

Medical Liability and the Emergency Physician: The Final Summary

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I have practiced in three vastly different medical liability environments, as my medical career has taken me from Chicago to South Bend to Dallas. For more than a year now, on behalf of AAEM's Legal Committee, I have been on a quest to understand our medical liability labyrinth. My goal was to construct the most accurate and comprehensive medical liability database **ever** for emergency physicians. My detailed report on all

50 states has now been completed, published in *Common Sense* in four installments (in the Jul/Aug 2013 issue and the Jan/Feb, Mar/Apr, and May/June 2014 issues). That series of articles attracted a lot of attention, and I was even invited to write a version of this summary for *Emergency Physicians Monthly*, which appeared in its July issue (Vol. 21, No. 7). I learned a lot in researching and writing these articles, and they generated many insightful questions and inquiries from friends, colleagues, and *Common Sense* readers. I would now like to answer some of those questions and summarize what I learned.

1. What constitutes a good liability environment for emergency physicians?

As an emergency physician in the trenches, the first answer that comes to mind is "an environment in which all plaintiff attorneys have been exterminated and physicians are completely immune from civil suit or criminal prosecution," but that is neither practical nor moral. We all know that on very rare occasions negligence does occur — although not nearly as often as the American Trial Lawyers Association has led the public to believe.^{93,94} So part of what makes an environment ideal is that meritorious cases are quickly identified and patients who are truly victims of negligence are compensated fairly, quickly, and efficiently — meaning that most of the money in the damage award actually goes to the injured plaintiff/patient.

While some states are getting it right, the United States as a whole has a malignantly unfair and unpredictable medical liability environment. Our profoundly aberrant medical-legal system rewards patients who have suffered bad outcomes rather than patients who have been harmed by negligence.^{93,94} Any bad outcome can result in a lawsuit that has a fair chance of ending successfully for the plaintiff, even if the defendant physician did everything right.

Given that injustice, the remaining factor that would establish an ideal medical liability environment is that physicians cannot be successfully sued unless they have actually done something wrong. If all parties (lawmakers, physicians, patients, lawyers) would strive to build an environment with this goal in mind, non-meritorious suits would be quickly dismissed and the stress and cost associated with litigation would be substantially reduced. Insurance premiums and wasteful defensive medicine would decrease. This would improve the quality of life for physicians thanks to decreased litigation stress, more money, heightened morale,

and the ability to practice good medicine without being defensive. Patient safety would improve as states had an easier time recruiting and retaining doctors, resulting in greater access to physicians — especially those performing high-risk procedures.

Theoretically, states that have enacted laws to reduce unreasonable litigation (expert witness reform, case certification requirements, medical review panels, etc.) and curb excessive damage awards (caps) should have the most favorable environments, with physicians paying the lowest annual premiums. However, this is not always the case. The relationship between tort reform, malpractice costs, and the overall medical liability environment is complex and nonlinear. A state's culture can overwhelm tort reform laws favoring physicians, or can protect physicians despite the absence of tort reform. Simply put, good tort reform on paper is not equivalent to a good medical liability environment.

2. Which states have the best medical liability environments for EPs? Which states have the worst? Which states are on the "watch list"?

The best states are California, Colorado, Kansas, and Texas. All four have enacted a reasonable cap (\$250k–\$300k) on non-economic damages.³ Litigation in these states has markedly decreased over time and annual malpractice premiums for physicians remain low.^{12,13,31,35} Following close behind are Indiana (which long ago implemented a \$1.25 million cap on total damages and a pre-litigation screening panel process), Alaska, North Carolina, North Dakota, and South Dakota (all have implemented caps on non-economic damages of \$500k or less).³ The majority of these states have some of the lowest annual medical malpractice payouts per capita.³⁶

The worst states include Illinois and a cluster of states on the east coast: New York, D.C., Pennsylvania, New Jersey, and Delaware. In these states litigation is frequent and malpractice premiums are debilitating. OB-GYNs and surgeons in New York City and Philadelphia pay more than \$100,000 per year.³¹ These states have some of the highest annual malpractice payouts per capita and meaningful tort reform is nonexistent.^{3,36}

States to watch include:

