premiums. Both studies had limited findings as one study found no significant changes in periodic payments and premium costs, while the other study showed varied results in different medical fields.

7. Statute of limitations reform

Statute of limitation reform limits the amount of time that a plaintiff has to file a claim related to a medical malpractice injury. The logic behind this reform is that as time passes the details regarding a particular medical legal case become less clearly recalled and this makes the litigation process much more difficult. This reform also helps insurers better predict their costs. A majority of states (over 30) have statute of limitation rules in place. The effect that statute of limitation reforms have had on the medical liability system have been examined in a number of studies. In theory, it would seem logical that they would decrease the frequency of claims but studies in this area have been mixed. These reforms may also reduce premiums by reducing insurance company costs. An expert review has concluded that there is no effect on defensive medicine, quality of care, or physician supply.

8. Pretrial screening panels

Pre-trial screening panels operate to settle legitimate claims and remove speculative suits before they are filed. In some states, these panels are mandatory. Screening panels are not required to follow formal rules of evidence. Once the panel has rendered its decision, the case can proceed to jury trial, and the panel’s conclusions can be introduced as evidence in a court of law. Many note that pretrial screening panels likely increase the number of suits because their “rules of evidence are less stringent than in a formal legal proceeding.”

Recognizing that panels may indeed increase the number of claims filed, other experts have stated that panels can decrease the number of claims leading to suits by screening out frivolous cases “in which negligence cannot be proven”. Pre-trial screening panels have been enacted in roughly 20 states. Some states, such as Maine, have been using mandatory pre-trial screening to reduce the number of court cases for over 20 years. In Maine, settlement time...
Tort Reform and Medical Liability in Emergency Medicine

is approximately half that of states without pre-trial screening and 84% of malpractice claims end in no payments.\textsuperscript{40} The use of pre-trial screening reduces Maine’s rate of cases going to trial to only 2.5% as compared to a 7% trial rate in the neighboring state of New Hampshire prior to their enacting a pre-trial screening law in 2005.

A 2008 AMA study showed that pre-trial screening panels reduced malpractice by 20%.\textsuperscript{40,41} The efficacy of pre-trial panels is best when the use of panels are mandatory, as seen in Maine. Some states, such as Nevada and Virginia, have stopped or repealed their laws. Causes for repealing these panels include the lack of both parties participating in states where pre-trial screening panels were optional. If both parties do not participate in the process then the decision made by the panel is nullified. Furthermore, in some states where the pre-trial panels are not adhered to they can create undue delay to the judicial process.\textsuperscript{40}

9. Expert Witness Standards

Tort law in many states requires a “physician expert’s statement of negligence and deviation from the standard of care in order to initiate a lawsuit.”\textsuperscript{42} Both the plaintiff and the defendant can hire expert witnesses to testify on their behalf during a medical malpractice suit.

This is an area where physicians can directly impact the medical liability system as expert witnesses. Early on, many recognized the lack of standardization and oversight of those appointed as “expert witnesses.” Consequently, the judicial system formulated the Federal Rules of Evidence thereby allowing the judge to determine the admissibility of expert witness testimony based on current scientific method and principles, and dismiss statements based on unsupported speculation.\textsuperscript{42}

Furthermore, many specialties, and some state legislatures, have since worked to devise guidelines that would qualify a physician as an expert witness for that given specialty (board certified in that specialty, practicing for >5 years in that same state, no more than 20% of their income should come from expert witness testimony, etc.), as well as enact ramifications should false or unsubstantiated testimony be rendered. Some have gone as far as to propose a national Expert Witness Peer Review Program that serves as a regulatory group to standardize and supervise the qualifications of expert witnesses, as well as validate the testimonies given in court by the then approved expert witnesses.\textsuperscript{43}

The American Medical Association’s House of Delegates passed resolutions 121 and 216 stating that expert witness testimony be subject to peer review, and suggested that disciplinary action be handled by state medical licensing boards should false or speculative testimony be given by an expert witness.\textsuperscript{44} To maintain neutrality and minimize bias in the case, the expert witness physician should testify for both the plaintiff and defendant, who would share the expense of the expert witness fees, and that “the receipt of contingency fees based on a percentage of the settlement or judgment for expert witness testimony be explicitly denounced as unethical”.\textsuperscript{42} These rigorous proposals may diminish the pool of potential expert witnesses.\textsuperscript{31}

