

Congress Renews Debate on Medical Malpractice AAEM Endorses Bills

On February 10, Senate Budget Committee Chairman Judd Gregg (R-NH) and Senate Health, Education, Labor, and Pensions Committee Chairman Mike Enzi (R-WY) introduced S.354, the **HEALTH (Help Efficient Accessible, Low-Cost, Timely Health Care) Act of 2005**, which would impose a \$250,000 cap on non-economic damages. The legislation would apply to "all health care providers, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product." S.354 is similar to legislation introduced in the last Congress, except that the new bill has a provision requiring experts called to testify in medical malpractice cases to be appropriately credentialed and experienced with standard of care in the case.

Judging from comments made upon introduction of the bill, it appears there will be few breaks in the partisan sniping that has dominated the issue in Congress in the last several years. Democrats say that Republican bills are too narrowly focused on medical litigation, fail to address patient safety problems, and fail to impose additional requirements on medical malpractice insurance carriers. While Republicans contend that the Democrats are under the thumbs of the trial lawyers.

The House companion bill – H.R.534 – was introduced on February 2, 2005, by Representative Christopher Cox (R-CA). The Small Business Committee held a hearing on the bill on February 17.

In letters dated, March 30, 2005, **AAEM** endorsed both the House and Senate **HEALTH** bills. **AAEM** President Antoine Kazzi stated, "Skyrocketing medical liability premiums . . . are debilitating the nation's health care delivery system forcing physicians to limit services, retire early, or move to a state with reforms where premiums are more stable. Many emergency physicians find themselves unable to obtain needed specialty consultation for victims of trauma. . . . Without federal legislation, the crisis in our nation's emergency departments will continue to grow and patients will find it increasingly difficult to obtain needed health care."

While the House is likely to pass medical malpractice legislation, the outlook in the Senate is less clear. Enzi told reporters at a briefing on S.354 that public opinion is beginning to turn in the direction of favoring limits on malpractice awards, which may push the Senate to act this year.

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Frist Open to Negotiation on Malpractice Reform

Senate Majority Leader Bill Frist (R-TN) said on March 15 that he is "absolutely committed" to bringing medical malpractice reform legislation to the Senate Floor this year, and is willing to talk with Democrats on possible compromises that would pave the way to action. Speaking to a group of OB-GYNs, Frist said he supports a \$250,000 cap on non-economic damages in malpractice cases, but he added that he is willing to consider other ideas and is seeking to start negotiations.

Frist Open to Negotiation on Malpractice Reform (cont'd)

Democrats have talked about raising the cap on non-economic damages. They have also said that the insurance industry should be focused on as one of the causes for rising malpractice premiums. Frist did not outline any specific insurance industry reforms to which he might be agreeable. He said he could consider measures to modify "joint and several liability" in lawsuits, place "reasonable limits" on attorneys' fees, and possibly raise the proposed cap on noneconomic damages. While Frist did not detail possible changes to insurance laws, he said he would consider "something that would adjust or modify or send signals to the insurance industry."

JCAHO Weighs in on Medical Liability Crisis

In mid-February, JCAHO issued a call to action to reform the nation's medical liability system, urging that the current proposal for caps on non-economic damages be expanded to pursue intermediate and long-term system changes which would truly facilitate improvements in patient safety. The Joint Commission suggests that the current medical liability system fails patients because it does not effectively deter negligence, truly offer corrective justice, or provide fair compensation to those who have been injured through the care process.

The call to action is set forth in the Joint Commission's newest public policy white paper, Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury. The report urges intensified attention to patient safety and medical injury prevention by health care providers and practitioners.

Among its 19 recommendations for reform, JCAHO said researchers should have access to open liability claims to permit timely identification of problematic trends in care. JCAHO also called for passage of legislation to protect disclosure of mistakes and associated apologies from being used against health care practitioners in litigation.

The report suggests that any redesign of the medical liability system should assure appropriate compensation for all injured patients, while also encouraging health care providers and practitioners to surface errors, learn from mistakes in the design and performance of care processes, and take action to ensure that adverse events do not recur.

