Health Justice Policy Recommendations by the Center for Health Transformation

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The Current System of Health Justice is Broken

Civil justice reform or "tort reform" has often been viewed as an important component in the health reform debate. Within any health reform proposal, there should be a strong commitment to the development of a fairer, less expensive and more timely system of health justice. The reform proposal should provide conflict resolution and equity protection, while protecting the rights of individual Americans and providing a more effective and less expensive system for the American society at large.

The closures of hospitals, the limitation of high-risk procedures; the elimination of entire categories of services such as labor and delivery; and the outcry about the expense of our current litigation system are all indications that we need to rethink the way we resolve conflicts about patients' rights in our healthcare system. One of the keys to ensure success is that we must protect the rights of the individual who has a legitimate grievance, to advance patient safety and to improve overall health outcomes within the system.

The Center for Health Transformation has created this document to highlight specific initiatives which advance patient safety; provide for fair and effective compensation for individuals who have legitimate claims; establish accountability and encourage disclosure of adverse medical events; incentivize the adoption and use of best practices and standards of health delivery; promote a healthy, non-adversarial physician-patient relationship; minimize the loss of competent health professionals driven out by the high cost of litigation insurance; establish conflict resolution at a lower cost; and ensure that legitimately injured patients receive a larger share of the total settlement than their personal injury attorney.

Specific Policy Recommendations

I. Expert Witness Standards

Expert witnesses provide an essential role in determining medical negligence under the health justice system. Courts rely on expert witness testimony to establish the standards of care which are pertinent and germane to a specific medical malpractice claim. Generally, the purpose of expert witness testimony in medical malpractice cases is to describe standards of care relevant to a given case, identify any breaches in those standards, and if so noted, render an opinion as to whether those breaches are the most likely cause of injury. An expert may also be needed to testify about the current clinical state of a patient to assist the process of determining damages.

However, standards of admissibility of expert witness testimony vary with state and federal rules of procedures and evidence. Although most state laws tend to conform with federal rules of procedure and evidence, some do not. Therefore, testimony from a given expert witness may be admissible in one state but not another and in a state court but not in federal court and vice-versa.[1]

The establishment of certain minimal qualifications or standards for physicians who serve as expert witnesses will improve the quality of testimony and promote just and equitable verdicts. Therefore, developing minimal qualifications for expert witnesses in medical negligence is essential. Only physicians with legitimate genuine expertise in the area of medicine in question should be allowed to be medical experts. These expert witnesses should hold a current, valid, and unrestricted medical license in the state in which they practice medicine. They

should be certified by the relevant board recognized by the American Board of Medical Specialties or a board recognized by the American Osteopathic Association. Physician expert witnesses should be actively engaged in clinical practice in the medical specialty or area of medicine about which they testify, including knowledge of or experience in performing the skills and practices at issue to the lawsuit.

II. Development of Health Courts

The current unpredictable, inefficient and emotionally taxing health justice system fails both patients and healthcare providers. Under the current system, most patients harmed by medical error receive no compensation at all. The Harvard Medical Practice Study found that only a fraction of those who have been injured due to negligent care choose to file a claim.[2] A recent Harvard University study revealed that those who are compensated endure an average of five years of litigation before their cases are resolved, and they see more than half of their awards spent on attorney fees and other attorney-driven costs.[3] According to this study, for every dollar paid in compensation to plaintiffs, 54 cents go to attorney fees and costs. This rate is much higher than other compensation schemes such as workers' compensation, in which overhead costs amount to roughly 20 to30 percent of total costs.[4]

The lengthy process and high cost of litigation prohibits patient access to the court system because, unless the promise of a large award is likely, most lawyers will not take the case as it is simply not worth their time.[5] At the same time, nearly universal distrust of the current health justice system drives up costs – billions of dollars are spent on defensive medicine alone – and drives down quality, in part because open professional interaction essential for effective care is otherwise chilled.[6] The Institute of Medicine has noted: "Patient safety is also hindered through the liability system and the threat of malpractice, which discourages the disclosure of errors. The discoverability of data under legal proceedings encourages silence about errors committed or observed. Most errors and safety issues go undetected and unreported, both externally and within health care organizations."[7]

The current system pits patients and providers against each other--and transformative steps are needed to enhance the physician-patient relationship. Both physicians and patients need what the health justice system today is not providing: reliability. Patients need a reliable system to hold doctors accountable when there is an avoidable error, and doctors need a reliable system to protect them when they have acted within the standard of care.