D. SECOND-GENERATION MEDICAL LIABILITY INNOVATIONS

There are many innovative ideas that have been proposed to change the manner in which cases of medical error and liability are handled in this United States. Some of these approaches do not represent true reforms of the current system, but rather propose new strategies that would significantly reduce the need to access the traditional medical liability system altogether. Some examples include administrative compensation systems,\textsuperscript{15} the creation of no-fault victims’ compensation funds, ‘apology’ laws, and early error disclosure and compensation systems,\textsuperscript{18} and safe harbor statutes.\textsuperscript{1}

1. Health Courts

Health courts involve expert panels who evaluate potential cases of medical error/injury or a specially trained judge and committee hears malpractice cases rather than the general court system. They are sometimes referred to as “No Fault” or administrative compensation systems.\textsuperscript{45} Health courts are appealing because they have the potential to eliminate large awards due to sympathetic juries. They may also compensate injured patients more quickly and with less cost to providers and patients. Moreover, they may be more appealing to providers because cases will be judged more on a deviation from standard/appropriate care than on injury a plaintiff/patient may have. These systems have
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been enacted in other countries with national health systems (e.g., New Zealand) and in more localized systems in the US (e.g. Florida Birth Related Neurological Injury Association).

2. Safe Harbor

Safe Harbor embodies the concept that if a physician practices evidence based medicine (EBM) in accordance with guidelines they would be protected from lawsuits regardless of the clinical outcome. Some theoretical positives of these systems are that they may encourage better quality medical care if EBM is practiced and reduce defensive medicine practices. Safe harbor provisions have been tried in a number of states including Connecticut, Maine¹, Minnesota², Vermont, and Florida. However, despite the appeal of Safe-Harbor provisions they have not gained sufficient traction or been used in a court case.⁴⁶ As a result, most Safe Harbor provisions that have been enacted have been repealed by state legislatures.⁹,⁴⁷ An AHRQ demonstration project (funded 2010) examined Safe Harbor protections in Oregon. The final progress report of the Oregon Safe Harbor study found an estimated savings of 5% of medical liability costs. These savings were not from a reduction in legal fees but from an improvement in care by adhering to medical guidelines.⁴⁸

3. Early disclosure, apology and offer

Early disclosure of medical errors with an apology from medical providers when appropriate has the potential to reduce medical liability.³,⁴⁹ Legally supported disclosure and apology systems are not reforms of the medical liability system per se, but instead may sidestep the medical-legal system altogether. Several states now have apology laws on the books that prevent apologies from being admissible in court.¹ There is reasonable evidence that an apology for a medical error with a frank and open discussion with the patient and/or their family may decrease the chance that a patient will file a lawsuit.⁴⁹

Some of these programs also couple disclosure and apology with an early offer of fair compensation to those patients who have been harmed.¹⁸ In some cases when this compensation is accepted, the patient gives up their right to further litigation. This type of system fosters transparency in error disclosure that may improve the physician patient relationship. It also can reduce litigation costs by avoiding a trial altogether.

Some large healthcare systems, such as the University of Michigan, have put in place disclosure/apology/offer systems with evidence to suggest cost savings and a reduced number of claims overall.¹⁸,⁴⁹,⁵⁰ In addition, four AHRQ funded demonstration projects (New York, Illinois, Texas, Washington) were aimed at studying disclosure and apology systems.¹⁰

At the state level, Oregon recently passed Senate Bill 483 that creates a structured channel for early disclosure and discussion between patients and providers when an adverse event has occurred. The goal is to improve communication and resolve issues related to medical errors without proceeding directly to litigation. This law is comprised of 4 components: 1) Notice of adverse event - when an adverse event occurs the provider reports it to the Oregon Patient Safety Commission; 2) Discussion – Provider and patient discuss events in an established time frame by the commission. They may discuss actions to prevent further occurrences and determine whether compensation is warranted; 3) Mediation --if no resolution is met between the parties, then they may enter into mediation; and 4) Litigation – if discussion and mediation do not reach resolution, a patient can bring a civil suit for negligence.²⁰

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Appendix 1

AHRQ Demonstration Grants

Medical Liability Reform and Patient Safety

The National Advisory Council for Healthcare Research and Quality provides advice and recommendations to
AHRQ's director and to the Secretary of the Department of Health and Human Services (HHS) on priorities for a
national health services research agenda.