- **California:** MICRA has been credited with reigning in health care costs.^{12,13} A ballot initiative is underway to index the state's cap on non-economic damages to inflation (the \$250,000 cap would be increased to \$1.1million). This initiative, coupled with physician drug testing in an effort to disguise the effort as a patient safety issue, is receiving significant support from trial lawyers and consumer groups.⁷³
- **Kentucky:** Known for a paucity of tort reform, KY may be turning the corner. The state senate recently passed a bill creating three-member expert pre-litigation panels to review malpractice suits before they are pursued in court.⁷¹

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- **Missouri:** The Show-Me state's medical liability environment has tragically collapsed since the state's high court ruled its damage cap unconstitutional in 2012. As lawmakers work to reinstate the cap, will Missouri docs hop across the border to physician-friendly Kansas?⁷⁴
- **Florida:** This litigious state continues to overturn the medical liability reforms that it once passed into law. In a recent landmark case, the state Supreme Court voided Florida's caps on non-economic damages in wrongful death cases. This will undoubtedly deteriorate what is already a beleaguered medical liability environment.⁶⁹
- **Georgia:** Once heralded as the best medical liability environment for EPs in the country, damage caps were overturned in 2010. Georgia enacted a formidable expert witness reform package in 2005, and both raised the burden of proof and redefined medical malpractice for cases taking place in an emergency setting. Plaintiffs must prove by "clear and convincing evidence" that the medical provider was "grossly" negligent. Despite these physician-friendly laws, in a recent GA case involving the death of a 15-year-old patient due to a missed pulmonary embolism, two emergency physicians who are well known pillars of our specialty testified that the treating physician was guilty of gross negligence rather than simple or ordinary negligence (the usual definition of malpractice). While this case is not over, these recent events have certainly undermined a state law that was designed to protect physicians forced by EMTALA to provide care in an emergency setting. Even scarier, any physician found guilty of gross negligence can lose hospital privileges and be barred from obtaining malpractice insurance.^{70,73,75}
- **Massachusetts and Oregon:** Both states have recently initiated avant-garde processes known as "D,A, and O" (Disclosure, Apology, and Offering).⁵⁸ Similar to early arbitration in other states, these

initiatives focus on early disclosure of mistakes, apologizing when appropriate, and offering up-front compensation in an effort to avoid costly and time-consuming litigation.⁵⁸

3. Which states have seen the most change in recent years and why?

- **Texas:** The poster child for tort reform. Litigation, paid claims, and premiums have been slashed in half after sweeping reforms were passed in 2003. Applications for Texas medical licenses have surged and the annual malpractice payout per capita (\$3.03) is now the lowest in the country.⁶⁸
- **Ohio:** Litigation has dropped 41% statewide following the enactment of reforms in 2004.⁶⁶
- **Pennsylvania:** Reforms were passed in 2003, including a case certification requirement and venue reform.⁶³ In the last ten years medical malpractice case filings have decreased 44% in the state and 65% in Philadelphia, although Philadelphia remains a very dangerous place to practice medicine.⁶³ A 65% decrease isn't as meaningful when the starting point is so bad.
- **Mississippi:** Since passing strong reforms in 2004 (a hard \$500,000 cap on non-economic damages and a case certification requirement), liability insurance costs have dropped nearly 50% and the number of lawsuits has fallen 70%.³⁵
- **North Carolina:** The state passed vigorous reforms in 2011 (a \$500,000 cap on non-economic damages and an enhanced burden of proof for EMTALA providers).³⁵ North Carolina's annual per capita malpractice payout (\$4.55) is now the seventh lowest in the nation.³⁶

4. Which reforms have had the greatest impact?

There are significant data to support the efficacy of a hard cap on non-economic damages.^{76,77,78} Twenty-five states currently implement a cap on **non-economic damages** (although Florida's cap is in the process of being overturned).³ A cap of no more than \$250k is most closely tied to good liability environments (Texas, Alaska, California, and Kansas). The benefits of a cap are significantly diminished if it allows too many exceptions (e.g., "does not apply in cases of debilitating injury"), if it is adjusted annually for inflation (Maryland), if it is increased in cases with multiple defendants (South Carolina), or if it is set too high to have an impact (Tennessee).³

