New Jersey Hospital Association

NJHA

NEW JERSEY HOSPITAL ASSOCIATION

ISSUE BRIEF

Medical Malpractice Reform

Background

In the mid-1980s many states enacted legislation that reformed the common-law rules and other court procedures involving tort litigation. There was a growing perception that liability insurance coverage was becoming more costly and less available which led to a push for reform. Despite those reforms, the U.S. tort liability system remains controversial. Some critics contend that the system, which holds parties liable for injuries to people or their property, is costly and inefficient, arbitrary and open to abuse. Since then, states have been looking to improve their system by adopting various reform measures.

To improve the affordability and availability of malpractice insurance and to reduce liability pressure on providers, states have adopted varying types of tort reform legislation. Tort reforms are generally intended to limit the number of malpractice claims to reduce malpractice costs and insurance premiums. Nationwide, states have adopted various reform measures including:

- Placing caps on the amount that may be awarded to plaintiffs for damages in a malpractice lawsuit, including noneconomic, economic and punitive damages;
- Imposing stricter statutes of limitations that shorten the time injured parties have to file a claim in court;
- Establishing pretrial screening panels to evaluate the merits of claims before proceeding to trial;
- Establishing a special medical malpractice part in the superior court; and
- Revising standards for expert witnesses in medical malpractice actions.

In New Jersey, our tort system has allowed for punitive damages and compensatory damages for pain and suffering to be awarded arbitrarily. Medical malpractice lawsuits are driving up the costs of liability insurance for physicians to the point that many are restricting their practices, moving out of state or retiring. These rising medical malpractice insurance premiums may have contributed to a worsening shortage of physicians in New Jersey. A study released in early 2011 by the N.J. Council of Teaching Hospitals predicted a deficit of more than 2,800 doctors in the state by 2020. Furthermore, hospitals also are facing rising medical malpractice premiums that continue to put a strain on hospital resources.

While tort reform has been a national trend, the extent and specifics of the reform have varied from state to state. The purpose of this brief is to examine tort reform measures that have been implemented across the country and determine whether these reforms would work to reduce premiums on providers and to support physician retention in New Jersey.

Trends:

Caps on Noneconomic Damages

As many as 26 states have passed legislation imposing limitations or "caps" on monetary damages recoverable in malpractice suits. These caps vary from state to state, but they're generally set around $250,000 to $500,000 for individual suits and up to $1 million against a hospital. Currently New Jersey is pursuing legislation that would cap noneconomic damages in medical malpractice actions at $250,000. **A-966**, sponsored by Assembly members Jay Weber (R-Whippany), Gary Chiusano (R-Sparta) and Alison Littell McHose (R-Sparta) was introduced for the 2012-2013 legislative session and is currently pending in the Assembly Financial Institutions and Insurance Committee.

In other states:

- **Ohio** passed a comprehensive reform bill that put limits on the amount of compensation those injured by medical malpractice may recover for their injuries.[1] Currently, Ohio's noneconomic damages cap is set at $250,000 per plaintiff or three times the amount of economic damages, whichever is higher, up to a maximum of $350,000 per plaintiff, $500,000 per occurrence (Enacted Jan. 10, 2003).
- **Texas** passed a comprehensive tort reform legislation package which established a tiered system for awarding noneconomic damages in medical malpractice cases. A $250,000 cap applies to all doctors involved in a case, with a $250,000 cap against any single institution and a $500,000 cap on all healthcare institutions combined (Enacted in 2003).
- **West Virginia** passed a law that awards noneconomic losses of $250,000 per occurrence and $1 million per occurrence for wrongful death, permanent and substantial deformity, and loss of limb or bodily function (Enacted in 2003).
- **Massachusetts** has set award limits, or caps, on noneconomic damages in medical malpractice cases to $500,000.[2] (Enacted in 1997).
  Florida also has a tiered system for awarding damages:
  - In emergency room cases, the state limits a victim's recovery for noneconomic damages to $150,000 from each physician and hospital involved in the medical malpractice case.
  - For non-emergencies, the state limits a victim's recovery for noneconomic damages to $500,000 from each physician, with an aggregate cap of $1 million for all claimants.