What is needed is a reliable health court system. These specialized administrative courts would be designed to handle medical injury disputes and would handle medical injury litigation with specialized adjudicators, independent expert witnesses, predictable damage awards, and strong linkages to patient safety programs to reduce errors. According to the Common Good, there are many ways in which the health court proposal can be created and tailored to fit particular circumstances at the state level. Among the options, state legislatures could establish pilot programs for compensating certain types of injuries outside the tort system. As another approach, healthcare providers could create a voluntary program linking error disclosure with structured arbitration and a predictable process for determining damages.

Under a health court system, healthcare providers have clear and reliable guidance on what constitutes proper standards of care because health court judges will issue written opinions that have a binding effect on future cases. With a more reliable health justice system in place, the fears of healthcare providers regarding litigation will be diminished, freeing them to share information and disclose adverse outcomes. This expanded and enhanced information flow will improve patient safety and the quality of care. Additionally, more consistent and reliable judgments will eventually lead to lower medical malpractice premiums which will lower overhead costs for providers, making the practice of medicine economically feasible for providers and cost-effective for patients, employers and health plans.

Finally, a specialized health court system will reduce the amount of time needed to bring a malpractice claim to resolution and lower the overall costs.[8] If a patient's injury qualifies as an Accelerated Compensation Event (ACE), the patient will receive compensation even faster, and at an even lower cost. An ACE is a predetermined malpractice scenario in which experts agree that actions by the provider(s) clearly lead to an avoidable injury. In an environment where they are less fearful of being sued for admitting mistakes, providers will be more likely to

share information, thereby improving patient safety. Health courts will also create a more suitable climate for liability insurance premiums, which in turn can help increase patients access to health care services.

III. Abolition of the Collateral Source Rule

The collateral source rule, sometimes referred to as the "collateral benefits rule," is a common law doctrine that was developed more than a century and a half ago.[9] The rule is both an evidentiary and substantive rule which dictates that a defendant may not introduce evidence of collateral sources in order to mitigate a potential damage award, nor may a plaintiff's damage award be reduced by benefits collateral to the tort action. Under the collateral source rule, evidence of collateral benefits is often inadmissible at trial. Similarly, an award cannot be reduced by financial benefits paid to the plaintiff from third-party sources, such as first-party insurance or unemployment benefits.[10]

In recent years, the rationale underlying this rule has been questioned as being out of step with modern realities as was illustrated in *Eastin v. Broomfield*, 570 P.2d 744, 752. While many states have considered legislation abolishing or modifying the collateral source rule by legislation, only 15 states have modified the collateral source rule whereby evidence of collateral benefits are admissible, in some form, at trial and may be considered by the court. These states include Alabama, Arizona, California, Delaware, Indiana, Iowa, Missouri, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Washington, and Wisconsin.[11]

We support abolition of the collateral source rule on the basis that plaintiffs should not be compensated twice for the same injury. The goal of a healthy tort system is to "make the injured patient whole"; not to turn an injury into a windfall. With the cost of the American tort system exceeding that of comparable nations, and the tort system taxing the financial and judicial resources of a straining American economy, the time has come for the abolition of the collateral source rule.

The rule is an outmoded common law doctrine, no longer appropriate in the age of insurance, managed care, and public benefit programs. Abrogation of the collateral source rule, in concert with other tort reforms, provides an avenue to reduce the cost of the American health justice system by eliminating many marginal cases.[12] Tort reforms like the elimination of the collateral source rule will also benefit consumers and the economy by reducing insurance rates.