Demonstration Grants

The demonstration grants for Patient Safety and Medical Liability Initiative support the implementation and
evaluation of evidence-based patient safety and medical liability projects. The Agency for Healthcare Research and
Quality (AHRQ) funded seven demonstration grants for a total amount of $19.7 million.
These seven grants include a variety of models that meet one or more of the patient safety and medical liability reform initiative goals, including:

- **Reducing preventable harms**
- Informing injured patients promptly, and making efforts to provide prompt compensation.
- Promoting early disclosures and settlement, through a court-directed alternative dispute resolution model.

**Timothy McDonald, M.D., J.D., University of Illinois at Chicago, IL, $2,998,083**

The project is designed to fill the evidence gap regarding the impact on patient safety and litigation rates of programs that feature improved communication with patients, transparency, disclosure of adverse events, early offers of compensation, and learning from mistakes. It will evaluate the impact on Medical Liability Reform and Patient Safety outcomes of extending an existing disclosure program from an academic hospital setting to diverse hospitals in the greater Chicago area.

**Stanley Davis, M.D., Fairview Health Services, Minneapolis, MN, $2,982,690**

The objective of this project is to improve perinatal (the period prior to and just after birth) patient safety and demonstrate the relationship between improved patient safety and a reduction in the number of malpractice claims. The project will implement and evaluate the use of perinatal best practices in 16 hospitals to assess the impact on patient safety and the level of malpractice activity. This initiative builds on the institution's prior efforts as part of a nationwide collaborative to eliminate preventable perinatal harm.

**Eric Thomas, M.D., M.P.H., University of Texas Health Science Center, Houston, TX, $1,796,575**

The project will review the use of a disclosure and compensation model, which informs injured patients and families promptly and makes efforts to provide prompt compensation. It will identify best practices for using disclosure to improve patient safety, and disseminate best practices to serve patients' needs and improve safety for subsequent patients. The project will investigate disclosure and compensation in the UT system over a three-year period, identify best practices for using disclosure to improve patient safety, and disseminate best practices with a focus on incorporating patient and family input into efforts to understand why errors occur.

**Ann Hendrich, M.S., R.N., F.A.A.N., Ascension Health System, St. Louis, MO, $2,990,612**

This project will focus on ways of improving both the quality of perinatal (the period prior to and just after birth) patient care delivery and the way adverse perinatal events are managed in five geographically dispersed hospitals. The project will establish a uniform, evidence-based obstetrics practice model based on the idea that eliminating variation in obstetrics practice will translate to improved patient safety.

**Thomas Gallagher, M.D., University of Washington, Seattle, WA, $2,972,209**

The project creates a statewide initiative involving communication training for health care workers and a collaboration between hospitals and a malpractice insurer to improve adverse event analysis, disclosure, and compensation. The goal is to enhance the culture of health care communication in order to improve patient safety and decrease medical malpractice liability.

**Judy Kluger, J.D., New York State Unified Court System, New York, NY, $2,999,787**

This project aims to protect obstetrical and/or surgery patients from injuries caused by providers' mistakes and reduce the cost of medical malpractice through the use of an expanded and enhanced Judge-Directed Negotiation Program currently used in New York's courts, coupled with a new hospital early disclosure and settlement model.

**Alice Bonner, M.S., APRN, BC, Massachusetts State Department of Public Health, Boston, MA, $2,912,566**

The project proposes to engage clinicians, patients, malpractice insurers, and the State public health agency to ensure...
more timely resolution of medical errors that occur in outpatient practices and improve communication in all aspects
of care. The project will identify key areas contributing to ambulatory medical errors and malpractice suits in order to
redesign systems and care processes to prevent, minimize, and mitigate such errors in a group of Massachusetts
primary care practices. The project will also transform communication culture, processes, and outcomes in these
practices so that they are more patient and family-centered, particularly with respect to proactively seeking out,
handling, and learning from patients' safety experiences, concerns, and complaints.

