



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

American College of Physicians
A Position Paper
2014

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

A Policy Paper of the
American College of Physicians

This paper written by Ryan Crowley and was developed for the Health and Public Policy Committee of the American College of Physicians (ACP); Thomas Tape, MD, (Chair); Jacqueline W. Fincher, MD (Co-Chair); Vineet Arora, MD; Ankit Bhatia; James F. Bush, MD; Douglas M. DeLong, MD; Susan Glennon, MD; Gregory A. Hood, MD; Mary Newman, MD; Kenneth E. Olive, MD; Shakaib U. Rehman, MD; Zoe Tseng, MD; and Jeffrey G. Wiese, MD. Approved by the ACP Board of Regents on 13 February 2014.

How to cite this paper:

American College of Physicians. Medical Liability Reform: Innovative Solutions for a New Health Care System. Philadelphia: American College of Physicians; 2014: Policy Paper. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.)

Copyright © 2014 American College of Physicians

All rights reserved. Individuals may photocopy all or parts of Position Papers for educational, not-for-profit uses. These papers may not be reproduced for commercial, for-profit use in any form, by any means (electronic, mechanical, xerographic, or other) or held in any information storage or retrieval system without the written permission of the publisher.

For questions about the content of this Policy Paper, please contact ACP, Division of Governmental Affairs and Public Policy, Suite 700, 25 Massachusetts Avenue NW, Washington, DC, 20001-7401; telephone 202-261-4500. To order copies of this Policy Paper, contact ACP Customer Service at 800-523-1546, extension 2600, or 215-351-2600.

SUMMARY

The medical liability crisis continues to have a profound effect on the medical system. While medical liability premiums have leveled off in the past few years, physicians still fear litigation, expect lawsuits, and feel the psychological burden of navigating the complex medico-legal system. Patients harmed by medical negligence also suffer under the existing medical liability system. Medical liability claims may take years to be decided, and verdicts and award amounts may hinge on the laws and legal climate of the state in which they are filed. ACP's previous policy paper on medical liability reform was published in the wake of a medical liability crisis seemingly brought on by surging plaintiff awards and court costs, which in turn propelled liability premiums to historically high levels.^{1,2} That paper expressed ACP's support for a number of federal medical liability reforms, including caps on noneconomic damages, limitations on punitive damages, and a sliding scale for attorney's fees. Many of these reforms were included in the Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002, but the bill was never passed, indicating the lack of Congressional action and the polarized nature of the issue. The HEALTH Act continues to languish in Congress; the latest iteration was introduced in 2011.

While traditional medical liability reforms may currently have little chance of passing at the federal level, states have taken action to approve laws that not only establish caps on noneconomic damages, but also delve into alternative dispute resolution, injury funds, and statute of limitations on the time frame during which injury claims can be filed. Perhaps more promising is the testing of innovative liability protection models, such as health courts, enterprise liability, safe harbor protections, and disclosure laws, which seek to break through the political impasse and create 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.³

As outlined in Recommendation 2 of this paper, evidence suggests that traditional tort reforms, particularly noneconomic damage caps, may help reduce liability claims and health care costs. Yet even in states where stringent tort limits have been enacted, physicians remain concerned about medical liability, which may undermine career satisfaction and influence their relationship with patients.⁴ Further, it remains unclear whether traditional tort reform improves patient safety and outcomes. There has been a renewed focus on medical liability reforms that move beyond traditional tort reforms, toward creating alternatives to jury trials in favor of quick decisions made by judicial experts, enhanced liability protection for physicians who follow established clinical guidelines and take responsibility for errors, and risk management efforts that focus on ensuring patient safety. To address the root causes of defensive medicine, Carrier et al. propose apology and disclosure programs; nonnegligent, standard administrative compensation or health courts systems; and safe harbors for delivering care that is in-line with trusted quality measures.⁵ Section 10607 of the Patient Protection and Affordable Care Act (ACA), authorized \$50 million in grant funding to states for testing innovative medical liability reform and patient safety improvement models beyond traditional tort reform (the ACA also established some medical liability

protections for free health clinics).⁵ While preventing errors should remain the paramount goal, these reforms may help lessen physician's liability fears while ensuring that patients are adequately and fairly compensated for any errors that do occur. Promising strides have been made since ACP's last position paper on medical liability was released in 2003. Despite the progress being made to develop and test new approaches to the medical liability system at both the national and state levels, the most effective medical liability reforms and the various innovative alternatives that may heal the rift caused by the existing broken system have not been widely or consistently adopted across the country.

It is imperative that in a post-Affordable Care Act health care landscape, all stakeholders work together to fix the nation's medical liability system for the sake of patients and providers alike. However, focus must not be diverted away from efforts to improve patient safety and prevent errors. ACP is strongly committed to reducing medical errors, consistent with the Institute of Medicine's Crossing the Quality Chasm report; ensuring fair and appropriate compensation to patients who are injured; promoting best practices to improve patient safety and reduce medical errors; developing and promulgating evidence-based clinical practice guidelines, including guidelines to reduce unnecessary, harmful, and ineffective tests through the High Value Care Initiative; and promoting team-based collaborative care to help improve efficiency and reduce duplication of services that may compromise patient safety.

This paper will provide an update of the medical liability landscape, state-based activity on medical liability reform, and summarize traditional and newer reform proposals and their ability to affect system efficiency and encourage patient safety.

RECOMMENDATIONS

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. The medical community should employ practices designed to lower the incidence of malpractice, including setting standards of care based on efficacy assessment data, implementing risk management programs in all health care institutions, and reviewing current and prospective medical staff members' malpractice and professional disciplinary records. Disciplinary actions, including restricting or denying clinical privileges, should be taken against unqualified, reckless, or incompetent physicians.

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.

NOTE: A glossary of relevant legal terms can be found in the Appendix.

The College advocates the following:

- a) Federal law should not preempt, supersede, or otherwise undermine any existing state law that provides for effective tort reform, nor should federal initiatives prevent the future enactment of effective state tort reform laws that reflect local needs.
- b) Federal law should preempt state law in instances where it would prevent stronger federal tort reform law from being enacted. Federal laws, such as the Federal Tort Claims Act, should be superseded by subsequent federal reforms that establish limits on damages or contingent fees, periodic payment of damages, collateral source disclosure and offsets, and others that are recommended in this section.
- c) The College favors a \$250,000 cap on noneconomic damages. Additionally, the College supports a \$50,000 cap on noneconomic damages for any physician performing immediate, life-saving care. ACP is opposed to limits on economic damages.
- d) Juries should be aware of collateral source payments and allow offsets for those payments.
- e) A reasonable statute of limitation on claims should be required. Lawsuits should be filed no later than 3 years after the date of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury—whichever occurs first, providing health care providers with ample access to the evidence that they need to defend themselves. Under some circumstances, however, patients should have additional time to file a claim for an injury that could not have been discovered through reasonable diligence.
- f) Defendants should remain jointly liable for all economic losses, such as medical bills and lost wages, but should be held liable only for their own portion of the noneconomic and punitive damages.
- g) Defendants should be permitted to make periodic payments of future damages over \$50,000, if the court deems appropriate, instead of a single lump sum payment. The plaintiff would still receive full and immediate compensation for all out-of-pocket expenses; noneconomic damages; punitive damages, if awarded; and future damages of \$50,000 or less.
- h) A sliding scale should be established for attorney's fees. This provision would place plaintiff attorneys on the following scale:
 - a. Forty percent (40%) of the first \$50,000 recovered
 - b. Thirty-three and one-third percent (33 1/3%) of the next \$50,000 recovered
 - c. Twenty-five percent (25%) of the next \$500,000 recovered
 - d. Fifteen percent (15%) of any amount recovered in excess of \$600,000
- i) Punitive damages should be awarded only if there is clear and convincing evidence that the injury meets the standard set by each jurisdiction. In those cases, damages should be limited to \$250,000 or twice compensatory damages (the total of economic damages plus noneconomic losses), whichever is greater.

Recommendation 3: Minimum standards and qualifications for expert witnesses should be established. At minimum, expert witnesses should be:

- Board certified by the entity relevant to their specialty;
- Active in full-time practice, or have sufficient experience as an educator at an accredited medical school in the relevant subject matter;
- Licensed in the state in which the case is filed or another state with similar licensure qualifications; and
- Required to disclose the frequency and percentage of income derived from expert witness activities as well as any conflicts of interest.

Witnesses should also be trained in the same discipline as the physician named in the lawsuit; experience and familiarity should be substantive and relevant to the subject matter and standard of care at the time of the alleged occurrence. Witnesses should demonstrate competence in type of care for which they are chosen to testify.

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. However, an examination of industry practices is not an adequate substitute for effective medical liability reforms.

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 following framework:

- Establishing public information campaigns to educate stakeholders about how such programs can improve patient safety, nurture the patient-physician relationship, and stabilize compensation awards;
- Enact strong, broad legal protections that ensure apologies from physicians and other health care professionals are inadmissible in a court of law;
- Educate providers and health care systems on related legal protections and offer training (i.e., coaching and peer mentoring) on effective apology communication;
- Establish legal protections and guidelines for the peer review process to determine the root cause of the unintended event;
- Change National Practitioner Data Bank and state medical board reporting requirements to encourage health care providers to engage in communication and resolution channels. Such health care providers who disclose unintended events to their patients should be shielded from disciplinary action by state medical boards;
- Develop a means for institution-based reporting when system-level errors occur beyond the individual physician's control;
- Include at least a six-month period to allow for thorough investigation before a patient can sue;
- Continue to collect and distribute data on the impact of communication and resolution programs.