IV. Advancing Evidence-Based Medicine (EBM)

In 1996, Dr. David Sackett defined evidence-based medicine as "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research."[13]

Evidence by itself does not remove decision-making power away from a clinician. However, it can help support the patient care process. The full integration of these three components — clinical expertise, patient values and best evidence — into clinical decisions enhances the opportunity for optimal clinical outcomes and quality of life. The practice of EBM is usually triggered by patient encounters which generate questions about the effects of therapy, the utility of diagnostic tests, the prognosis of diseases, or the etiology of disorders. Evidence-based medicine requires new skills of the clinician, including efficient literature-searching, and the application of formal rules of evidence in evaluating the clinical literature.

As medical practices, clinics and health systems continue to integrate technology solutions into their everyday practice, clinicians will have even more opportunities to incorporate evidence-based medicine and clinical best practice into individual patient care. Electronic Medical Records (EMR) systems usually provide evidence-based medicine and clinical best-practice support systems from any number of medical content providers including the Mayo Clinic and EBSCO (Dynamed). Additionally, with electronic systems, physicians will be able to better document the use of best-practice medicine.

Using EBM is beneficial for both sides in professional liability cases. Plaintiffs' attorneys can use it to avoid frivolous cases, and concentrate instead on those with merit. Physicians accused of negligence or malpractice can use EBM to defend their medical decisions and care. If EBM is allowed into evidence, judges and juries could rely on it instead of the often confusing and conflicting opinions of various expert witnesses. The use of evidence-based medical testimony will result in fewer cases going to court, less money being wasted, and overall lower medical malpractice insurance rates.[14]

Clinicians should be shielded from liability if they demonstrate the integration evidence based medicine and/or clinical best practices into the care and treatment of patients. Such documentation would be exculpatory and presumptive evidence that the standard of care was followed. . Practitioners should then be able to petition the court for a motion for summary judgment based on the use of evidence based medicine and/or clinical best practices. No less important is preserving the right of physicians to exercise their clinical judgment to make personalized decisions based on the circumstances of the patient and his/her condition. The physicians may choose to deviate from accepted algorithms, if in that case, it makes better clinical sense. In that scenario, the doctor would merely document he was aware of algorithms recommended by EBM but consciously chose a different path for specific reasons. This would serve two goals: (a) to prevent EBM from being abused as inculpatory evidence (that is, failure to embrace such algorithms being misconstrued as a violation of the standard of care); and (b) responding to the concern that blind adherence to EBM algorithms is "cookbook medicine" - applicable to all patients. The goal is to take advantage of EBM where it benefits patients; but provide clinicians some latitude to use their judgment to deviate from these algorithms when it makes sense. Documentation of the use of EBM or conscious deviation from EBM could both be exculpatory.

V. Allowing Physicians to Apologize without Implication (The 'I'm Sorry' Laws)

The American Medical Association *Code of Medical Ethics*, which sets forth standards of professional conduct, states that "when a patient suffers significant medical complications that may have resulted from the physician's mistake or judgment, the physician is ethically required to disclose to the patient all the facts necessary to ensure understanding of what has occurred." The guidelines go on to state that a physician's concern about legal liability that might result from full disclosure should not affect his or her decision to deal candidly with a patient.[15]

We believe that most physicians would agree with this principle in theory. However, full disclosure has not always been the norm. Medical malpractice premiums have skyrocketed in recent years, most significantly in specialties such as obstetrics-gynecology and neurosurgery, and as a result many physicians fear that every patient is a potential litigant.[16] National surveys designed to assess attitudes toward disclosure revealed that fear of litigation was the primary reason for both physician and hospital reluctance to disclose errors and unanticipated outcomes.[17]

In response to the ongoing national medical malpractice crisis, 29 states have enacted evidentiary rules that make expressions of sympathy following an accident or error inadmissible in civil court to prove liability.[18] This body of legislation is often referred to as "I'm sorry" laws and encourages full disclosure of mistakes or errors in judgment by eliminating physicians' and hospitals' fear that their admissions will be used against them in a court of law. Additionally, these statutes encourage physicians to express their empathy with a bad medical outcome even though it may have nothing to do with the standard of care provided.