[1] S.B. 281 limited the amount of noneconomic damages medical malpractice plaintiffs are entitled to recover. Noneconomic damages include compensation for pain and suffering, permanent disfigurement, disability and loss of consortium. Ohio law does not impose a cap on the amount of economic damages a plaintiff may recover, which includes compensation for medical expenses, lost wages and other quantifiable monetary losses. The cap is set higher for malpractice victims who have suffered catastrophic injury at $500,000 per individual, $1 million per occurrence. Under Ohio law, catastrophic injuries include the following: Permanent and substantial physical deformity, loss of use of a limb, loss of a bodily organ system, permanent physical injury that prevents self-care.

[2] Mass. Ann. Laws ch. 231, § 60H (Law. Co-op. Supp. 1997).

- For non-emergencies, the state limits a victim's recovery for noneconomic damages to $750,000 from each hospital, HMO, hospice provider and other non-physician provider, with a $1.5 million aggregate cap for all claimants.
- The cap may be raised in non-emergency situations if a judge determines it would be unjust not to exceed the cap[3] (Enacted in 1998).

- **Pennsylvania's** Assembly recently approved legislation[4] that would limit the amount of punitive damages that can be recovered in lawsuits against nursing homes. The bill limits punitive damages to no more than 200 percent of the compensatory damages awarded in a case. The bill awaits passage in the Senate and final approval by the Governor. (Enacted Jan. 18, 2012).

Statute of Limitations

The statute of limitations runs from the time an injury was either sustained or discovered to the date of the filing of the suit. Each state has a statute of limitations but some are tightening the time frame, reducing the statute of limitations for medical malpractice liability to four years or less. New Jersey is pursuing legislation, **S-474,** sponsored by Sen. Samuel D. Thompson (R-Old Bridge), that reduces the statute of limitations for medical malpractice liability actions to four years.

The statute of limitations for medical malpractice actions is two years in New Jersey, however, under the discovery rule, the time frame does not begin until the plaintiff knows of or, through the exercise of reasonable due diligence, should have known of the injury. The result of this rule is that medical malpractice liability actions can be virtually infinite. This bill limits the discovery rule and provides that medical malpractice liability actions must be filed within four years of the occurrence of the negligence. According to research many states have a time frame of three years with a discovery rule not to exceed four years following act or omission.

- **California**- three year statute of limitations with a one year discovery rule.
- **Connecticut**- two year statute of limitations from date of injury or discovery, but no more than three years from date of alleged malpractice.
- **Delaware**- two year statute of limitations from date of injury with a discovery rule of no more than three years from malpractice.
- **Illinois**- two year statute of limitations with a discovery rule in which no action may be commenced after four years from act or omission causing injury unless concealment by defendant.
- **New Hampshire**- two year statute of limitations in which actions against healthcare providers must be filed within two years of the malpractice.[5]

[3] Fla. Stat. Ann. § 768.73 (West 1997 & Supp. 1998).
[4] Medical Care Availability and Reduction of Error Act.—January 18, 2012
[5] http://www.medicalmalpractice.com/lawsuit-and-award-limits/medical-malpractice-statutes.htm (Please see website for a list of statute of limitations by state).

Health Courts

Proposed mainly through scholarly work known as *The Common Good*, in collaboration with Michelle Mello and the Harvard School of Public Health, and through the support of the Robert Wood Johnson Foundation, research has been done developing a health court proposal and generating support for this new reform.[6] Quite simply, health courts are special courts for medical injury cases. There are five key features to the health courts proposal.