Medical Liability Reform and Patient Safety

The National Advisory Council for Healthcare Research and Quality provides advice and recommendations to
AHRQ's director and to the Secretary of the Department of Health and Human Services (HHS) on priorities for a
national health services research agenda.

Planning Grants

The planning grants for the Patient Safety and Medical Liability Initiative give States and health systems the
opportunity to create detailed plans for patient safety and medical liability reform. AHRQ funded 13 planning grants
for a total amount of $3.5 million.

These 13 grants represent a variety of models that meet one or more of the patient safety and medical liability reform
goals, including 11 that are intended to reduce preventable medical injuries in a variety of ways. The planning grants
include:

- Supporting the development of a "Safe Harbor" for physicians who can prove they followed State-endorsed evidence-
based care guidelines.
- Promoting shared decision making
- Supporting early disclosure and offer models that inform injured patients and families promptly, and make efforts to
provide prompt compensation.
- Promoting transparency and enhanced communication between providers and patients when avoidable injuries occur.

Lynn Marie Crider, J.D., Office for Oregon Health Policy and Research, Portland, OR, $299,458
This project will develop and implement a method for setting priorities for developing evidence-based practice
guidelines, craft a broadly supported safe harbor legislative proposal that will define the legal standard of care, and
develop a plan to evaluate the effectiveness of the legislative proposal, if enacted.

Richard David, M.D., Johns Hopkins University, Baltimore, MD, $293,224
This project will develop a measurement and analysis system to monitor the quality of care at hospital discharge to
identify safety concerns and improve patient safety, and to alert Johns Hopkins leaders in real time of events that
place the health care organization at risk for malpractice claims and to identify patient safety problems.

Dianne Garcia, J.D., Multicare Health System, Tacoma, WA, $291,810
The project will develop a plan for implementing an integrated medical liability and patient safety program based on
identifying avoidable patient safety problems, and providing an acknowledgement, apology, and standardized
compensation to patients who have been harmed or their families.

Wendell Hoffman, M.D., Sanford Research, Sioux Falls, SD, $294,137
This project will develop the infrastructure for implementing a patient advocacy reporting system throughout a multi-
state, multi-facility system. This would include improving the collection of information on patients' and families'
concerns about their care and identifying the parts of the system and individual physicians with disproportionate risk
for unsafe care and possible lawsuits.
Elizabeth Guenther, M.D., M.P.H., University of Utah, Salt Lake City, UT, $299,994
This project will implement and evaluate a system-wide evidence-based, ethical, and legally sound policy on disclosing safety issues and other unanticipated outcomes of care. The goal is to develop a standardized protocol that will be used for disclosure of these events to patients and their families.

Karen Domino, M.D., M.P.H., University of Washington, Seattle, WA, $295,837
This project will develop and implement patient-friendly shared decisionmaking tools and processes for patients undergoing orthopaedic surgery in the University of Washington Health Care System. Shared decisionmaking improves patient safety by enhancing patient understanding and empowering patients to actively participate in the care.

David Baker, Ph.D., Carilion Medical Center, Roanoke, VA, $280,924
The project examines how improved teamwork—through better communication among providers, patients, and patients' families—can improve the quality of obstetrical care and patient safety and reduce risk and liability claims.

Kenneth Sands, M.D., M.P.H., Beth Israel Deaconess Medical Center, Boston, MA, $273,782
The main goal of the project is to develop a roadmap for implementation of a "disclosure-and-offer" patient safety initiative in Massachusetts, which may be applicable to other states. The ultimate goal is to create a new medical liability system that improves patient and provider trust, reduces fear, and improves patient safety.

Nicoletta Tessler, M.A., Psy.D., Jackson Memorial Hospital, Miami, FL, $299,576
This project will develop and pilot a model to reduce patient suicides and suicide attempts at its health system by focusing on staff training, patient care, environmental safety, and incident reporting. The project is also designed to gather information through surveys and focus groups from internal and external stakeholders to generate recommendations of how medical liability can be restructured to improve the production and use of information about quality and safety.