- Pilot programs should test the applicability of communication and resolution programs in small group, rural, and solo physician practices operating outside of closed health care systems. Funding should be directed toward establishing resource centers, statewide risk-pooling or reinsurance products to ensure the viability of communication and resolution programs in such practice environments. Pilot projects should also test the effect of communication and resolution programs in states with and without damage caps.

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. States would have flexibility in devising their ADR programs as long as federal standards were met. Federal standards should require ADR systems to incorporate some sort of disincentive to proceeding through the court system so that the ADR would not become a costly “add-on” rather than a cost-effective and faster way of resolving claims.

Recommendation 7: ACP supports the development of safe harbor protections when clinicians provide care consistent with evidence-based guidelines providing the following conditions are met:

- Selection of evidence-based guidelines protected under safe harbor should be conducted by a panel of medical experts organized by a qualified entity, such as the Institute of Medicine. To be considered for safe harbor status, evidence must support that clinical guidelines are reliable; valid; clearly defined; based on current data; adjusted to compensate for variations in case mix, severity, risk; selected based on strong consensus among stakeholders and predictive of overall quality performance; reflective of processes of care that physicians and other health care professionals can influence and impact; and are not administratively burdensome. Selection of guidelines should seek to improve patient safety, encourage collaborative care, and control health care costs.
- Clinical guidelines under safe harbor should be regularly evaluated for relevance and effectiveness by objective stakeholder organizations with physician input. Safe harbors should be sunsetted if it is determined that a clinical guideline may have a harmful effect on patient health, or does not meet the characteristics described in this recommendation.
- Physicians should not be held culpable in a court of law if, having considered a patient’s individual medical circumstances and preferences for care and applying their best professional judgment, they do not follow guidelines.
- An extensive education campaign should be initiated to inform physicians and other health care professionals of the safe harbor status of selected clinical guidelines and to provide clear information on how physicians may be protected by safe harbors.

Recommendation 8: ACP supports initiating pilot projects to determine the effectiveness of health courts and administrative compensation models. The College recommends that:

- Programs be structured to provide fair and expeditious review of medical liability claims, with the goal that claims should be resolved within one year of being filed.
- Judges and administrative agency staff have training and experience in the delivery of medicine and of medical claims adjudication matters. Judges should be advised by objective medico-legal experts employed by the health court or administrative compensation entity.
- The negligence standard for compensation be replaced by an avoidability standard based on what information was known by the provider at the time the care was given.
- Economic damages not be considered by a health court or administrative agency. Noneconomic damages may be considered and compensation should be based on a predetermined schedule. Collateral source rules should be revised so that awards are offset by payments received from health insurance and other sources.
- Patient appeals be considered by an administrative law judge.
- Health care providers be given an opportunity to appeal the adjudicator's decision.
- A sunset mechanism should terminate the pilot project if it fails to meet the goal of improving patient safety, strengthening the patient-physician relationship, expediting legitimate medical claims decisions, and infusing objectivity and predictability into the liability process.

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.

BACKGROUND

The medical liability system intends to award financial compensation to injured patients and incentivize high-quality care while reducing provider negligence. According to one estimate, annual medical liability system costs are about \$55.6 billion in 2008 dollars, or 2.4% of total health care spending.⁶ Reflected in this estimate are costs related to claims payments; administrative expenses; and defensive medicine, which occurs when physicians and other health care professionals provide services (or avoid high-risk patients and services), to prevent a medical liability claim. 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.⁷

Specifically, administrative expenses, such as attorney fees and overhead, cost roughly \$4.1 billion per year. Indemnity claims paid by liability insurers are estimated at about \$5.7 billion.⁸ Defensive medicine costs are difficult to estimate because of uncertainty regarding the influence of liability fears on the ordering of services, the potential patient benefits of such services, and lack of agreement on the definition of "defensive medicine." However, Mello et al. estimate that defensive medicine costs about \$45.6 billion a year, \$39 billion of which is attributed to hospitals.⁶ Hospitals are not the only providers forced to take a defensive stance because of medical liability concerns. Office-based physicians who report high levels of medical liability concern are more likely to order aggressive diagnostic tests than physicians with low levels of liability concern.⁹ The CBO now includes savings from reduced health care utilization (i.e., reduced use of defensive medicine) in its estimates of tort reform proposals, reflecting current evidence that medical liability reforms reduce health care utilization. JW Thomas et al. acknowledge that defensive medicine does occur, but that its impact on medical costs is limited.¹⁰ 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 65.¹¹ 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.⁴

Physicians, especially those in high-risk specialties and those practicing in select geographic regions, continue to pay high premiums for liability insurance, although rates in much of the nation have moderated in recent years. In 2012, 60% of medical liability premiums nationwide remained level compared with the previous year, while 26% decreased, and 15% increased.¹² In some areas of the nation, however, premiums remain exceedingly expensive: for example, internists in Dade County, Florida, pay nearly \$48,000 compared with \$2,381 per policy in Nebraska. Certain specialties pay even more: an OB-GYN in Nassau and Suffolk counties of New York can expect to pay nearly \$205,000 for liability insurance.¹²

The medical liability system is rife with inefficiencies and fails to proportionately compensate patients. According to one estimate, only 22 cents of every dollar that goes into the medical liability system is directed to patient compensation.¹³ The system 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.¹⁴ Most patients who are injured as a result of negligence do not even receive compensation, often because they are unable to find legal representation or they elect not to file a claim.

RECOMMENDATIONS

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. The medical community should employ practices designed to lower the incidence of malpractice, including setting standards of care based on efficacy assessment data, implementing risk management programs in all health care institutions, and reviewing current and prospective medical staff members' malpractice and professional disciplinary records. Disciplinary actions, including restricting or denying clinical privileges, should be taken against unqualified, reckless or incompetent physicians.

One of the most promising trends in the medical liability reform discussion is the emphasis on the need to avoid preventable medical errors, thereby eliminating harm to the patient, the severed patient-physician bond, and the stress of serving and fighting a claim in court. As medicine continues to evolve toward team-based collaborative care, health systems throughout the country are exploring new ideas on how to work together to improve patient safety and as a result, avoid lawsuits from injured patients.

As part of its Medical Liability Reform and Patient Safety Initiative, AHRQ has distributed seven demonstration grants and awarded over a dozen planning grants to institutions and providers around the country. The patient safety-focused projects seek to "put patient safety first and work to reduce preventable injuries and foster better communication between doctors and their patients" while also working to ensure that frivolous lawsuits are reduced and patients are justly compensated for warranted claims.¹⁵ Minnesota's Fairview Health Services developed provider team drills where surgical teams simulated a critical event to develop communication skills. Fairview also implemented and evaluated perinatal best practices in 16 hospitals in 12 states. Initial reports were positive; according to an AHRQ progress report participating hospitals complied with improvement interventions, reducing the number of adverse events.⁴⁴

Improving communication among physicians and other health care professionals in charge of a patient's care is a key element of the AHRQ grants. The University of Washington received funding to develop best practices to train providers on how and when to speak up if they foresee a potential error occurring. The project also worked to facilitate communication between physicians and hospital administrators following an injury.¹⁶ The Massachusetts State Department of Public Health developed best practices targeted at post discharge care. The project has engaged outpatient practices, including 30 primary care physician practices, many of which are solo or small groups, to identify potential areas of improvement and coach them on how to address deficiencies, such as management of patient phone calls and communicating test results.

These projects were completed in 2013. Should the project evaluations conclude that they achieved their goals to prevent medical errors and reduce liability costs, best practices should be developed and disseminated to clinicians so they can apply them to their practices.

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.

NOTE: A glossary of relevant legal terms can be found in the Appendix.

The College advocates the following:

- a) Federal law should not preempt, supersede, or otherwise undermine any existing state law that provides for effective tort reform, nor should federal initiatives prevent the future enactment of effective state tort reform laws that reflect local needs.
- b) Federal law should preempt state law in instances where it would prevent stronger federal tort reform law from being enacted. Federal laws, such as the Federal Tort Claims Act, should be superseded by subsequent federal reforms that establish limits on damages or contingent fees, periodic payment of damages, collateral source disclosure and offsets, and others that are recommended in this section.
- c) The College favors a \$250,000 cap on noneconomic damages. Additionally, the College supports a \$50,000 cap on noneconomic damages for any physician performing immediate, life-saving care. ACP is opposed to limits on economic damages.
- d) Juries should be aware of collateral source payments and allow offsets for those payments.
- e) A reasonable statute of limitation on claims should be required. Lawsuits should be filed no later than 3 years after the date of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury—whichever occurs first, providing health care providers with ample access to the evidence that they need to defend themselves. Under some circumstances, however, patients should have additional time to file a claim for an injury that could not have been discovered through reasonable diligence.
- f) Defendants should remain jointly liable for all economic losses, such as medical bills and lost wages, but should be held liable only for their own portion of the noneconomic and punitive damages.
- g) Defendants should be permitted to make periodic payments of future damages over \$50,000, if the court deems appropriate, instead of a single lump sum payment. The plaintiff would still receive full and immediate compensation for all out-of-pocket expenses; noneconomic damages; punitive damages, if awarded; and future damages of \$50,000 or less.
- h) A sliding scale should be established for attorney's fees. This provision would place plaintiff attorneys on the following scale:
 - a. Forty percent (40%) of the first \$50,000 recovered
 - b. Thirty-three and one-third percent (33 1/3%) of the next \$50,000 recovered
 - c. Twenty-five percent (25%) of the next \$500,000 recovered
 - d. Fifteen percent (15%) of any amount recovered in excess of \$600,000

- i) Punitive damages should be awarded only if there is clear and convincing evidence that the injury meets the standard set by each jurisdiction. In those cases, damages should be limited to \$250,000 or twice compensatory damages (the total of economic damages plus noneconomic losses), whichever is greater.