- First, injury compensation decisions are made by specially trained judges outside of the regular court system with consultative support from neutral experts.
- Second, the standard of care used will be the "avoidability" standard, which is broader than the traditional negligence standard. An avoidable injury is one that most likely would not have occurred if medical care had been delivered with the skill of the best practitioner practicing in substantially similar circumstances.
- Third, compensation criteria are based on evidence, such as *ex ante* guidelines addressing the preventability of certain common medical adverse events.
- Fourth, such evidentiary knowledge will be coupled with precedent and converted into decision aids that allow for fast-tracking certain cases for compensation.
- Finally, the guidelines also will provide direction regarding how much in economic and noneconomic damages should be paid, essentially creating a schedule.
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Recently, there has been momentum behind states establishing pilot "health courts" as an alternative to taking medical malpractice cases to court. Legislation to create health courts or small pilot experiments has been introduced in several states, including New Jersey and New York; however none have come to fruition.

- **New Jersey** has introduced legislation, **A-1689**, sponsored by Assemblyman David C. Russo (R-Midland Park) that would establish a special medical malpractice part in the Superior Court. This bill would create a Special Medical Malpractice Part of the Law Division. The Special Medical Malpractice Part would have jurisdiction with respect to any action for injury against a healthcare provider based on professional negligence. Matters in the Special Medical Malpractice Part would be heard by a judge sitting without a jury. This bill is currently pending in the Assembly Judiciary Committee.
- **New York** also introduced legislation, **S-03437**, in February 2011 that would establish a health court pilot program. The bill would allow the establishment of specialized health courts within the Supreme Court of up to five counties to govern claims for medical, dental or podiatric malpractice.
- [7]

Revises Standards for Expert Witness

The expert witness plays an essential role in determining medical negligence under the U.S. system of jurisprudence. By and large, courts rely on expert witness testimony to establish the

[6] COMMON GOOD,WINDOWS OF OPPORTUNITY 3 (2006), http://commongood.org/assets/attachments/Windows_of_opportunity_web.pdf .
[7] New York Bill Number S03437, sponsored by Senator Parker

standards of care germane to a malpractice suit. Generally, the purpose of expert witness testimony in medical malpractice is to describe standards of care relevant to a given case, identify any breaches in those standards, and if so noted, render an opinion as to whether those breaches are the most likely cause of injury. Some states are tightening the standards and requirements for expert witnesses in actions involving medical malpractice. New Jersey is currently introducing legislation that would make changes to the expert witness requirements.

- **West Virginia** has enacted a law that outlines specific requirements concerning expert witnesses' knowledge, professional activity and licensure.[8] The bill sets requirements for qualifying as an expert witness. The following bars are placed in order to be an expert witness: A witness is qualified as an expert by knowledge, skill, experience, training or education and may only offer expert testimony with respect to a particular field in which the expert is qualified.
- **New York** has introduced a bill, A05465, which relates to the use of expert medical testimony in which clear guidelines are outlined which specify the qualifications of an expert and the basis of an expert's opinion. In addition, the bill takes into consideration the clinical training, teaching or experience in the area of expertise of the witness.[9]
- **Florida** also has introduced a law in which physicians in Florida are required to get an expert witness certificate to show that they are qualified to give medical testimony. The Department of Health issues a certificate authorizing a physician who holds an active and valid license to practice osteopathic medicine in another state or province of Canada to provide expert testimony.[10]

No-Fault Liability for Birth-Related Neurological Injury

Some states have implemented no-fault liability schemes in cases of babies born with devastating neurological injuries. In these states, obstetricians and hospitals pay into a fund from which parents can draw compensation if experts determine that their infants' injuries meet certain clinical criteria and were related to the birthing process.

The no-fault approach was passed in two states, **Virginia** and **Florida**. Both states experienced escalating premiums and a statewide stoppage for obstetricians and severe obstetric access problems in several rural and urban communities. Passage of the laws led to an almost immediate lifting of a statewide obstetric insurance moratorium in both states and to lower premiums for those participating in the compensation fund program. It also held the promise of future relief for those subject to the most severe and costly obstetric lawsuits. For the patient, the benefit of this approach over others was the guarantee of speedy compensation and lifetime care of injuries.[11] Participation in this program is voluntary for obstetricians, with annual fees for