Cynthia Shellhaas, M.D., M.P.H., Ohio State University, Columbus, OH, $187,437
This project will plan an effective statewide pregnancy-associated mortality review ("PAMR") system in Ohio and develop comprehensive, coordinated statewide recommendations with short- and long-term, evidence-based interventions focusing on patient safety to address maternal mortality and disparities. PAMR is a good example of a process where a focus on patient safety and prevention of adverse events could lead to improvement in both health care system operations and clinical care. This could, in turn, decrease the potential for medical liability claims.

John Buckley, M.D., Wishard Health Services, Indianapolis, IN, $154,124
The project will collect, analyze, and evaluate data regarding Wishard Health Services' Claims Management Model to promote open communication and identify risk-prone areas, ultimately increasing patient safety by removing risks early.

Cindy Lou Corbett, Ph.D., Washington State University, Pullman, WA, $298,810
This project will use stakeholder focus groups to design best practice medication risk management systems that can be integrated into transitional care. Upon successful completion, researchers expect to demonstrate that they can integrate medication risk management efforts into transitional care models to maximize safety, quality, and cost-effectiveness while reducing medical liability.

Steven Crane, M.D., NC State/Department HHS, Raleigh, NC, $297,710
The goal of this project is to better understand the barriers, facilitators, and results of implementing a near-miss reporting and improvement tracking system in primary care. This project will also explore the potential of using near-miss events to increase providers' confidence and experience disclosing errors to patients, and to determine whether these disclosures decrease the likelihood that patients seek legal advice and file malpractice claims.
Notes on the Medical Liability and Tort Reform Paper for the ACEP BOD

First Generation Medical Liability Reform Efforts:

**Caps on Damages:** While there is little evidence at this point to suggest that this type of tort reform indeed decreases the practice of defensive medicine, these behaviors and attitudes are highly ingrained. They are particularly problematic for those physicians who have experienced a lawsuit or have had close friends or associates who have. So it is premature to throw this out as a means of cost savings in this regard.

Additionally, the escalating and disproportionate awards, relative to the injury, need to be made more predictable and fair for all parties. While it is true that physicians carry liability insurance, it is generally for $1M to $2M per event. Awards over that put the physician’s home and accumulation of wealth from a lifetime of hard work and sacrifice in jeopardy.

An award that “makes the victim whole” includes all economic damages. Allowing for an award of non-economic damages (i.e., pain and suffering) beyond that may be warranted. But when multi-million dollar non-economic judgments are handed down, with no predictability and excessive amounts, there is a problem. And in law, once a precedent is set, such as an award that once seemed extreme, others are sure to follow, and more reasonable amounts become increasingly less common.

Finally, there is absolutely a reduced cost to the system in terms of liability insurance costs. In an era in which we worry about hospital and emergency department closures, a savings of $100M to a hospital may represent the tipping point in remaining open or shutting its doors forever. In this way, it could potentially be an access to care issue.

**Resources for Members on ACEP Website:**
I agree that this can be better and more useful. My suggestions are as follows:

1. There are a lot of ACEP publications that can be organized by general topic within the legal area for ease of searching and browsing on the ACEP website.
2. There are great resources on legal rules in each state (such as statute of limitations, type of expert who can testify, caps on damages, joint and several liability, and the like). We ought to have an easily accessible place for College members to find this information. Once established, it needs to remain up to date. Information on this may be gathered by and maintained by our D.C. advocacy staff.
3. There should be monthly articles on legal topics that are useful and of interest to College members through the new ACEP Now. I understand that the format for this publication will be changing in 2014, so perhaps this can be a regular feature.

**Limits on Attorneys Fees:** Even in liability cases, as a College we ought to be advocates for our patients. The attorney is playing an all-or-none game with our system of contingency fees and takes this big risk because, in part, of the possibility of a big reward. However, when he or she takes up to a third of an award (after expenses, mind you), it often leaves the injured patient short of that truly needed.

So the argument by the Plaintiffs’ bar, in an effort to derail or repeal limits on non-economic caps, is that these awards are required to give the patient what he or she needs for compensation, while still allowing the attorney to earn a living. But it is also a strong incentive for the attorney to fight for higher and higher awards. In our current system, and given human nature, this is a natural result. For example, on a $1,000,000 case, let’s say that expenses totaled $200,000. That is taken off the top. Suppose again, that the attorney was limited to 30%. That’s still $240,000 for one case, plus the $200,000 in deducted expenses, leaving the patient with a mere $560,000. It seems reasonable to set limits and still reward an attorney for taking the risk of losing money, while at the same time protecting the awards for patients.