ACP and most of the medical community have long supported efforts to reform the medical liability system and hold down torts. Smaller awards may lead to lower medical liability premiums paid by physicians, ultimately reducing provider charges for health care services. Tort reform should also reduce the volume of health care services, as physicians will be less inclined to provide services as a precaution against liability claims.¹⁷ Support for tort reform is not limited to medical organizations. The Moment of Truth Project and National Coalition for Health Care's "A Bipartisan Path Forward," proposal recommended, for example, establishment of a statute of limitations on filing medical claims, replacing joint and several liability with a fair-share rule, and limits on attorney contingency fees.¹⁸ CBO finds that if tort reform were enacted at the federal level, total national medical liability premiums would drop by 10%.⁷

Evidence is conflicting, or in some cases too limited, on the effect of tort reform on health outcomes. Lakdawalla and Seabury estimate that the nation's overall mortality rate would increase by 0.2% with a 10% reduction in medical liability costs, while Sloan and Shagle conclude that tort reforms do not have a systematic effect on patient outcomes.^{19,7} A literature review conducted by AHRQ found evidence on the effect of tort reform on patient safety to be inconclusive.²⁰ Kachalia and Mello studied the evidence on 8 of the major traditional medical liability reforms and found that evidence of their effect on quality of care was for the most part too limited to draw conclusions.²¹ Rigorous research into the effects of tort reform on patient care is needed to ensure that the right changes are made to achieve the goals of improved patient safety, reduced defensive medicine, and physician practice viability so patients can continue to access the provider of their choice.

Caps on noneconomic damages: Noneconomic damages provide compensation to the plaintiff for pain and suffering, inconvenience, mental distress, or other nonmonetary losses. Caps can either be placed on the amount of compensation awarded to the plaintiff or the amount of compensation paid by the defendant.²¹ Limits on noneconomic damages seek to curb excessive awards, stabilize medical liability insurance premiums, and make the process of setting premiums more predictable and accurate. Noneconomic damage caps have been shown to stimulate reductions in liability insurance premiums, claims, and awards.³ Kachalia and Mello conducted a review of the literature on noneconomic damage caps, concluding, "(s)tudies have nearly uniformly found that caps are an effective means of reducing the size of indemnity payments."²¹ The same review also found that damage caps were connected to a reduction in defensive medicine practices, and some improvement in the physician supply. Tort reform may also lead to lower health insurance costs for employer-based health insurance.²² Caps on damages may also encourage liability insurers to enter the market, potentially increasing competition on rates. After Texas established limits on noneconomic damages, the number of liability companies writing policies in the state rose.²³ As of 2011, 38 states have caps on damage awards.²⁴

Collateral source rule: The collateral source rule prohibits the defense from introducing evidence of compensation paid to the plaintiff, from sources such as health insurance payments. By eliminating this rule, juries would be able to consider all injury-related compensation received by the plaintiff and potentially eliminate double recovery of damages, leading to fairer payments. Some states have restricted the collateral source rule, allowing the disclosure of some types of compensations, while New Hampshire has eliminated it entirely.

Statute of limitations: Establishing a statute of limitations on liability claims would ensure that juries consider liability claims based on the most recent evidence while it is fresh in the minds of the affected individuals, witnesses are available, and information is accessible and accurate. Studies have shown that such statutes may constrain liability insurance premiums growth.²¹ As of 2011, all states have statutes of limitation for medical liability claims.²⁴ The College supports longer statutes of limitations for certain cases and plaintiffs. For example, many states have special rules for claims filed on behalf of injured minors.

Limits on attorney fees: Placing caps on attorney fees helps to ensure patients receive their fair share of compensation as well as discourage attorneys from taking cases of insubstantial merit. As of 2011, 28 states limit attorney's fees.²⁴

Joint and several liability reform: Joint and several liability rule applies to cases with multiple defendants, permitting any defendant to be the primary target of litigation, regardless of his or her level of responsibility in caring for the patient. The result is that attorneys will file suit against the provider who can pay the biggest award, regardless of their proportion of fault. Regarding noneconomic and punitive damages, ACP supports amending joint and several rules to a "fair-share" system in which defendants are held liable for only the portion of the patient's injury for which they are responsible.

Periodic payment of damages: This provision would allow insurers to pay compensation in installments, rather than a lump sum. As a result, payout schedules will be more predictable and insurers can buy annuities to cushion the financial loss.²¹

Limits on punitive damages: Punitive damages are awarded as a way to punish the defendant for negligent or egregious behavior.⁶ They are provided in addition to any economic and noneconomic compensation.

Effect on state law (Recommendations a and b): A number of states have taken action to address the medical liability problem, particularly by protecting physicians and other health care providers from liability, loss, and damages. Others have yet to enact meaningful tort reform, highlighting the need for federal legislation to address the liability crisis. The HEALTH Act includes language that would protect state tort reform laws. ACP believes that tort reform needs to be enacted nationwide, but states that take the initiative to create even stronger safeguards should be permitted to do so.

Recommendation 3: Minimum standards and qualifications for expert witnesses should be established. At minimum, expert witnesses should be:

- Board certified by the entity relevant to their specialty;
- Active in full-time practice, or have sufficient experience as an educator at an accredited medical school in the relevant subject matter;
- Licensed in the state in which the case is filed or another state with similar licensure qualifications; and

- Required to disclose the frequency and percentage of income derived from expert witness activities as well as any conflicts of interest.

Witnesses should also be trained in the same discipline as the physician named in the lawsuit; experience and familiarity should be substantive and relevant to the subject matter and standard of care at the time of the alleged occurrence. Witnesses should demonstrate competence in type of care for which they are chosen to testify.

The *ACP Ethics Manual, 6th edition* states “Although physicians cannot be compelled to participate as expert witnesses, the profession as a whole has the ethical duty to assist patients and society in resolving disputes. In this role, physicians must have the appropriate expertise in the subject matter of the case and honestly and objectively interpret and represent the medical facts. Physicians should accept only noncontingent compensation for reasonable time and expenses incurred as expert witnesses.”³⁰

The medical liability litigation process often includes the testimony of an expert witness to provide input on standard medical practice and, if testifying on behalf of the plaintiff, whether the defending physician strayed from that standard. Defendants may call an expert witness to help support the assertion that their actions reflected clinical standards. Given the substantial influence that an expert witness’ testimony could have on the outcome of the case, it is imperative that expert witnesses have the necessary certification and experience enabling them to understand the subject matter on which they are testifying.

Among the concerns raised about physician expert witnesses are those who frequently take such work on behalf of plaintiffs, often for out-of-state cases. One study of physicians who frequently acted as witnesses for the plaintiff in neurologic birth injury litigation found them to be older, to have fewer publications in medical literature, and to have subspecialty board certification less frequently than typical defendant witnesses.²⁵ Judicial supervision, state medical boards, and state regulation are the usual means of ensuring expert witness impartiality and qualifications.²⁶ These enforcement levers must be coordinated to ensure that expert witnesses act with good judgment and impartiality and are well-versed in the most current and accepted standards of care that are relevant to the case.

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. However, an examination of industry practices is not an adequate substitute for effective medical liability reforms.

In recent years, medical liability insurance premiums have “softened” or dropped even though the cost of insurance for physicians remains high. This is due to fewer claims and more competition among insurers.¹² Critics of tort reform often argue that it is these market factors that contribute to higher liability insurance premiums and that caps on damages and other reforms will not affect premium increases that occur because of market competition or investment decisions.²⁷ Critics also assert that California’s medical liability crisis was resolved not because of MICRA-based tort reforms, but because of a broad insurance industry reform law that was passed in the late 1980s.³

There is some evidence supporting the need to monitor medical liability premium trends to scrutinize outliers. Some insurers may slash premiums during “soft” markets to gain market share, then abruptly and dramatically increase premiums during hard market shifts because their reserves do not sufficiently cover claims.²⁸ ACP reaffirms its position that premium schedules for medical liability insurance should be based on the actual cost and risk of providing that insurance to each individual group or category.²⁹ Efforts should be made to monitor premiums to ensure that issuers are prepared to adequately provide affordable liability coverage in the face of market fluctuations.

