Exploring the Use of Health Courts – Addendum to "Reforming the Medical Professional Liability System"

American College of Physicians
A Position Paper
2006

Exploring the Use of Health Courts – Addendum to "Reforming the Medical Professional Liability System"

A Position Paper of the
American College of Physicians

This paper, written by Patrick Hope, Esq. and Tracy Novak, was developed for the Health and Public Policy Committee of the American College of Physicians: Jeffrey P. Harris, MD, *Chair*; David L. Bronson, MD, *Vice Chair*; CPT Julie Ake, MC, USA; Patricia P. Barry, MD; Molly Cooke, MD; Herbert S. Diamond, MD; Joel S. Levine, MD; Mark E. Mayer, MD; Thomas McGinn, MD; Robert M. McLean, MD; Ashley E. Starkweather, MD; and Frederick E. Turton, MD. It was approved by the Board of Regents on 3 April 2006.

Addendum to "Reforming the Medical Professional Liability Insurance System"
Exploring the Use of Health Courts

Executive Summary

The American College of Physicians (ACP), representing over 119,000 internal medicine physicians and medical students, including 20,000 residents and fellows, continues to explore alternative reforms to the medical malpractice crisis. As the largest medical specialty society and the second largest medical society in the United States, the College is growing increasingly concerned about rising malpractice premiums and the effect this is having on patient access to care.

Over the years, the College has published comprehensive position papers on reform of the medical professional liability insurance system.[1] This paper is an addendum to the 2003 position paper as another means for Congress to explore as a way to improve the unstable premium market. It should be emphasized that the College strongly believes alternative approaches, such as demonstrating the effectiveness of health courts, should not be a substitute to enacting MICRA-type reforms that have been helpful in stabilizing the medical liability insurance market in California. ACP believes that the call for demonstration projects be considered as supplemental to MICRA-type reforms.

This position paper proposes the following new ACP policy positions:

1. **ACP supports the idea that patients who are injured due to medical negligence should receive fair compensation and improved access to the judicial system.**

2. **ACP supports the use of demonstration projects to determine the effectiveness of health courts.**

A summary of the 2003 position paper follows:

Position

1. Congress should immediately pass medical professional liability insurance reforms similar to those contained in the California Medical Injury Compensation Reform Act (MICRA), particularly caps on non-economic damages, as necessary changes in a flawed system.

ACP makes the following recommendations concerning MICRA-type reforms:

- The College favors a $250,000 cap on non-economic damages. Additionally, the College supports a $50,000 cap on non-economic damages for any doctor performing immediate, life-saving care. The College strongly believes that a cap

on non-economic damages is the most effective way to stabilize premiums and should be the centerpiece of any legislative proposal to reform the medical professional liability insurance system. ACP is opposed to limits on economic damages.

- Juries should be aware of collateral source payments and allow offsets for those payments.

- A reasonable statute of limitation on claims should be required. Lawsuits should be filed no later than 3 years after the date of injury, providing health care providers with ample access to the evidence they need to defend themselves. In some circumstances, however, patients should have additional time to file a claim for an injury that could not have been discovered through reasonable diligence.

- 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 non-economic and punitive damages.

- Allow the defendant to make periodic payments of future damages over $50,000, if the court deems appropriate, instead of a single lump sum payment. The plaintiff still would receive full and immediate compensation for all out-of-pocket expenses, non-economic damages, punitive damages, if awarded, and future damages of $50,000 or less.

- Establish a sliding scale for attorneys' fees. This provision would place plaintiff attorneys' on the following scale:

    - Forty percent (40%) of the first $50,000 recovered;
    - Thirty-three and one-third percent (33 1/3%) of the next $50,000 recovered;
    - Twenty-five percent (25%) of the next $500,000 recovered;
    - Fifteen percent (15%) of any amount recovered in excess of $600,000.

- 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 non-economic losses), whichever is greater.

- Authorize the Secretary of Health and Human Services to make grants to states for the development and implementation of Alternative Dispute Resolution (ADR) programs. 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 simply be a costly "add-on" rather than a cost-

effective and faster way of resolving claims. Additionally, the ADR decision should be admissible in court if the parties proceed to litigation.

- Nothing that Congress passes should preempt or supercede any state law: (1) on any statutory limit on the amount of compensatory or punitive damages that may be awarded in a health care lawsuit; (2) on any defense available to a party in a health care lawsuit; and (3) that imposes greater protections for health care providers and health care organizations from liability, loss, or damages.