Saying "I'm sorry" may cut costs and increase efficiency.[19] According to the AMA, having realized the benefits of apologizing, several hospital systems throughout the country, in conjunction with their attorneys and insurance carriers, have implemented full disclosure policies, so a procedure is in place when an unintended outcome occurs, and health care professionals are trained in how to apologize and make settlement offers. Since the University of Michigan Health System adopted its program in 2002, the number of medical malpractice claims has dropped each year, attorney fees have declined significantly and the university has reduced its claims processing period by more than 50 percent.[20]

An upfront apology or expression of sympathy can relieve anger and frustration and reduce the level of emotion, paving the way for a quick settlement rather than lengthy and costly litigation. In many cases, patients do not sue because they are greedy but because they want to know what went wrong and are seeking acknowledgement of the error.[21] Lastly, by encouraging honest, open communication, "I'm sorry" statutes facilitate the continuation of the patient-physician relationship following an adverse event.

VI. Cap on Non-Economic Damages

In the early 1970s, a medical malpractice insurance crisis gripped California. Liability premiums soared more than 300 percent because of more frequent and severe liability claims and larger malpractice jury awards. Many physicians — particularly in high-risk specialties such as obstetrics and neurosurgery — were forced to close their doors, either unable to get insurance or unable to afford inflated rates. Denied access to affordable care, California patients suffered. In 1975, Governor Jerry Brown called a special session of the California Legislature to solve the state's malpractice crisis.[22]

The result of that special legislative session was the enactment of the Medical Injury Compensation Reform Act (MICRA). MICRA provided critical support of California's fragile safety net for access to healthcare. It was enacted in 1975 by overwhelming bipartisan support in response to a crisis of runaway medical liability costs and the resulting shortage of healthcare providers, most predominately in high-risk specialties. Over thirty-five years later, MICRA continues to save the healthcare system billions of dollars each year and increases patients access to healthcare by keeping doctors, nurses and other healthcare providers in practice while keeping hospitals and clinics open to the public. MICRA's most significant achievement was the creation of a $250,000 limit on non-economic damages.

Texas enacted comprehensive tort reform including capping non-economic damages in 2003. Since enacting civil justice reforms, medical malpractice insurance rates have stabilized and many physicians have experienced significant reductions in premiums. Overall, medical malpractice insurance rates have decreased an average of 21.3%.[23] Additionally, the Texas Medical Board reports that more than 12,000 new physician licenses have been issued since the cap on non-economic damages were adopted. A recent study specifically examined the economic benefits related to limiting non-economic damages in medical malpractice alone lead to increases of $55.3 billion in spending per year and more than 223,000 jobs. According to this same study, nearly 430,000 Texans now have health insurance coverage who would have otherwise been uninsured had it not been for civil justice reforms enacted in Texas.[24]

Non-economic damages include those for pain and suffering, whereas economic damages include items like medical expenses and lost wages. Determining appropriate levels for non-economic damages is largely subjective whereas economic damages are much easier to ascertain. Placing caps on non-economic damages is one approach which many states have taken to address the rising and unpredictable costs of medical malpractice cases, which are blamed for the rise in the cost of medical liability insurance. Currently, 26 states limit non-economic damages or place "caps" them. Laws limiting non-economic damages seek to control one part of the expense of medical malpractice cases and make the system more predictable for insurers and medical professionals.

Conclusion

States that have enacted tort-reform measures have reported significantly improved access to health care, reduced costs, and strengthened economies. As the nation moves to reform our health system, civil justice reform *must* be included. The standardization of expert witness standards, the creation of specialized health courts, the abolition of the collateral source rule, the development of evidence based medicine and clinical best practices as a way to reduce exposure, allowing physicians to apologize without the implication of liability, and capping of non-economic damages will improve access to medical care, reduce overall healthcare costs, enhance medical care and improve patient outcomes.

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