Twenty-four states are currently implementing a case certification mandate, which requires the plaintiff to provide a signed statement from a qualified expert, typically before or within 60 days of filing suit.⁸ This has been credited for reducing the volume of frivolous lawsuits in many states, such as Pennsylvania and Tennessee.⁶³

Nineteen states currently use a pretrial review panel (mandatory in 14 states, optional in five). Most states allow cases to move forward in the courts despite a panel ruling in favor of the defendant, while in some states the panel's findings are not admissible in court. Pretrial review panels have been criticized for the length of time it takes to come to a decision. In Indiana the average is four years.^{23,24} This negatively impacts both patients who are victims of negligence and physicians who have been wrongly accused and continue to suffer from litigation stress. Based

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on my own experience in Indiana, where I sat on both sides of the panel, the law is effective in weeding out frivolous claims and reducing practitioner fear.

5. Which reforms have had the least impact?

- While Apology Laws are well meaning, their impact is unclear and likely to be minimal.
- Alaska is the only state to have a “Loser Pays” law in the books. The rule is applied to no more than 20% of the winner’s fees and is actually collected in a minority of cases.²⁷
- Five states currently implement a cap on **total damages**. In Virginia the \$2 million cap (increased annually) is simply too high to be effective. In other states such as Nebraska, which has higher than average awards/settlements, plaintiff attorneys seem to push awards for pain and suffering close to the \$1.75 million cap.³
- While expert witness reform is a vital piece of the tort reform package, I am amazed at how many states get it wrong. Ideally, an expert witness is a physician in active clinical practice, board certified in the same specialty as the defendant, and practicing in the same state.
- Very few states require all these things, and even worse are the loopholes contained in these laws. For example, Pennsylvania law says that “expert testimony is required to establish the requisite standard of care, unless negligence is obvious to a lay person” and “the court can waive this requirement if the expert has sufficient training, experience, or knowledge as a result of active practice or teaching within five years prior to the incident.”⁸ This opens the door for any doc with a pulse to testify.
- To quote my AAEM colleague Andy Walker, there are three types of plaintiff’s experts who testify against emergency physicians: (1) the prostitute who will say anything for money, (2) the non-EM specialist blinded by ignorance or arrogance or both, and (3) the well-meaning EP who either doesn’t understand “negligence” and

“standard of care” or cannot get past his own hindsight bias. The third type is impossible to police even with fabulous expert witness requirements.⁸⁰ I would love to see a law that requires expert testimony to be reviewed by the respective specialty’s professional organization before being used in court. Or, to prevent some experts from selling their souls, cap expert witness fees at 1.5 times the hourly rate for the specialty’s clinical work.

6. Do laws specifically protecting EPs and others bound by EMTALA have a protective effect?

Eight states have passed laws that specifically protect emergency physicians and other specialists taking call and bound by EMTALA to provide care. These laws include an enhanced burden of proof (plaintiffs must prove “gross” negligence by “clear and convincing evidence”) in Georgia, South Carolina, North Carolina, Utah, West Virginia, and Texas; and lower caps on non-economic damages in Florida and Nevada.^{8,35} These laws have been passed only in the last ten years, so it is too soon to determine their effect. In Utah the law does not apply if the physician has access to the patient’s medical record.⁷⁹ I am told by EPs working in Georgia that these laws have improved their quality of life and their ability to recruit and retain physicians. And, the practice of defensive medicine has decreased to some degree. I do know of one case in which this Georgia law helped an EP, but the law is being challenged (Johnson vs. Omond).^{19,70,73,75}

7. How does one rationalize the weak correlation between malpractice premiums and tort reform?

Intuitively, states with tort reform should see a decrease in litigation and ultimately a decrease in malpractice premiums. However, this relationship is far from linear. A state’s culture evolves over hundreds of years and becomes firmly established. States as a whole are slow to change, and with many reforms being new it may take decades for these laws to have an impact. In simpler terms, if the public is accustomed to suing and lawyers

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are accustomed to aggressively pursuing cases, that may go on for years regardless of the obstacles placed in their way. In some states litigation has decreased, but because reforms are so new, premium dollars are still being paid on cases that were settled years ago. This may explain states with good reforms and relatively high premiums such as Ohio, Georgia, Utah, West Virginia, and Massachusetts.³¹