Any law that Congress passes should preempt state law if the state law differs with the federal law to the extent that it: (1) provides for the greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages; and (2) prohibits the introduction of evidence regarding collateral source benefits, or mandates or permits subrogation or a lien on collateral source benefits.

Position

2. Congress 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 MICRA-type reforms.

Position

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

Position

4. Demonstration projects should be authorized and funded to test no-fault system(s), enterprise liability, the bifurcation of jury trials, and study raising the burden of proof.

Exploring the Effectiveness of Health Courts

Under today's judicial system, judges and juries decide medical malpractice cases with little or no medical training. The majority of medical malpractice cases involve very complicated issues of fact, and these untrained individuals must subjectively decide whether a particular provider deviated from the appropriate standard of care. Therefore, it is not at all surprising that juries often decide similar cases resulting in very different outcomes. Circumstances in one particular case may lead to no compensation for the plaintiff, while the similar circumstances can result in a multi-million dollar verdict in another. It is this kind of uncertainty that is a substantial contributor to the unstabilized insurance market we face today.

The American College of Physicians believes the goal of every tort reform measure should be assessed according to its ability to fairly compensate injured parties, to promote patient safety, and to create predictability in the medical malpractice insurance premium market. It is with those qualities in mind that **ACP supports the use of demonstration projects to determine the effectiveness of health courts**.

Benefits of Health Courts

The concept of health courts (also called "medical courts") is a specialized administrative process where judges, without juries, experienced in medicine would be guided by independent experts to determine contested cases of medical negligence. The health court model is predicated on a "no-fault" system, which is a term used to describe compensation programs that do not rely on negligence determinations. The central premise behind no-fault is that patients need not prove negligence to access compensation.[1] Instead, they must only prove that they have suffered an injury, that it was caused by medical care, and that it meets whatever severity criteria applies; it is not necessary to show that the third party acted in a negligent fashion. The goal of the no-fault concept is to improve upon the injury resolution of liability. Workers' compensation is an example of a no-fault model

In the initial phase of the health court model the process would work similar to a workers' compensation system in that patients would be compensated for medical injuries according to a predetermined schedule of benefits. Injured parties would submit a form to a review board that would make a determination whether there is a clear, uncontestable case of medical malpractice. In such cases, the review board would immediately pay non-economic damages according to the predetermined schedule of benefits. ACP strongly supports a health court model that pays 100% of the patient's economic damages, taking into consideration other collateral sources of payments. In cases where additional review is necessary, or where the parties may wish to appeal the decision by the review board, the formal health court process would ensue.

PHASE 1

Review Boards – The first phase of the health court model would involve a patient filing a claim with the health care review board. The health court review board would serve as a certifying body to validate claims of medical negligence made by patients. These review boards would review medical charts, interview patients, physicians, and nurses, and investigate other relevant evidence to determine medical negligence. If the evidence points to clear negligence, the patient would immediately be awarded compensation of non-economic damages according to a predetermined schedule of benefits. At this point, there would be no further legal proceeding. If, however, the review board finds no clear evidence of medical negligence, the patient would have the option to appeal to the health court. Further, if the review board finds that additional medical review is necessary, the case may go to a health court.

PHASE II

This optional phase would only be triggered if the patient is not satisfied with the ruling of the review board, or if the review board determines further inquiry is necessary. Below is a summary of the key elements and arguments in favor of the establishment of health courts:

