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Medical Liability Reform: Innovative Solutions for a New Health Care System

A Summary of a Position Paper Approved by the ACP Board of Regents, February 2014

Why Do We Need to Reform the Medical Liability System?

7KH H[LVWLQJ V\VWHP,W¶V GRHVQ¶W ZRUN IRU SDWLHQWV DV SK\VLFL avoid being sued, the patient-physician relationship is fractured. The system also spends an enormous amount of money to compensate a small percentage of patients, distributing large awards to the 2% of injured patients who bring a suit to court following an unintended medical episode.

Another reason for medical liability reform is cost to the health care system. The Congressional Budget Office (CBO) estimated that in 2009, providers would incur $35 billion in direct medical liability costs, including premiums, settlements, awards, and administrative costs not included in insurance.

Physicians are adversely affected. For internists, the prospect of being targeted for a medical liability claim is almost inevitable: 89% of internists and related subspecialists receive a claim by the age of 65. Evidence also shows that the experience of being sued, and the lingering anxiety caused by the prospect of being sued, causes significant psychological stress for physicians.

New reform models show exciting promise. Health courts, enterprise liability, safe harbor protections, and disclosure laws, may be the key to breaking through the current political impasse and creating a system that encourages the prevention of errors, improved patient safety, and timely resolution of legitimate claims.

Both proponents and opponents of tort reform must realize that the existing health care system allows for too many preventable injuries and that fear of liability undermines the patient-physician relationship.

How Can the System Be Fixed?

A solution to the broken medical liability system should include a multifaceted approach, since no single program or law by itself is likely to achieve the goals of improving patient safety, ensuring fair compensation to patients when they are harmed by a medical error or negligence, strengthening the patient-physician relationship, and reducing the economic costs associated with the current system.

Recommendations from the Paper

Recommendation 1: Improving patient safety and preventing errors must be at the fore of the medical liability reform discussion. Emphasizing patient safety, promoting a culture of quality improvement and coordinated care, and training physicians in best practices to avoid errors and reduce risk will prevent harm and reduce the waste associated with defensive medicine.

Recommendation 2: Caps on noneconomic damages, similar to those contained in the California Medical Injury Compensation Reform Act (MICRA), should be part of a comprehensive approach to improving the medical liability system. While ACP strongly prefers that such caps and other tort system reforms be enacted by Congress to establish a national framework for addressing medical liability lawsuits, the College also advocates that states lacking such reforms enact legislation modeled after MICRA.

The College advocates for caps on noneconomic damages, statute of limitations, a sliding scale for attorney fees, collateral source rule restrictions, fair share liability, periodic payment of damages, limits on punitive damages.

Recommendation 3: Minimum standards and qualifications for expert witnesses should be established. At minimum, expert witnesses should be board certified, active in full-time practice or experience as an educator at an accredited and relevant medical school, licensed in the state in which the case is filed or another state with similar licensure qualifications, required to disclose expert witness-derived income, and have training similar to that of the defendant.

Recommendation 4: Legislatures should examine the insurance industry's financing operations, with a view toward identifying the sources of industry difficulty with predicting loss and setting actuarially appropriate rates.

Recommendation 5: States and the federal government should continue to pilot-test communication and resolution (also known as early disclosure and apology) programs. Pilot programs should follow the framework described in the position paper.

Recommendation 6: In addition to communication and resolution programs, the Secretary of Health and Human Services should be authorized to make grants to states for the development and implementation of Alternative Dispute Resolution (ADR) models, including mediation.

Recommendation 7: ACP supports the development of safe harbor protections when clinicians

Recommendation 9: Additional research is needed to determine the effect of team-based care on medical liability. Physicians and other health care professionals working in dynamic clinical care teams may be compelled to acquire individual liability protection policies. Enterprise liability coverage should be pilot-tested to determine its effectiveness in covering clinical care teams, accountable care organizations (ACOs), patient-centered medical homes (PCMH) and PCMH "neighbors" and other team-based delivery system models.

Additional Information

The complete paper can be accessed here