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 following framework:

- Establishing public information campaigns to educate stakeholders about how such programs can improve patient safety, nurture the patient-physician relationship, and stabilize compensation awards;
- Enact strong, broad legal protections that ensure apologies from physicians and other health care professionals are inadmissible in a court of law;
- Educate providers and health care systems on related legal protections and offer training (i.e., coaching and peer mentoring) on effective apology communication;
- Establish legal protections and guidelines for the peer review process to determine the root cause of the unintended event;
- Change National Practitioner Data Bank and state medical board reporting requirements to encourage health care providers to engage in communication and resolution channels. Such health care providers who disclose unintended events to their patients should be shielded from disciplinary action by state medical boards;
- Develop a means for institution-based reporting when system-level errors occur beyond the individual physician’s control;
- Include at least a six-month period to allow for thorough investigation before a patient can sue;
- Continue to collect and distribute data on the impact of communication and resolution programs.
- Pilot programs should test the applicability of communication and resolution programs in small group, rural, and solo physician practices operating outside of closed health care systems. Funding should be directed toward establishing resource centers, statewide risk-pooling or reinsurance products to ensure the viability of communication and resolution programs in such practice environments. Pilot projects should also test the effect of communication and resolution programs in states with and without damage caps.

The ACP Ethics Manual, 6th edition recommends that “physicians should disclose to patients information about procedural or judgment errors made in the course of care if such information is material to the patient’s well-being. Errors do not necessarily constitute improper, negligent, or unethical behavior, but failure to disclose them may.”³⁰ Some evidence suggests that when physicians disclose errors or unanticipated outcomes to their patients, provide an explanation, and

express sympathy, the number of claims filed and attorney fees drop, and efficiencies are improved.³⁴ Further, disclosure may encourage a culture of honesty that sustains a positive patient-physician relationship and may improve clinician morale.³¹ The Joint Commission and National Quality Forum have supported apology and disclosure policies as key elements of patient safety improvement efforts.^{31,32}

Communication and resolution models mark a dramatic reversal from the current practice of “deny and defend,” in which physicians are counseled to deny rather than admit error, leading to protracted court battles and a fracturing of the patient–physician relationship.³³ This mindset is somewhat necessitated by state and federal laws, which permit apologies to be admissible in a court of law as evidence of malpractice.³⁴ If a physician’s apology might instigate a lawsuit and be used against him or her in court, the incentive to admit error and apologize is substantially reduced.

Many states are now recognizing the potential benefits of communication and resolution, and have enacted laws providing some liability protection for health care providers who discuss unintended errors with their patients. However, these laws vary significantly, with some states requiring disclosure and explanation of error and others providing some liability protection if the provider chooses to apologize.³⁵ Apology laws in 25 states and the District of Columbia protect an expression of sympathy, 6 states protect an expression of sympathy and fault, and 3 states protect an expression of sympathy and explanation.³⁵ States vary on the type of event that may trigger a protected apology and the form of communication through which it must be delivered. Similar variance exists with disclosure laws; some disclosure laws also offer legal protection.

Some hospitals and providers have taken the concept a step further and established early disclosure with compensation programs, seeking to prevent the filing of a court case and initiate the healing process. The decade-old Early Disclosure and Offer program at the University of Michigan Health System (UMHS) has increased accountability, reduced claims, and quickened the disbursement of legitimate awards to patients, while maintaining a positive patient-physician relationship and open communication.³³ When UMHS discovers that an unintended outcome has occurred, it begins an investigation; engages the patient and family; conducts an internal review of the error; and if it’s determined that a provider caused an error, a prompt apology is given and compensation is allocated. If UMHS does not find fault, it does not settle with the patient, but continues to engage the patient to explain that the proposed suit lacks merit. Indicating success, the rate of claims and liability costs dropped after implementation of the disclosure-and-offer program.³⁶ The UMHS also uses the data derived from the program to study why the error occurred and what can be done to prevent similar outcomes in the future.²⁰ Lexington, Kentucky’s Veterans Affairs Medical Center also saw a reduction in total liability compensation costs resulting from adoption of a full disclosure-and-offer policy.

Lack of uniformity among existing early disclosure and apology laws may undermine their effectiveness. Best practices for state apology and disclosure laws, developed by Mastroianni et al. and based on NQF guidelines, provide recommendations on protected content, covered parties, triggering event, required content, and the recipient of communication.³⁵ National Practitioner Data Bank and state-level reporting requirements should also be revised to

encourage physician participation in communication and resolution programs. Washington State regulators and AHRQ are developing a pilot program that would alleviate the need for state medical boards to take disciplinary action if a case was resolved through the communication and resolution process.³⁷ Preliminary evidence on communication and resolution programs shows great promise, but as with other reforms, further testing should be done to determine best practices, investigation methods, overhead costs, and effect on patient safety particularly for physicians and other health care professionals operating outside of closed health care systems.

In 2012, Massachusetts enacted a law to encourage communication and resolution programs, which was supported by the commonwealth's medical society, bar association, and trial lawyers.³⁸ Many of the recommendations made under this section were derived from an AHRQ-funded planning grant report titled "A Roadmap for Transforming Medical Liability and Improving Patient Safety in Massachusetts."³⁹ Among the recommendations were support for patient and provider information campaigns, liability protections for providers who apologize for errors, a 6-month "cooling off" investigation period before a patient can file a suit, and changes to reporting requirements to encourage apology and disclosure while protecting the reputations of physicians who have not acted in a negligent manner.

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. States would have flexibility in devising their ADR programs as long as federal standards were met. Federal standards should require ADR systems to incorporate some sort of disincentive to proceeding through the court system so that the ADR would not become a costly "add-on" rather than a cost-effective and faster way of resolving claims.

In addition to communication and resolution programs, other alternative dispute resolution (ADR) models typically permit claims to be considered by medical experts who decide whether the claim has merit and, if so, encourage the plaintiff to reach a settlement and avoid a potentially drawn-out jury trial. ADR processes may facilitate patient-physician communication and an opportunity for physicians and other health care professionals to provide an explanation of why an unintended event occurred and what could be done to prevent a similar outcome in the future.⁴⁰

In mediation, a neutral party guides negotiations between the plaintiff and defendant; the process is nonbinding so either party can leave the mediation process and choose to proceed to a jury trial. Mediation may not always result in a monetary award to the plaintiff. For example, some defendants may be asked to make a donation to charity or conduct seminars to educate physicians on how to avoid medical errors.⁴³ A study of mediation programs involving New York public and private hospital systems found that most participants rated the experience as positive and that the process reduced transaction costs, gave plaintiffs an opportunity to discuss their experience, and provided defendants with insight on how to improve the quality of care.⁴¹ However, physicians were not included in the mediation process, muting the potential for quality improvement gains. The

study recommended that expediency and efficiency could be improved if mediation occurs soon after the adverse event, and that mediators help to facilitate constructive communication between the plaintiff and defendant. The study also encouraged defendant physicians to participate in the mediation, to allow for reconciliation with the patient, and maximize the opportunity for quality improvement. A mediation program implemented by the University of Pittsburgh Medical Center has also generated fast resolutions for patients and lower defense costs for the hospital system.⁴² Overall, mediation has proven to be a very successful alternative to the jury trial. According to Sohn and Bal, "Mediation boasts a 75% to 90% success in avoiding litigation, cost savings of \$50,000 per claim, and 90% overall satisfaction rates among plaintiffs and defendants."⁴³

The federal government has funded a project conducted by the New York State Unified Court System to expand judge-directed negotiations (and an early disclosure program) for New York City public hospitals. If one of the participating New York City hospitals is named in a lawsuit, the case is sent to a judge with training in medical liability claims adjudication. The judge shepherds the claim through the settlement negotiation process, frequently engaging attorneys and parsing out the details of the claim in an effort to reach a settlement, although the judge does not assess a settlement amount. An early observation of the AHRQ-funded program found:

Judge-led conferences have not encountered any major obstacles, and, notably, far more judges signed up for training than initially expected. Attorneys have been receptive to a more hands-on approach to discovery and are very open to early settlement negotiations. Defense attorneys have demonstrated improved communication with hospitals and carriers regarding early case conferences.⁴⁴

New York City hospitals claim that judge-directed negotiation paired with enhanced attention to patient safety improvement has reduced malpractice costs by \$66 million a year.⁴⁵ The model promotes expeditious resolution compared with the previous process, which often takes up to 4 to 5 years.⁴⁶

While ADR models hold potential for improving the medical liability system, additional testing should be done to determine which ADR models should be adopted. Pilot projects should be conducted to determine whether ADR achieves the goals of improving patient outcomes, provides fair awards to patients, facilitates timely resolution of claims, and disposes of non-meritous liability claims.

Recommendation 7: ACP supports the development of safe harbor protections when clinicians provide care consistent with evidence-based guidelines providing the following conditions are met:

- Selection of evidence-based guidelines protected under safe harbor should be conducted by a panel of medical experts organized by a qualified entity, such as the Institute of Medicine. To be considered for safe harbor status, evidence must support that clinical guidelines are reliable; valid; clearly defined; based on current data; adjusted to compensate for variations in case mix, severity, risk; selected based on strong consensus among stakeholders and predictive of overall quality

performance; reflective of processes of care that physicians and other health care professionals can influence and impact; and are not administratively burdensome. Selection of guidelines should seek to improve patient safety, encourage collaborative care, and control health care costs.

- Clinical guidelines under safe harbor should be regularly evaluated for relevance and effectiveness by objective stakeholder organizations with physician input. Safe harbors should be sunsetted if it is determined that a clinical guideline may have a harmful effect on patient health, or does not meet the characteristics described in this recommendation.
- Physicians should not be held culpable in a court of law if, having considered a patient's individual medical circumstances and preferences for care and applying their best professional judgment, they do not follow guidelines.
- An extensive education campaign should be initiated to inform physicians and other health care professionals of the safe harbor status of selected clinical guidelines and to provide clear information on how physicians may be protected by safe harbors.