If litigation has decreased and previous settlements have been fully paid but premiums still remain high, then we must point our fingers at insurance companies reaping excessive profits. This may apply to Nevada, which has great reform on paper and one of the lowest annual per capita payouts, suggesting low litigation costs throughout the state, but high malpractice premiums that average around \$47,250 and are much higher in Las Vegas.^{36,31}

8. State law vs. state culture - which one more strongly influences a state's medical liability environment?

Without a doubt, it is state culture. Minnesota is devoid of tort reform, yet physicians pay some of the lowest malpractice premiums in the country. I once asked a Minneapolis colleague why this is so, and he replied, "People here don't sue. Some call it 'Minnesota nice.'"³² The average malpractice premium in Minnesota is estimated at \$8,500, while the average premium in Florida is estimated at \$79,000! Why such an astronomical difference? Do Florida doctors make more mistakes than those in Minnesota? Of course not. In fact, Florida physicians are probably less risk tolerant and practice medicine more defensively. There are approximately 4,000 emergency physicians in Florida. If they could pay what a Minnesota emergency physician pays for insurance, each year they would save \$70,000 per doc — for a total of \$280 million! Where does that \$280 million come from and where does it go? EPs in both states earn approximately the same compensation. However, Medicare spending is \$6,911 per capita in Minneapolis and \$13,824 in Miami.⁸¹ Put another way, each year we taxpayers make a \$280 million donation to Florida's trial lawyers.

The bottom line: It's not about justice. It's not about good medicine. It's about money for lawyers.

9. Does tort reform improve an emergency physician's quality of life?

In my experience, in states where tort reform has been successfully upheld emergency physicians do enjoy a higher quality of life. On one of my shifts during residency in Chicago, I encountered a young pregnant patient with a hip dislocation. While this is a challenging, high-risk case in any environment, in Chicago — possibly one of the most litigious and physician-unfriendly cities in the country — it was an absolute nightmare. The hours that followed involved a toxic game of hot potato between the ED, the trauma service, anesthesiology, OB-GYN, and administration. At first I couldn't even convince an attending to staff the case with me and put his or her name on the chart. The message was clear. No one wanted to assume the risk. Who loses in these situations? The patient.

While I absolutely loved my residency, working in a painfully broken medical liability system was challenging — even miserable at times. Despite being the busiest trauma center in Illinois, we repeatedly lost pediatric neurosurgery and orthopedic coverage. These well-meaning specialists

simply couldn't afford the insurance coverage that came with practicing in Chicago. My attendings clearly feared litigation, and for good reason. One of my medical school OB-GYN attendings, who wrote many of the chapters in our textbook, told me about all the cases he was forced to settle despite being right, because it was less expensive for his insurance carrier to settle than defend. I watched EPs in Chicago endure not only excess risk and stress but also deficient compensation, because so much of their revenue went to lawyers via insurance premiums. State politicians never intended to make the situation any better, and physician morale was low.

In 2006, as a newly minted attending, I moved across the border to Indiana — a tort reform state since the 1970s. My malpractice premiums were so low I paid them out of pocket. Many of my partners had trained in the state and their risk tolerance was incredible. I realized that I could simply use good *common sense*. Bad outcomes and occasionally even lawsuits still occurred, but thanks to Indiana's Medical Review Panel — the hallmark of the state's tort reform package — most of these cases "died in panel" after being reviewed by other EPs. Despite being in a smaller community, specialty coverage was never an issue. The docs in the community were relaxed, happy, and well paid. Physician morale was high. In 2012, I moved to Texas, another tort reform state with a phenomenal medical liability environment, and I've experienced the same benefits as in Indiana.