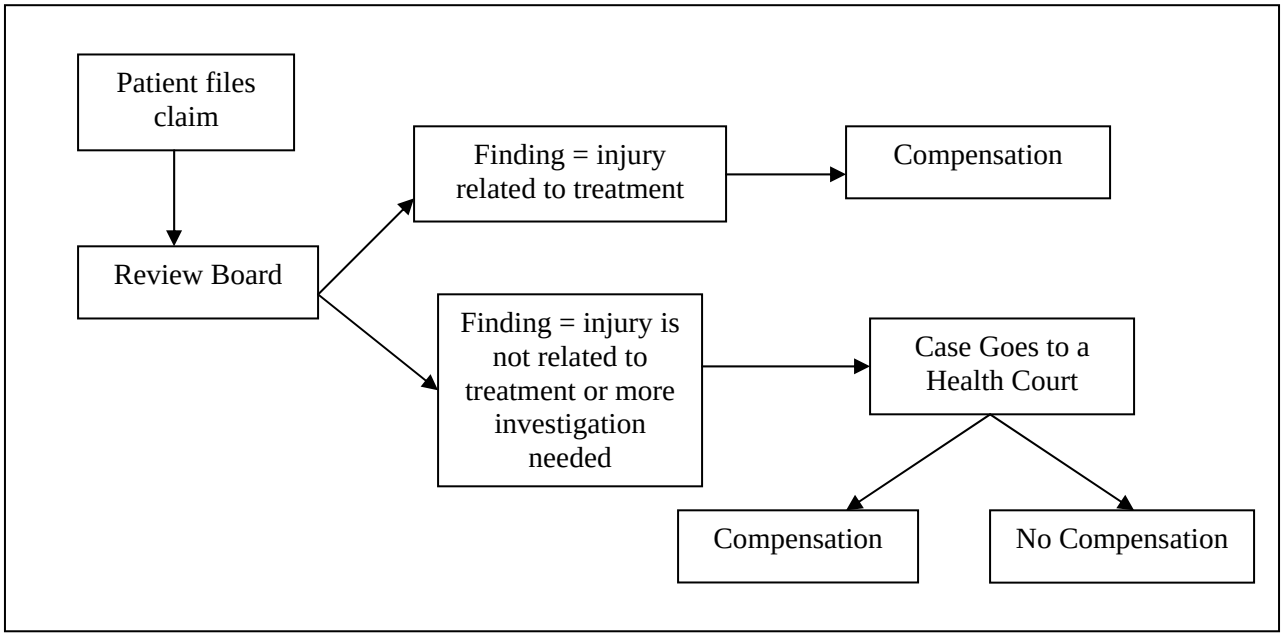
Independent Experts - Going to trial in today's legal environment can be a gamble. So-called "expert witnesses" hired by both plaintiffs and defendants are brought in to make the best argument on the appropriate standard of care, hinging the outcome on the most believable of experts. This battle of "dueling experts" represents a significant portion of court costs and attorneys fees that is passed on in the form of higher insurance premiums. One of the desired goals of health courts would be to take the bias out of expert testimony by utilizing qualified, independent expert witnesses paid directly by the court. These experts would guide judges in determining the appropriate and accepted standard of care. Such independent experts should be qualified and have up-to-date training on quality measures and standards that could be set by agencies such as the Agency for Healthcare Research and Quality (AHRQ), the Ambulatory Care Quality Alliance (AQA), or other quality standard setting organizations.

Specialized Judges to Define Standard of Care – The judicial system has failed in keeping up with the complexity and the appropriate standards of medical care. Decisions in one court as to what is determined to be the appropriate standard of care is irrelevant in another court. It's often these inconsistencies that contribute to a costly judicial system that does little to promote deterrence and to improve patient safety. To address this problem, health courts would use specialized judges -- similar to tax courts, bankruptcy courts, and family courts -- with a specific background in medical malpractice to guide decisions on the appropriate standards of care, along with the assistance of independent experts. Under the health court model, judicial decisions would serve as precedent to other courts and act as guidance to the physician community in overall efforts to improve quality and patient safety.

Efficient and Less Expensive – The average payment for a medical malpractice claim has risen sharply from about $95,000 in 1986 to $320,000 in 2002.[2] Studies further indicate that parties are waiting longer for a resolution to a claim - up to eight years for resolution.[3] Additionally, costs of defending medical malpractice cases have risen significantly over the last decade.[4] If run correctly, the use of health courts would significantly speed up the judicial process by resolving matters at a much faster rate than the current system allows. In those instances where a patient is injured through medical negligence, under the health courts model, the claim would be resolved and compensation processed in a more timely fashion. In addition, with the use of independent experts and a streamlined process, the costs of defending such cases will be greatly reduced.

Improve Access to the Courts – It is estimated that only 2 percent of patients injured by negligent care ever file malpractice claims.[5] In many circumstances, only patients that have a serious enough injury with the potential for a large jury award are able to find a lawyer willing to take a case due to the high costs of putting on such a trial. Because the costs of presenting a case will be lower and the process streamlined through the health court model, it is anticipated that patients will be able to file a claim to get their day in court. **ACP supports the idea that patients who are injured due to medical negligence receive fair compensation and improved access to the judicial system.**

Judicial System Should Be Fair and Reliable – Insurance premiums are set so that the revenue from premiums equals total expenses less income from financial investments. Over the last decade, however, the increased costs for paying and defending malpractice claims have risen at a rate far above the rate of inflation. For all the above reasons, we believe health courts have the potential to ensure the fair compensation of victims of medical malpractice and serve as a reliable tool for insurance premium adjusters to accurately set premiums, avoiding erratic spikes in the market.