Some states have enacted laws to protect health care providers who adhere to evidence-based practice guidelines. The justification for "safe harbor" laws is multifold: physicians will perform less defensive medicine since excess services and tests will not be supported by guidelines, and unfounded malpractice claims may be disposed of if it is determined that the physician performed according to quality measures.⁴⁷ Rather than basing the compensation decision on a variable and potentially local standard of care, liability would be predicated on whether the physician or other health care provider followed the evidence-based standard.⁴⁸ Most important, it may also improve patient health outcomes by increasing adherence to best practices. Kachalia et al. found that safe harbors had a limited influence on liability claims but did encourage physicians to follow clinical guidelines, potentially leading to improved patient safety.⁴⁹ Safe harbor proposals have been considered during the health reform push of the 1990s, by MedPAC, and during development of the Affordable Care Act.⁴⁴ Brookings Institution's "Bending the Curve" proposal recommends establishing safe harbors to protect providers who achieve positive health outcomes by following quality and safety measures.⁵⁰ Other organizations, such as the Center for American Progress, the Moment of Truth Foundation, the National Coalition on Health Care, and the American Enterprise Institute, have expressed support for the safe harbors concept.⁵¹

A handful of states have tested programs that allow clinicians to use adherence to quality measures as a defense against liability claims. Currently, Kentucky is the only state with a safe harbor law, but it applies only to physicians treating patients with workers' compensation claims. At this point, evidence of the efficacy of safe harbors is limited, but the literature does show improved care quality and reduced malpractice risk for obstetricians who followed clinical guidelines.⁵² Liability case history also shows that juries have decided in favor of physicians who followed the standard of care, potentially undermining arguments that a physician acted negligently in delivering care.⁵³ Oregon received funding from AHRQ to develop a safe harbor program. According to an evaluation of closed claims files, 5% of claim injuries would have

been avoided if clinicians had followed guidelines, nearly 10% of claims would have been settled more quickly, and a limited number of indemnity payments would have been avoided if a safe harbor rule had been in place. The project also surveyed stakeholders on their opinion of a legal safe harbor:

- 72% of providers surveyed felt that a safe harbor rule would likely reduce the impact of medical liability on their clinical decision-making.
- 71% of providers said a safe harbor rule would be an effective approach to medical liability reform. Newer providers and those who were employees or contractors were far more optimistic about safe harbor laws than more tenured physicians or those who were owners of their own practices.
- 82% of providers reported that a safe harbor rule would increase their adherence to guidelines and 69% thought it would result in improved patient safety due to better adherence to guidelines.⁵⁴

There is some concern that new health system payment standards established by the federal government may expose physicians to greater liability risk. For instance, a plaintiff's attorney could attempt to establish fault by disclosing that a physician did not receive payment because of a "never event." The AMA has drafted model legislation designed to protect physicians who do not follow payment guidelines because they are not in the patient's best interest.⁵⁵ Georgia recently became the first state to sign the proposal into law; a bill to establish similar protections at the federal level has also been introduced in Congress.⁵⁶

Safe harbor protections theoretically fulfill a number of goals: improved patient outcomes, reduced use of defensive medicine, and quick dismissal of lawsuits with limited merit. Quality and performance measurements must be thoroughly vetted and receive ongoing scrutiny to determine whether they reflect existing best practices. Safeguards must be put in place to provide physicians some leeway when the most effective treatment is outside the established standard of care. If done properly, safe harbor protections may improve patient safety while protecting providers from egregious lawsuits.

Recommendation 8: ACP supports initiating pilot projects to determine the effectiveness of health courts and administrative compensation models. The College recommends that:

- Programs be structured to provide fair and expeditious review of medical liability claims, with the goal that claims should be resolved within one year of being filed.
- Judges and administrative agency staff have training and experience in the delivery of medicine and of medical claims adjudication matters. Judges should be advised by objective medico-legal experts employed by the health court or administrative compensation entity.
- The negligence standard for compensation be replaced by an avoidability standard based on what information was known by the provider at the time the care was given.

- Economic damages not be considered by a health court or administrative agency. Noneconomic damages may be considered and compensation should be based on a pre-determined schedule. Collateral source rules should be revised so that awards are offset by payments received from health insurance and other sources.
- Patient appeals be considered by an administrative law judge.
- Health care providers be given an opportunity to appeal the adjudicator's decision.
- A sunset mechanism should terminate the pilot project if it fails to meet the goal of improving patient safety, strengthening the patient-physician relationship, expediting legitimate medical claims decisions, and infusing objectivity and predictability into the liability process.

Health courts are designed to facilitate speedy decisions, promote consistency and reliability of verdicts, discourage the filing of unnecessary claims, and justly compensate patients, while nurturing the patient-physician relationship. Quality information gathered from health court claims can be used to track common problems and design responses to improve patient safety.

Health courts are modeled on workers' compensation courts, similarly replacing the jury (and expert witnesses' employed by the plaintiff or defendant) with a specially-trained judge. Generally, a panel of court-employed medical experts investigates the claim. If it's determined that injury was avoidable (although other standards such as pure no-fault or negligence may apply), then a payment for noneconomic damages is made; the amount of the award would be based on a compensation schedule.⁵⁷ If further investigation is needed or the plaintiff is not satisfied with the investigator's decision, an administrative judge trained in medico-legal matters would consider the case. The judge would receive counsel from independent experts employed by the court, rather than expert witnesses brought in by the plaintiff or defendant's attorney. The judge would deliver a verdict, establishing precedent and providing data toward improving the standard of care. Once the case is decided, the judge provides written documentation of the decision and recommends standards of care to prevent future errors.⁵⁸

Under some proposals, plaintiffs are not required to establish that the provider acted with negligence; instead, "avoidability" must be determined, meaning "whether an injury could've been prevented had best practices been followed."^{59,60} Health courts may also require a "no-fault" standard, "compensating all injuries attributable to medical management, except for some known, frequent complications."⁴⁴ In the 2006 addendum to its comprehensive medical liability reform position paper, ACP expressed support for investigating and testing health courts. The health courts concept has gained substantial momentum, with President Obama and 2012 presidential candidate Mitt Romney, the National Commission on Fiscal Responsibility and Reform (AKA Simpson-Bowles Commission), and numerous state and federal legislators supporting such reforms.⁵⁷ According to a poll conducted by Common Good, 66% of the public supports the health courts concept. Support is also bipartisan, with 68% of Republicans, 67% of Democrats, and 61% of independents approving.⁶¹

Administrative Compensation Models of Sweden, Denmark, and New Zealand

While the concept of health courts has been tested on a piecemeal basis in the United States, evidence from other countries shows that administrative compensation models (ACM) can have a positive effect on the medical liability system by improving efficiency and engendering patient-physician cooperation. ACMs are similar to judge-directed health courts, but claims decisions are made by an administrative agency outside the court of law. New Zealand's Accident Compensation Corporation features medical experts who review the case, determine compensation for the patient's lost wages and rehabilitation costs, and provide a one-time payment for miscellaneous expenses incurred by the claimant.⁶² Physician fault or negligence does not have to be demonstrated.⁶³

Sweden also has experience with no-fault health courts. Most physicians are covered by the LOF, a mutual insurance company formed by Swedish regional hospital authorities. The LOF conducts claims investigations and evaluations and compensates patients who meet the criteria, which are based on an avoidability standard. A separate body finances the Patient Claims Panel, which hears patient claims appeals regardless of whether the provider involved had liability insurance coverage.⁶⁵ Likewise, Denmark's administrative compensation system is mostly funded by regional hospitals that self-insure, although some purchase private liability insurance. Both self-insured and private insurers operate the Patient Insurance Association, which considers medical liability claims.⁶⁵ Sweden and Denmark's claims investigators are assisted by senior physicians with a variety of specialty backgrounds. These health care professionals are employed through long-term contracts enabling them to gain critical insight and institutional experience to buttress their clinical background.

Studies of the Swedish, Danish, and New Zealand medical liability compensation systems found that they managed to preserve the patient-physician relationship while facilitating appropriate awards for injured patients and making the system operate more efficiently. New Zealand's administrative system has improved efficiency and reduced overhead, as total administrative costs have stabilized at 10%.⁶² The reformed system may have a part in strengthening the patient-physician relationship, as up to 80% of physicians help their patients file claims.⁶⁵ Cases are also resolved faster than in the United States, as injury-to-disposition period averages 8 months in Sweden and Denmark and 16 days in New Zealand. In the United States, claims may languish for 5 years after the injury occurs to when the claim is disposed.⁶⁵ The foreign administrative compensation systems do compensate more claims than the U.S. system, but a number of safeguards help to ensure that costs are manageable. Collateral source offset rules apply to compensate for payments rendered through other social insurance systems, such as the national health insurance or worker's compensation programs. Low overhead costs (roughly a third of what is spent in the U.S. system) also help to manage spending. Finally, damage caps and pre-determined compensation schedules further drive down costs.⁶⁵ Administrative compensation systems are also designed to track medical errors to determine where solutions are needed and to help develop health care quality standards. Each nation's system prohibits information sharing between the compensation system and the authority that investigates patient complaints concerning medical care.