[8] Bill No. S578, sponsored by Senators Hall and Barnes, Introduced Feb. 21, 2011, "Reliability in Expert Testimony Standards Act."
[9] Bill No. A05465, sponsored by Assembly members Towns and Schime.
[10] Bill No. 459.0066
[11] http://www.acog.org/About_ACOG/ACOG_Departments/State_Legislative_Activities/No_Fault_Liability_For_Birth_Related_Neurological_Injury.aspx

membership of $5000. All other licensed Florida physicians, including non-participating obstetricians, also contribute by paying a $250 assessment each year.[12]

Pretrial Screening

Pre-trial screening panels, like most alternative dispute resolution mechanisms, operate to encourage parties to settle meritorious claims and to deter or eliminate "nuisance" suits. Some states have established such screening panels to evaluate the merits of claims before proceeding to trial.

- **New Hampshire** lawmakers have approved pretrial screening panels in medical malpractice lawsuits in hopes of controlling rising insurance costs for doctors. The screening panel is comprised of a judge, a lawyer and a doctor who review cases before they go to trial. The panel would consider evidence and testimony from witnesses. If the panel unanimously felt the case was weak and the parties continued to trial, the panel's finding would be presented to the jury.[13]
- **Connecticut** implemented a medical malpractice pre-trial screening panel (CGS § 38a-32) to curb the medical malpractice crisis. Use of the panel depends on the consent of the parties. The panel is composed of two doctors and one attorney with trial experience in personal injury cases, who acts as chair. One of the doctors must practice in the same field of specialty as the defendant.[14] The panel holds confidential hearings when and where it decides; transcripts are available at cost to either party.

Early Offer

New Hampshire recently became the first state to adopt an "early offer" program for medical liability claims after state lawmakers overrode the governor's veto of SB 406. Effective in January, the voluntary program allows patients to settle medical liability claims with healthcare providers within 90 days to receive payment from the provider for their economic damages (medical expenses and lost wages) plus an additional payment based on the level of harm. Early Offer also defines precisely what the settlement terms will be, so that an injured person can be fully informed before entering the voluntary early offer process.

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[12] Impact of the Florida Birth-Related Neurological Injury Compensation Association (NICA) on Obstetrician and Attorney Practices , Karen W. Geletko, MPH, Andrew Hunt, MPH, Leslie M. Beitsch, MD, JD

[13] See SB 214 to reference law

[14] The panel's conclusion as to liability is set forth in a finding signed by the members and recorded by the Insurance Commissioner. The panel does not address the issue of damages. Each party receives a copy of the panel's findings. If a subsequent trial is held, only unanimous findings of the panel are admissible. The trier of fact (court or jury) determines the weight assigned to such admissible findings. No member can be compelled to testify.

Sorry Works! Pilot Program

The Sorry Works! Coalition[15] was officially launched in February 2005 and currently has more than 1,500 members. The coalition is not funded by any medical, insurance or trial lawyer organizations, and the board members and staff are volunteers.

Illinois was the first state to develop a pilot program, similar to programs used by hospitals and insurance companies, to encourage open communications. In 2005, Illinois enacted legislation that included the Sorry Works Program under which participating hospitals and physicians must promptly acknowledge and apologize for mistakes in patient care and offer early compensation.[16]

Other states have followed the lead of Illinois and are considering similar legislation. Tennessee is considering Sorry Works! pilot program legislation (SB 3325), while Vermont legislators are reviewing legislation (SB 198) that will provide grants to healthcare institutions to assist with implementation of Sorry Works!–type programs. Also, legislators in South Carolina, Utah, Hawaii and Massachusetts are pushing apology-immunity laws.

Conclusions

While there is evidence that tort reforms have reduced the rate of growth in medical malpractice costs across the country, New Jersey has yet to take the lead on this pressing issue. At the onset of the 2012-2013 legislative session, NJHA will be considering innovative ways to reduce medical malpractice premiums in our state to retain our physicians and provide quality and accessible health care to all of our communities. It is imperative that as healthcare providers continue the road of improving quality outcomes that the state pursues legislative and regulatory remedies to provide relief to this already strained system.

[15] (http://www.sorryworks.net)
[16] Stat. 710 ILCS 45/405 (2005)