International Experiences

A few countries in Europe have experienced a similar health court process with success – both for patients and the insurance market.

Sweden

Sweden has a no-fault system based on the 'avoidable injury' principle. In other words, if an injury is avoidable or results from treatment that is medically unjustifiable and causes the patient to spend at least 10 days in the hospital or miss at least 30 days of work, the patient receives compensation automatically. Funding for this no-fault system is provided from premiums charged through Swedish local authorities (counties) and physicians. Under the Swedish model, physicians generally take full responsibility for their medical errors and even assist the patient with the required paperwork to file a claim.[6] When a claim is submitted, the physician prepares and files a written report surrounding the circumstances of the injury. The adjuster makes an initial determination of eligibility, and then forwards the case to one or more specialists retained by the system for final determination of eligibility and to help judge compensation. According to studies of the Swedish model, roughly 40% of all claims receive compensation. Dissatisfied patients may initiate a two-step appeals process involving a review of the determination by a claims panel and an arbitration procedure.[7]

Through the years, the Swedish model has undergone minor changes. Sweden first began its voluntary patient insurance program for health care providers in 1995. This program covered a patient's physical and mental injuries related to treatment, diagnosis, infection, accidents, medication and defects in equipment. Compensation can be paid to the patient if an experienced practitioner or specialist could have avoided the injury. In cases where the provider did not have insurance, the Patient Insurance Association investigated and compensated the injury; payment was later reclaimed from the caregiver. In 1997, Sweden broadened the reach of their program through the 'The Patient Injury Act," requiring all health care providers to purchase patient insurance. A "Patient Claims Panel," appointed by the government and the Patient Insurance Association, serves as an advisory body and represents the interests of the patients. Panel members have specific knowledge of health care and are familiar with the handling of claims.

The advantages to the Swedish system include: easier to get compensation; more patients receive compensation; payment is based on objective grounds; the rule of evidence is more liberal; no economic risk for the patient; short timeframe for claims handling; lower administrative costs; and better relations between the health professional and patient. The weaknesses of this system are that the availability criteria are difficult to understand, and injuries due to insufficient information or failure to obtain consent are not covered.

Based on annual statistics, about 10,000 claims were submitted to the Swedish Patient Insurance Association and 5,000 received payments. Of the total claims, 1,000 went to the Patient Claims Panel and 100 received payment. Ten claims went to court where two received payment. In 2005, Sweden paid $60 million to patients (at a cost of $7 per

inhabitant) who sustained injuries. A study of Scandinavian patient injury insurances concluded that only 2% of patients reported an avoidable adverse event and only 0.2% of them submitted claims to the insurance association.[8]

New Zealand

New Zealand established a no-fault system in the early 1990's which generally settles cases in just a few months. Their program is financed primarily through a tax on employers, employees, motor vehicle owners and is designed to cover all accidental injuries, including medical malpractice. The determination of whether a claim is the result of negligence is based primarily on certification by the treating physician. Because the system did not allow for the acknowledgement of error, there was no incentive to improve the quality of care or prevent injury. In 1992, however, injury resulting from proven medical error was added to the accident compensation statute. This revision abolished lump-sum payments for pain and suffering and introduced some notion of fault.[9]

New Zealand's no-fault system, which exists within the context of universal state-funded health care coverage, also has an accountability component. In 1994, the government established a code of patients' rights and designated the health and disability commissioner as the independent health ombudsman to enforce those rights. Complaints are handled through advocacy or mediation; formal investigations are used for only the serious complaints. In a typical year, 530 complaints are filed leading to 151 investigations and 10 disciplinary hearings. Experience has shown that patients do not wish to punish their physicians but instead want to see systematic changes that will prevent mistakes in the future.[10]

In May 2005, however, New Zealand reverted back to providing compensation for any personal injury caused by medical treatment, thereby compensating all injuries regardless of the rarity/severity of the injury, and regardless of negligence. A patient, however, is not eligible for compensation if the injury was not caused by the treatment at issue.

Legislative History

During the 109th Congress, Representative William "Mac" Thornberry (R-TX) introduced H.R. 1546, the "Medical Liability Procedural Reform Act," which would authorize the Attorney General to award up to seven grants to States for the development, implementation, and evaluation of health care tribunals. The bill defines a health care tribunal as a trial court or administrative tribunal with the sole function of settling disputes over injuries allegedly caused by health care providers, to which all or a portion of such disputes within a jurisdiction are assigned. The judges have health care expertise and render decisions about the standard of care with reliance on independent expert witnesses commissioned by the court.