Mello, Kachalia, and Studdert found that the move away from the standard of negligence to an avoidability standard proved most consequential:

Perhaps the strongest lesson to be learned from the international examples is that replacing the negligence standard with a more liberal, less stigmatizing compensation standard, such as avoidability, reaps multiple benefits. In addition to easing injured patients' access to compensation for preventable injuries, it preserves physician-patient relationships, encourages transparency about adverse events, and fosters physician participation in the claims process. In this way, an administrative compensation system can help move American health care toward the culture of safety necessary to prevent medical injuries.⁶⁵

These authors see international administrative compensation systems as potential models for a U.S.-based program. Sweden, Denmark, and New Zealand transformed from a tort-based system to an administrative compensation system and believe that the new structure will endure despite controversy over the proper compensation standard and relatively low compensation amounts. The authors caution that all three programs exist in countries that have more generous social insurance programs and less litigious societies than the United States. However, they maintain that the U.S. system could integrate neutral medical experts to hear appeals of claims investigations conducted by the health care professional's private insurance carrier. Also, private insurers could be induced to expedite claims decisions.

The Need for Health Court Pilot Projects

Other evidence suggests that states and providers can save significant money by replacing the existing medical liability system with a health court or administrative compensation model. An evaluation of a Georgia no-blame health court bill found that such reform could save the state's taxpayers \$7 billion over 10 years.⁶⁴ Evidence from existing vaccine, birth defect, and workers' compensation administrative court programs show that such structures may successfully drive down administrative costs and strengthen quality and safety improvement efforts. Administrative courts also provide more timely resolution and award disbursement to qualifying plaintiffs.⁶⁵ Advocates also claim that injecting more predictability and reliability into the existing medical liability system will help reduce defensive medicine.

Despite the positive evidence and political support surrounding health courts, a several issues remain. The constitutionality of such reforms has been questioned by opponents concerned that one's right to a jury trial may be infringed; however, workers' compensation courts have survived legal challenges.⁶⁶ The issue of health court constitutionality may be addressed by making health courts an option for patients, thus retaining their right to seek a jury trial. Patients may prefer the tort system if they perceive juries to be fairer or provide a more substantial award.⁴⁷ While establishing a voluntary health court may increase the likelihood of constitutionality, it also reduces the cost-efficiency potential if claimants believe they can receive a better outcome from a jury trial. Reforms would also have to include a means to inform patients of their rights to seek a jury

trial and verify consent of their choice. Elliot, Narayan, and Nasmith conclude that federal compensation systems through an administrative health court would pass the constitutionality test provided that “the statute is appropriately drafted and that appropriate factual findings are made concerning the benefits to patients and the public as well as to doctors and their insurers.”⁶⁷

Other issues that warrant further investigation include appeal process standards and the types of claims considered by a health court.⁴⁷ Some suggest that the overhead and the higher number of compensated patients may offset any cost savings from lower compensation.⁶⁸ Also, while specialized judges may have more medico-legal expertise than juries, they may be just as likely to decide against the defendant, as evidenced in some veterans and military hospital-based cases.⁶⁹ The means for disciplining health care providers is an open question, as it remains unclear how state boards of medicine would interact with a health court. Indeed, the Medical Association of Georgia opposed a health court bill over concerns that it would lead to an increase in the number of claims awarded, triggering a storm of investigations and augmenting the number of claims submitted to the National Practitioner Data Bank.⁷⁰ Because of these concerns, health court and administrative compensation pilot projects should include a sunset mechanism if it is determined that the financial, administrative, or other burden on patients or physicians negates the benefits of the health court model.

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.

Team-based, collaborative care seeks to improve patient health outcomes; inject high-value, evidence-based care into patient treatment; share patient responsibility among all team members based on the needs of the patient at the time of care; and other goals. Many physicians are affiliating with hospital and other large provider systems to improve care integration through ACOs. ACP has established principles supporting the development of dynamic clinical care teams.⁷¹ The College acknowledges that the U.S. health care system is shifting toward clinical care teams consisting of physicians and other health care professionals with the training and skills needed to provide high-quality, coordinated care specific to the patient’s clinical needs and circumstances. Different members of the team may have responsibility for specific elements of a patient’s care based on their training and skills, to provide the best care for the patient as the patient’s needs dictate. Clinical care teams, which include PCMHs, can also be developed in remote and underserved practice areas by forming “virtual care teams” with the aid of telemedicine and other technology. At its core, team based care intends to improve collaboration and cooperation among providers and thus reduce medical errors. Further, ACP has developed policy to facilitate the creation of PCMH “neighbors,” which seek to connect and coordinate care between primary care teams and physician specialists.⁷²

More collaboration among physicians and other health care professions may also present liability challenges. If an error occurs, it may be difficult to discern who is at fault—the physician who may have overall clinical responsibility for care provided by the team, or the clinician who treated the patient at the time of injury? In many cases, the supervisor of the care team may be held responsible for any errors committed by team members, depending on their level of control over the other providers.⁷³ Alternatively, ACOs or other team-based models may be held accountable, rather than the individual health care provider, under the direct corporate negligence theory.⁷³ In models where supervision and responsibility for the patient is fluid and less well-defined, determining liability may be more difficult. Enterprise liability seeks to shift responsibility from the individual physician to the health system, hospital, or ACO. The potential benefit of enterprise liability is that it removes the specter of a lawsuit from the individual physician, potentially promotes system-based quality improvements, and lessens the potential that physicians will be held responsible for a system-level error over which they have no control. However, enterprise liability may increase the amount of institutional control over affiliated physicians, compromising their autonomy.⁷⁴ More research is needed to test the efficacy of enterprise liability on providers working in teams.⁷⁵

Other quality-focused reforms may help providers avoid errors and subsequent lawsuits, such as better adherence to clinical guidelines (especially if strong safe harbors are in place), teamwork training and development, and innovative tort alternatives discussed elsewhere, such as no-fault health courts and apology and offer programs.⁷⁶ Of course, avoiding a medical error connected to team-based care is preferable. Communication and understanding of leadership roles is key—a study of 901 sentinel events found that 62% were related to poor leadership and 59% were the result of poor communication among team members.⁷⁷ Thorough documentation of patient handoffs may also provide the team with the necessary information to deliver care without duplicating interventions. A hierarchical culture may also hamper effective communication. Team members must feel comfortable with their skill level and know when to transfer the patient to the provider who can best meet the patient's needs at that time. Best practice checklists, team reviews and consultations, and a culture of openness can enable providers to focus on areas that need most attention and increase overall effectiveness.⁷⁷ Liability protections for these new methods of care coordination—including telephone consults—should also be developed.

CONCLUSION

A solution to the broken medical liability system in the United States 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 rather than undermining the patient-physician relationship, and reducing the economic costs associated with the current system. A multifaceted approach should allow for innovation, pilot-testing, and further research on the most effective reforms. The American College of Physicians believes that the following approaches should be incorporated into a multifaceted medical liability reform initiative:

- Continued focus on patient safety and prevention of medical errors;
- Passage of a comprehensive tort reform package, including caps on noneconomic damages;
- Minimum standards and qualifications for expert witnesses;
- Oversight of medical liability insurers;
- Testing, and if warranted, expansion of communication and disclosure programs;
- Pilot-testing a variety of alternative dispute resolution models;
- Developing effective safe harbor protections that improve quality of care, increase efficiency, and reduce costs;
- Expanded testing of health courts and administrative compensation systems;
- Research into the effect of team-based care on medical liability, as well as testing of enterprise liability and other products that protect and encourage team-based care.

Appendix: Glossary of Medical Liability Terms

Alternative dispute resolution: Liability claim resolution process other than a traditional jury trial. Examples include mediation and arbitration.

Collateral source rule: A rule preventing admission of evidence of compensation to patients from sources such as health insurance and life insurance.

Fair-share rule: Requirement that defendants are held liable only for the portion of the patient's injury for which they are responsible.

Joint and several liability: A type of liability in which a single defendant is held liable for the actions of multiple defendants—including the entire judgment amount—irrespective of their proportion of fault.

Non-economic damages: Compensation for pain, suffering, inconvenience, or other nonmonetary losses. Economic damages are awards to compensate monetary losses related to medical or other health care services, loss of income, or other verifiable losses.

Statute of limitation: A law establishing a cap on the period of time a lawsuit can be filed after the date of discovery of an injury.

Communication and resolution (also known as early disclosure, apology, and offer): Generally, a process where a health provider or their representative investigate a patient injury, disclose and apologize for fault, and offer the patient compensation.