10. Does tort reform decrease overall health care costs?

This is a complicated question, but unfortunately, here in Texas the answer is no. The Lone Star State's dynamite 2003 reform package has accomplished a lot, but it has failed to curb the practice of defensive medicine. While tort reform should increase a physician's risk tolerance, it often doesn't. Fear lingers on. I see it every day in the practice patterns of my partners, many of whom trained locally in the 80s and 90s when Texas was one of the most litigious and unjust states in America. Once ingrained, CYA patterns are rooted deep and will take decades to correct. On a personal note, as a Texas EP I don't fear bad outcomes as much and I think I discharge more and CT less, but I'm sure there are times my decisions reflect my Chicago roots, where every patient was viewed as a lawsuit in the making. The proof is in the pudding - overall health care spending in Texas has not changed since the implementation of tort reform and Texas spends more per Medicare patient than the national average.⁶⁸

11. So what do I do if I'm in a lousy state?

Will tort reform ever be successful in Illinois? Sadly, probably not. The same can be said for Florida, New York, and many more. So now what? You can vote with your feet and move — though I realize it's not always that simple. While an area's medical liability environment is a significant factor in deciding where to live and practice, I don't want to diminish the importance of family proximity and other factors. For a variety of reasons, some physicians must practice in high-risk environments. Unfortunately, that's one of the reasons why things remain the way they are. Places like NYC and D.C. are popular, and there is no shortage of well-trained emergency physicians there despite the legal climate.

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Alternatively, learn to adapt. Lots of docs live and work in high-risk environments and still have fulfilling careers. Many of my former Chicago colleagues have been there for 10-20 years and have never been sued. They practice defensively and focus on meticulous documentation and good communication. Many of these physicians work at big medical centers where their employer pays their malpractice premiums, so they never see the bills and don't even know the cost.

12. I want to attempt tort reform. What should I try?

What reforms support the "ideal medical malpractice environment?" The most effective reforms halt non-meritorious lawsuits early in the process. Examples include case certification requirements and medical review panels. Indiana has used a medical panel review process for over thirty years. The panel consists of three physicians selected from a pool of volunteers who practice in the same specialty as the defendant physician. I served on the panel on four occasions during my six years of practice in that state. The process is highly objective and enormously beneficial for all involved. Both sides benefit from the expertise of three neutral specialists not paid by either side. Contrary to the prostitute-like fees that are often paid to hired-gun experts, Indiana panelists are paid \$350 per panel appearance and each side pays half. While some advocacy groups argue that physicians serving on the panel are just looking out for their buddies, records show that the panel finds negligence 20-30% of the time.⁹⁵ Although the panel process often prevents a trial — many cases are dropped or settled based on the panel's findings — the panel's decision is not binding and plaintiffs may push the case further. However, they historically have little chance of winning if the panel has found in the defendant's favor. One major criticism of the panel is that, on average, it takes three to four years from the time the complaint is filed to receive a final panel opinion. The reasons for this are unclear, but one hypothesis is that attorneys on both sides have a financial motive to go slow, as they bill for all the meetings, phone calls, and depositions associated with the pre-panel process. Another limitation is that any case involving damages of less than \$15,000 does not get a panel review. All things considered, the panel process is a win-win for both plaintiffs and defendants, and it

may be the best option as you consider where to direct your lobbying efforts. The process is inexpensive and relatively easy to recreate — Kentucky recently passed a law implementing a panel process modeled after Indiana's.

When it comes to Texas reform, the state's \$250k cap on non-economic damages receives all the attention. However, a significant component of Proposition 12 was the expanded role of the Texas Medical Board (TMB).⁹⁶ Beginning in 2003, the TMB began to handle the majority of cases involving alleged physician negligence. Similar to the medical review panel in Indiana, Texas utilizes its medical board (comprised of volunteer physicians receiving modest fees) to investigate and discipline physicians accused of malpractice. In fact, many plaintiff's attorneys ask patients seeking damages to first file a complaint with the medical board. These attorneys then make their decisions on whether or not to proceed with the case based on the TMB's response. Moving forward, I would love to see other state medical boards step up to the plate and take control of these issues.

13. I live in one of the good states. What's next?

Be grateful, but realize that your job is not done. Sadly, there is no time to rest. Many "haters" are eager to prey on you. For example, Indiana's cap on total damages was recently challenged.²⁶ Numerous advocacy groups are fighting to overturn the Texas reforms, claiming the \$250,000 cap on non-economic damages is preventing injured parties from finding an attorney willing to take the case.⁶⁸ (And all this time I thought lawyers were more interested in justice than money!)

Increase your involvement in organized medicine, especially AAEM. Start a chapter if your state doesn't already have one. Protect the policies your colleagues have worked long and hard to establish, and **keep fighting the good fight!**

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