Senators Michael Enzi (R-WY) and Max Baucus (D-MT) introduced S. 1337, the "Fair and Reliable Medical Justice Act," which would award various demonstrations to states

to study alternatives to current tort litigation, including a health care court model for timely settlement disputes over injuries allegedly caused by health care providers. This model would ensure that a health court is presided over by judges with health care expertise who meet applicable state standards and provide authority to such judges to make binding rulings on causation, compensation, standards of care, and related issues with reliance on independent expert witnesses commissioned by the court. The model would also provide an appeals process to allow for review of decisions.[11]

Conclusion

The American College of Physicians has strongly advocated for MICRA-type reforms to provide immediate relief to physicians and to help provide more compensation to patients in a timely fashion. We affirm our strong support for these concepts and believe that the MICRA law must remain the centerpiece of any reform. Moreover, we restate our belief that every tort reform measure should be assessed toward its ability to lower professional liability insurance premiums or reduce the severity and frequency of malpractice claims without denying injured patients fair and appropriate redress for negligence.

We also believe, however, that in the absence of a federal movement toward MICRA-type reforms, demonstration projects should be conducted to study the feasibility and efficiency of other types of reform. This position paper calls for demonstration projects to create specialized health courts as an addendum to the more comprehensive study of the medical malpractice issue and should be taken in that context.

There will be opponents who will argue that the creation of specialized health courts is unconstitutional by denying individuals their Seventh Amendment right to a trial by jury. However, we already have special courts that deal with certain areas of the law: U.S. Bankruptcy Court, U.S. Tax Court, Armed Services Court, Veterans Appeals Court, and numerous federal agencies and boards. In addition, family courts as well as specialized mental health and drug courts are growing in popularity in many states as a way to handle cases outside traditional civil and criminal court proceedings.

This position paper is intentionally short on specifics. Such details as: where will initial funding for health courts come from, what should the qualifications of judges be, who will appoint judges, how will the initial schedule of awards be determined, what the appeals court structure would look like, etc., are not described. Instead, this paper seeks to propose the study and feasibility of the creation of health courts as a possible means to impact the medical liability environment in a positive way for patients and physicians. The remaining details should be sorted out at that time in a manner that ensures fair compensation to the patient, serves as deterrent to medical negligence, and brings stability to the medical malpractice system.

[1] American College of Physicians. Restructuring the Medical Professional Liability System [position paper]. 7 October 1986. Also, American College of Physicians. Reforming the Medical Professional Liability Insurance System [position paper]. 13 January 2003.

[2] The Congressional Budget Office. Limiting Tort Liability for Medical Malpractice, p. 4. 8 January 2004.

[3] Thorpe, Kenneth E. The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms. W4-22 Health Affairs, 21 January 2004.

[4] Id. Legal defense costs grew by 8 percent annually during the 1986-2002 period, from around $8,000 per claim to more than $27,000.

[5] Brennan, TA; Leape, LL; Laird, NM; Hebert, L; Localio, AR; , Lawthers, AG; et al., "Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study," *New England Journal of Medicine*, vol. 324, 1991, pp. 370-6. The study was repeated in Colorado and Utah hospitals in 1991 with similar findings. Studdert, DM; Thomas, EJ; Burstin, HR; Zbar, Brett IW; Orav, EJ; and Brennan, TA. "Negligent Care and Malpractice Claiming Behavior in Utah and Colorado," *Medical Care*, vol. 38, 2000, p. 253.

[6] Weiss GG. Malpractice: Can no-fault work? *Medical Economics* 2004 June 4;81(11):66-71.

[7] Studdert, David M; Brennan, Troyen A. No-fault compensation for medical injuries: the prospect for error prevention. *JAMA* 2001;286(2):217-223.

[8] Espersson, Carl. The Swedish Patient Insurance Association, discussion on the Swedish Patient Injury Act, October 31, 2005.

[9] Weiss, Gail G. Malpractice: Can no-fault work? *Medical Economics* 2004 June 4;81(11):66-71.

[10] Schneider, Mary E. New Zealand offers no-fault compensation model. *Ob/Gyn News*, January 1, 2005.

[11] Rep Enzi introduced similar legislation (S. 1518) during the 108th Congress but it never made it past the Committee on Health, Education, Labor, and Pensions.