REFERENCES

- 1 Bovbjerg RR. Will the Patient Protection and Affordable Care Act Address the Problems Associated with Medical Malpractice? The Urban Institute. August 2010. Accessed at www.urban.org/UploadedPDF/412193-ppaca-medical-malpractice.pdf on May 1, 2013.
- 2 American College of Physicians. Reforming the Medical Professional Liability Insurance System. Philadelphia: American College of Physicians; 2003: Position Paper.
- 3 Bovbjerg RR and Berenson RA. Surmounting Myths and Mindsets in Medical Malpractice. The Urban Institute. October 2005. Accessed at www.urban.org/UploadedPDF/411227_medical_malpractice.pdf on May 1, 2013.
- 4 Carrier ER, Reschovsky JD, Mello MM, Mayrell RC, Katz D. Physicians' Fears of Malpractice Lawsuits Are Not Assuaged By Tort Reforms. *Health Affairs*. 2010; 29(9):1585-1592.
- 5 Bovbjerg RR. Will the Patient Protection and Affordable Care Act Address the Problems Associated with Medical Malpractice? Urban Institute. August 2010. Accessed at www.urban.org/UploadedPDF/412193-ppaca-medical-malpractice.pdf on May 8, 2013.
- 6 Mello MM, Chandra A, Gawande AA, Studdert DM. National Costs of the Medical Liability System. *Health Affairs*. 2010;29(9)1569-1577.
- 7 Congressional Budget Office. Letter to Senator Orrin Hatch. October 9, 2009. Accessed at www.cbo.gov/sites/default/files/cbofiles/ftpdocs/106xx/doc10641/10-09-tort_reform.pdf on May 7, 2013.
- 8 Mello MM, Chandra A, Gawande AA, Studdert DM. National Costs of the Medical Liability System. *Health Affairs*. 2010; 29(9)1569-1577.
- 9 Carrier ER, Reschovsky JD, Katz DA, Mello MM. High Physicians Concern About Malpractice Risk Predicts More Aggressive Diagnostic Testing in Office-Based Practice. *Health Affairs*. 2013;32(8); 1383-1391.
- 10 Thomas JW, Ziller EC, and Thayer DA. Low Costs of Defensive Medicine, Small Savings from Tort Reform. *Health Affairs*. 2010; 29(9); 1578-1584.
- 11 Jena AB, Seabury S, Lakdawalla D, Chandra A. Malpractice Risk According to Physician Specialty. *N Engl J Med*. 2011;365: 629-636. Accessed at www.nejm.org/doi/full/10.1056/NEJMs1012370#t=articleResults on September 12, 2013.
- 12 Krupa C. Liability premium relief good for doctors, unsettling for insurers. *American Medical News*. October 22, 2012. Accessed at www.amednews.com/article/20121022/profession/310229946/1/ on May 7, 2013.
- 13 Rubin PH and Shepherd J. Tort Reform and Accidental Deaths. *Journal of Law and Economics*. 2007; 50: 221-238. Accessed at papers.ssrn.com/sol3/papers.cfm?abstract_id=781424 on May 7, 2013.
- 14 Gerencher K. Health courts for those who never thought they'd have a case. *Marketwatch.com*. November 13, 2009. Accessed at blogs.marketwatch.com/healthmatters/2009/11/13/health-courts-for-those-who-never-thought-theyd-have-a-case/ on September 18, 2013.
- 15 AHRQ. Medical Liability Reform & Patient Safety Initiative. Accessed at www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/liability/index.html on September 25, 2013.
- 16 Langel S. Averting Medical Malpractice Lawsuits: Effective Medicine - or Inadequate Cure? *Health Affairs*. 2010;29(9):1565-1568.
- 17 Congressional Budget Office. Reducing the Deficit: Spending and Revenue Options. CBO. March 2011. Accessed at www.cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12085/03-10-reducingthedeficit.pdf on September 12, 2013.

- 18 Moment of Truth Project and National Coalition on Health Care. Achieving Real Savings Through Better Care. September 2013. Accessed at www.momentoftruthproject.org/sites/default/files/Final%20Delivery%20Systems%20Reform%20Paper.pdf on September 12, 2013.
- 19 Lakdawalla DN and Seabury SA. The Welfare Effects of Medical Malpractice Liability. National Bureau of Economic Research. Working Paper 15383. September 2009. Accessed at www.nber.org/papers/w15383.pdf?new_window=1 on May 7, 2013.
- 20 Hellinger FJ and Encinosa WE. Review of Reforms to Our Medical Liability System. Agency for Healthcare Research and Quality. AHRQ. December 31, 2009. Accessed at www.ahrq.gov/legacy/qual/liability/reforms.htm on May 7, 2013.
- 21 Kachalia A and Mello MM. New Directions in Medical Liability Reform. *N Engl J Med*. 2011; 364(16):1564-1572.
- 22 Avraham R, Dafny LS, and Schanzenbach MM. The Impact of Tort Reform on Employer-Sponsored Health Insurance Premiums. National Bureau of Economic Research. Working Paper 15371. Spetember 2009. Accessed at www.nber.org/papers/w15371.pdf?new_window=1 on May 7, 2013.
- 23 Kaminsky JL. Medical Malpractice – Impact of Texas Liability Reform. OLR Research Report. December 6, 2004. Accessed at www.cga.ct.gov/2004/rpt/2004-r-0918.htm on September 17, 2013.
- 24 National Conference of State Legislatures. Medical Liability/Medical Malpractice Laws. August 15, 2011. Accessed at www.ncsl.org/issues-research/banking/medical-liability-medical-malpractice-laws.aspx on September 12, 2013.
- 25 Kesselheil AS and Studdert DM. Characteristics of physicians who frequently act as expert witnesses in neurologic birth injury litigation. *Obstet Gynecol*. 2006;108(2): 273-9. Accessed at www.ncbi.nlm.nih.gov/pubmed/16880295 on January 31, 2014.
- 26 Kesselheim AS and Studdert DM. Role of Professional Organizations in Regulating Physician Expert Witness Testimony. *JAMA*. 2007;298(24):2907-2909. Accessed at jama.jamanetwork.com/article.aspx?articleid=209820#REF-JCO70088-4 on January 31, 2014.
- 27 Perrecone FA and Fabiana LR. The Fleecing of Seriously Injured Medical Malpractice Victims in Illinois. *NIU Law Review*. April 23, 2006. Accessed at www.niu.edu/law/organizations/law_review/pdfs/full_issues/26_3/Perrecone.pdf on September 25, 2013.
- 28 Harrington SE. Tort Liability, Insurance Rates, and the Insurance Cycle. Prepared for the Brookings-Wharton Conference on Public Policy Issues Confronting the Insurance Industry. January 2004. Accessed at fic.wharton.upenn.edu/fic/papers/04/Harrington.pdf on September 25, 2013.
- 29 American College of Physicians. Reforming the Medical Professional Liability Insurance System. Philadelphia: American College of Physicians; 2003: Position Paper.
- 30 American College of Physicians. Ethics Manual, Sixth Edition. *Ann Intern Med*. 2012;156:73-104.
- 31 Wojcieszak D, Banja J, and Houk C. The Sorry Works! Coalition: Making the Case for Full Disclosure. *Jrl of Quality and Patient Safety*. 2006;32(6):344-350. Accessed at www.jointcommission.org/assets/1/18/Sorry_Works.pdf on May 8, 2013.
- 32 AHRQ. Patient Safety Primers: Error Disclosure. AHRQ Patient Safety Network. October 2012. Accessed at psnet.ahrq.gov/primer.aspx?primerID=2 on May 8, 2013.
- 33 Boothman R and Hoyler MM. The University of Michigan’s Early Disclosure and Offer Program. *The Bulletin of Am Coll Surgeons*. March 2013.
- 34 Bender FF. “I’m Sorry” Laws and Medical Liability. *Virtual Mentor*. 2007;9(4): 300-4. Accessed at virtualmentor.ama-assn.org/2007/04/hlaw1-0704.html on May 8, 2013.
- 35 Mastroianni AC, Mello MM, Sommer S, Hardy M, Gallagher TH. The Flaws in State ‘Apology’ and ‘Disclosure’ Laws Dilute Their Intended Impact on Malpractice Suits. *Health Affairs*. 2010; 29(9):1611-1619.