There may not be evidence yet of a reduction in frivolous lawsuits for a couple of reasons. First, there are many attorneys who practice only personal injury law, and it would be very difficult to change areas of law and/or continue
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Chair, Medical Legal Committee  

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to enjoy their current income level, so it may take some attrition and weeding out of the field. Regardless, limiting fees will still allow attorneys taking cases with merit to earn an excellent living, give the patient the monetary damages they require, and avoid putting the physician at such high risk of losing personal assets. Second, most of the limits continue to allow quite a windfall for the attorney, as noted in the above example. Finally, there is a large plaintiffs’ bar, and this is their livelihood. They will not take these changes without a big fight, in a way that is similar to our fight for an SGR fix.

Periodic Payment of Damages: As mentioned before, our primary advocacy efforts must always start with our patients. There may be scant evidence that this benefits the EP directly in terms of decreased claims, decreased malpractice insurance costs, and the like, but it is generally viewed as a good thing for the patient in terms of managing any bad outcome over time.

And again, sometimes these reform efforts do not realize immediate benefits, but if they change the culture of medical malpractice over time, it will be a win-win for emergency medicine and our patients. This, along with other reforms such as eradicating joint and several liability, is something that should definitely be pursued and defended by the College.

Statute of Limitations: These are necessary to add predictability, allow for adequate fact gathering, and to allow for financial planning on the part of insurance carriers. I would not expect this to decrease defensive medicine or change provider supply. Still, it is something that should be expected in every state.

Pre-Trial Screening Panels: Maine is a great example of how effective this can be if properly implemented. This ought to be an example for other states pursuing tort reform.

Expert Witness Standards: A bigger issue not raised is that some states allow experts from various specialties to provide expert testimony about the standard of care of EPs. This means that the EP is held to the standard of every specialist, which is unreasonable and not necessarily reflective of the true standard of care. Less than half the states currently require that the testifying physician be of the same specialty as the defendant physician.

Another point made is that it is unethical to accept payment on a contingency fee basis. Without such a rule, the expert has a conflict of interest. Expert fees are costly, so procuring an expert puts “some skin in the game” for the plaintiff attorney, and in theory allows the expert to look objectively at the case and reach a conclusion based upon the known facts and literature/standard of care at the time of the incident.

One can argue, however, that with the very lucrative fees demanded and offered, the expert is already biased, and that he or she may wish to please the employing attorney by advocating for one side or the other. This is why other expert witness laws such as minimizing the percentage of time a physician may engage in this work, or requiring the expert physician to practice in the same state may be of value in reducing bias and allowing for more fair and predictable outcomes in medical malpractice cases.

Second Generation Medical Liability Innovations:

Health Courts: I have written on and advocated for these extensively. I agree that this should be an area of focus for tort reform. Moreover, this could be an effort at a national level, like the establishment of Bankruptcy Courts, which would eliminate the fight in 50 different jurisdictions.

This makes sense. It is a specialized area of law that is difficult to understand. There should be a professional fact finder knowledgeable in medical legal law who will decide cases, rather than very unpredictable and often uneducated juries.
Notes on the Medical Liability and Tort Reform Paper for the ACEP BOD

Further, these courts would allow for more rapid resolution of cases, benefiting both patients and physicians. There should be more predictability in awards, without runaway verdicts that continue to set precedent for higher and higher awards. Advocacy efforts would be well spent on this front.

**Safe Harbor:** This is a double-edged sword, as we well know. On the one hand, we can provide guidelines and say that it is *prima facie* evidence that the provider met the standard of care if he or she followed guidelines, regardless of outcome.

On the other hand, it could also be used *against* a provider who is exercising clinical judgment in contradiction to guidelines, yet still meet standard of care. Overall, I think it is a good thing to have guidelines in certain cases, one excellent example being early goal directed therapy in sepsis. And these guidelines are likely something that we are moving towards anyway in terms of quality measures and payment, so it is good to be onboard and to help direct this in a way that is most useful and least harmful to both patients and physicians.