- 36 Kachalia A, Kaufman SR, Boothman R, Ajnderson S, Welch K, Saint S, Rogers MAM. Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program. *Ann Intern Med.* 2010;153(4):213-221.
- 37 Sage WM, Gallagher TH, Armstrong S, Cohn JS, McDonald TM, Gale J, Woodward AC, Mello MM. How Policy Makers Can Smooth the Way for Communication-And-Resolution Programs. *Health Aff.* 2014;33(1):11-19. Accessed at content.healthaffairs.org/content/33/1/11.full on February 5, 2014.
- 38 Insurance Journal. Mass. Embraces 'Disclosure, Apology, Offer' Approach for Med Mal Cases. *Insurance Journal.* August 7, 2012. Accessed at www.insurancejournal.com/news/east/2012/08/07/258509.htm on May 9, 2013.
- 39 Beth Isreal Deaconess Medical Center and Massachusetts Medical Society. A Roadmap for Removing Barriers to Disclose, Apology, and Offer in Massachusetts. April 2012. Accessed at www.macmi.info/files/3513/5394/0268/FinalRoadmapApril2012.pdf on September 24, 2013.
- 40 Szmania SJ, Johnson AM, Mulligan M. Alternative Dispute Resolution in Medical Malpractice: A Survey of Emerging Trends and Practices. *Conflict Resolution Quarterly.* 2008; 26(1):71-96. Accessed at onlinelibrary.wiley.com/doi/10.1002/crq.224/pdf on October 1, 2013.
- 41 Liebman CB. Medical Malpractice Mediation: Benefits Gained, Opportunities Lost. *Law and Contemporary Problems.* 2011;74:135-149. Accessed at scholarship.law.duke.edu/cgi/viewcontent.cgi?article=1637&context=lcp on September 30, 2013.
- 42 Creo RA, Shogan JO, Turner CT. Malpractice case alternative dispute resolution. *Physicians News Digest.* November 13, 2005. Accessed at www.physiciansnews.com/2005/11/13/malpractice-case-alternative-dispute-resolution/ on November 22, 2013.
- 43 Sohn DH and Bal S. Medical Malpractice Reform: The Role of Alternative Dispute Resolution. *Clin Orthop Relat Res.* 2012;470:1370-1378. Accessed at www.ncbi.nlm.nih.gov/pmc/articles/PMC3314770/ on November 20, 2013.
- 44 Agency for Healthcare Research and Quality. Medical Liability Reform and Patient Safety Initiative Progress Report. Accessed at www.ahrq.gov/legacy/qual/liability/mediabrep.pdf on May 9, 2013.
- 45 Glaberson W. To Curb Malpractice Costs, Judges Jump in Early. *NY Times.* June 12, 2011. Accessed at www.nytimes.com/2011/06/13/nyregion/to-curb-malpractice-costs-judges-jump-in-early.html?pagewanted=all&r=0 on May 9, 2013.
- 46 Makulowich G, ed. AHRQ-funded medical liability and patient safety initiative shows promise for reducing patient harm, lawsuits, and costs. U.S. Department of Health and Human Services. AHRQ Research Activities. Number 385, September 2012. Accessed at www.ahrq.gov/legacy/research/sep12/0912RA.pdf on December 11, 2013.
- 47 Mello MM and Kachalia A. Evaluation of Options for Medical Malpractice System Reform. MedPAC. April 2010. Accessed at www.medpac.gov/documents/Apr10_MedicalMalpractice_CONTRACTOR.pdf May 8, 2013.
- 48 Emmanuel Z, Spiro T, Calsyn M. Reducing the Cost of Defensive Medicine. Center for American Progress. June 11, 2013. Accessed at www.americanprogress.org/issues/healthcare/report/2013/06/11/65941/reducing-the-cost-of-defensive-medicine/ on September 17, 2013.
- 49 Kachalia A, Little A, Isavoran M, Crider L, Smith J. Greatest Impact of Safe Harbor Rule May Be to Improve Patient Safety, Not Reduce Liability Claims Paid By Physicians. *Health Aff.* 2014;33(1):59-66. Accessed at content.healthaffairs.org/content/33/1/59.full on February 4, 2014.
- 50 Brookings Institute. Bending the Curve: Person-Centered Health Care Reform: a Framework for Improving Care and Slowing Health Care Cost Growth. Engelberg Center for Health Care Reform. 2013. Accessed at www.brookings.edu/~media/research/files/reports/2013/04/person%20centered%20health%20care%20reform/person_centered_health_care_reform.pdf May 8, 2013.

- 51 Moment of Truth Project and National Coalition on Health Care. Achieving Real Savings Through Better Care. September 2013.
- 52 Ransom SB, Studdert DM, Dombrowski MP, Mello MM, Brennan TA. Reduced medicolegal risk by compliance with obstetric clinical pathways: a case-control study. *Obstet Gynecol.* 2003; 101(4): 751-5. Accessed at www.ncbi.nlm.nih.gov/pubmed/12681881 on May 8, 2013.
- 53 Mackey TK and Liang BA. The Role of Practice Guidelines in Medical Malpractice Litigation. *Virtual Mentor.* 2011; 13(1): 36-41. Accessed at virtualmentor.ama-assn.org/2011/01/hlaw1-1101.html on May 8, 2013.
- 54 Smith J, principal investigator. AHRQ Medical Liability & Patient Safety Planning Grant: Final Progress Report. Oregon Health Policy and Research. Accessed at www.oregon.gov/oha/OHPR/PSDM/AHRQ_MLPS_Report.pdf on September 15, 2013
- 55 Gallegos A. Doctors win first safe harbor against ACA use in liability suits. *American Medical News.* April 15, 2013.
- 56 Robeznieks A. Georgia enacts physician shield law. *ModernPhysician.com.* May 7, 2013. Accessed at www.modernphysician.com/article/20130507/MODERNPHYSICIAN/305079975/georgia-enacts-physician-shield-law?utm_source=articlelink&utm_medium=website&utm_campaign=Today'sHeadlines on May 8, 2013.
- 57 Mello MM and Gallagher TH. Malpractice Reform - Opportunities for Leadership by Health Care Institutions and Liability Insurers. *N Engl J Med.* 2010;362:1353-1356. Accessed at www.nejm.org/doi/full/10.1056/NEJMp1001603 on September 23, 2013.
- 58 Common Good. Establish Health Courts. *Commongood.org.* Accessed at www.commongood.org/pages/establish-health-courts on May 9, 2013.
- 59 American College of Physicians. Exploring the Use of Health Courts - Addendum to "Reforming the Medical Professional Liability System." Philadelphia: American College of Physicians; 2006: Position Paper.
- 60 Robert Wood Johnson Foundation. Resolving Medical Malpractice Cases in Health Courts - Alternative to the Current Tort System. RWJF. August 15, 2010. Accessed at www.rwjf.org/content/dam/farm/reports/program_results_reports/2010/rwjf63703 on May 9, 2013.
- 61 Howard P. Growing Bipartisan Support for Health Courts. *Health Affairs Blog.* October 2, 2012. Accessed at healthaffairs.org/blog/2012/10/02/the-growing-bipartisan-support-for-health-courts/ on September 18, 2013.
- 62 Howard PK and Maine RG. Health courts may be the best cure for what ails the liability system. *The Bulletin of Am Coll Surgeons.* March 2013.
- 63 Sohn DH. Negligence, genuine error, and litigation. *Intl Jrl Gen Med.* 2013; 2013(6); 49-56. Accessed at www.dovepress.com/negligence-genuine-error-and-litigation-peer-reviewed-article-IJGM on May 9, 2013.
- 64 Common Good. Momentum for Health Courts Continues to Build. March 4, 2013. Accessed at www.commongood.org/blog/entry/momentum-for-health-courts-continues-to-build on October 1, 2013.
- 65 Mello MM, Kachalia A, and Studdert DM. Administrative Compensation for Medical Injuries: Lessons from Three Foreign Systems. The Commonwealth Fund. July 2011. Accessed at www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/Jul/1517_Mello_admin_compensation_med_injuries.pdf on May 9, 2013.
- 66 Chen SA and Sohn DH. Health Courts: A Potential Answer for Tort Reform. *AAOS Now.* 2013;7(9). Accessed at www.aaos.org/news/aaosnow/oct12/managing7.asp on September 25, 2013.

- 67 Elliot ED, Narayan SA, Masmith MS. Administrative "Health Courts" for Medical Injury Claims: The Federal Constitutional Issues. *The Journal of Health Politics, Policy and Law*. 2008;33(4):761-798. Accessed at www.willkie.com/files/tbl_s29Publications%5CFileUpload5686%5C2664%5CA%20Administrative%20Health%20Courts%20for%20Medical%20Injury%20Claims.pdf on October 1, 2013.
- 68 Maine RG and Hoyler MM. New directions in liability reform. *The Bulletin of Amer Coll Surgeons*. March 2013.
- 69 Malone PA and Hoyler MM. Attorneys and Physicians share common goals: The medical liability lawyer's perspective. *The Bulletin of Amer Coll Surgeons*. March 2013.
- 70 Medical Association of Georgia. MAG Advocacy Brief: Oppose S.B. 141 "Patient Injury Act." Medical Association of Georgia. Accessed at www.mag.org/sites/default/files/downloads/issue-brief-patient-injury3-act2013.pdf on September 23, 2013
- 71 Doherty RB and Crowley RA. Principles Supporting Dynamic Clinical Care Teams: An American College of Physicians Position Paper. *Ann Intern Med*. 2013;159. Accessed at annals.org/article.aspx?articleid=1737233 on October 1, 2013.
- 72 American College of Physicians. The Patient-Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices. Philadelphia: American College of Physicians; 2010: Policy Paper.
- 73 Blake V. Scope of Practice in Team-Based Care: Virginia and Nationwide. *Virtual Mentor*. June 2013. 15(6):518-521. Accessed at virtualmentor.ama-assn.org/2013/06/hlaw1-1306.html on September 24, 2013.
- 74 Tappan K. Medical-Malpractice Reform: Is Enterprise Liability or No-Fault a Better Reform? *Boston College Law Review*. 2005;46(5):1095-1130. Accessed at lawdigitalcommons.bc.edu/cgi/viewcontent.cgi?article=2315&context=bclr on October 1, 2013.
- 75 Burkle CM. Medical Malpractice: Can We Rescue a Decaying System? *Mayo Clin Proc*. 2011;86(4):326-332. Accessed at www.ncbi.nlm.nih.gov/pmc/articles/PMC3068892/ on September 25, 2013.
- 76 Joint Commission on Accreditation of Healthcare Organizations. Health Care at a Crossroads: Strategies for improving the Medical Liability System and Preventing Patient Injury. 2005. Accessed at www.jointcommission.org/assets/1/18/Medical_Liability.pdf on September 24, 2013.
- 77 Gallegos A. Physician liability: Your team, your risk. *American Medical News*. July 29, 2013. Accessed at www.amednews.com/article/20130729/profession/130729942/4/#relatedcontenthed on September 25, 2013



Product #510140010