Budget Proposals to Affect Physician Payments Over Time

The Bush Administration's FY 2006 budget proposal contains no legislative proposals that directly affect physician payments, including ways to avoid a projected 5% Medicare payment reduction in 2006. According to Administration officials, the annual payment update to Medicare providers under current law would not be reduced by the budget recommendations, but provider representatives point out that provider payments would be cut by more than \$15 billion over five years through a series of administrative actions.

The Medicare program's trustees have announced that physician payment rates will be cut 31% from 2006-2013. If these cuts are not prevented, Medicare payment rates in 2013 will be less than half what they were in 1991, after adjusting for practice cost inflation. Medicare payments are already lagging behind increases in practice costs because of a flawed formula called the Sustainable Growth Rate, or SGR. Instead of the SGR, most physician advocates believe that payment updates should be based on increases in practice costs. The SGR is expected to result in a 31% decrease in Medicare physician payments over the next seven years.

Other Medicare providers are not subject to the SGR. In fact, hospital payments are slated to rise by more than 3% a year.

CMS Administrator Mark McClellan recently told reporters that the Administration wants to emphasize implementing pay-for-performance provisions into Medicare this year. Under such provisions, some providers would be paid more than others for delivering high quality care.

CDC Report Shows Limited Use of EMRs

According to a new report from the Centers for Disease Control and Prevention (CDC) – **Use of Computerized Clinical Support Systems in Medical Settings: United States, 2001-2003** – less than a third of the nation's hospital emergency and outpatient departments, and even fewer doctors' offices, use electronic medical records (EMRs). CDC's ambulatory medical care surveys, conducted from 2001 to 2003, shows that about 31% of hospital emergency departments, 29% of outpatient departments, and 17% of doctors' offices have EMRs to support patient care.

The use of electronic records in health care lags far behind the computerization of information in other sectors of the economy. While many physician offices and hospitals use computer records for billing purposes, health care providers overall have been slower to adopt computerized medical records.

The survey measured the use of systems to improve the accuracy and safety of prescription drug use. About 8% of physicians use a computerized physician order entry system in which orders for drugs and diagnostic tests are entered electronically. The study found physicians

under 50 were twice as likely as physicians over 50 to use the computerized system for ordering prescriptions.

The report states that about 40% of hospital EDs use automated drug dispensing systems (ADDs), compared to about 18% of outpatient departments. Other studies have shown that ADDs can reduce medical errors. These automated systems are more likely used in EDs located in metropolitan areas and those with the highest volume of patients. For out-patient departments, medical school affiliation was associated with use of automated drug systems.

The role the federal government plays in creating a nationwide health information technology network is a major factor in the debate over how to convince hospitals, physicians, and other providers to incorporate such technology into their facilities. President Bush as well as many Republicans and Democrats in Congress say EMRs will reduce health care costs and improve patient care. The President has indicated that he wants most Americans to have an electronic medical record within 10 years and has named David Brailer as National Coordinator for Health Information Technology

FDA Issues MedWatch Alerts - Potential Emergency Care Impact

Based on a review of adverse events for Phenergan in pediatric patients less than two years of age, the manufacturer has implemented the following labeling changes following a request from the Food and Drug Administration (FDA):

“Phenergan Tablets and Suppositories are contraindicated for use in pediatric patients less than two years of age based on the potential for fatal respiratory depression.”

Additional information can be found at http://www.fda.gov/medwatch/SAFETY/2005/Phenergan_PI.pdf.

The FDA also issued a Medical Product Safety Alert based on information received from Medtronic, Inc. Medtronic is voluntarily advising physicians and health professionals about a potential battery shorting mechanism that may occur in a subset of implantable cardioverter-defibrillator and cardiac resynchronization therapy defibrillator models. In a letter to physicians, Medtronic reported that nine batteries (0.01 percent or approximately 1 in 10,000) have experienced rapid battery depletion due to this shorting action. If shorting occurs, battery depletion can take place within a few hours to a few days, after which there is loss of device function. No patient injuries or deaths have been reported to date.

For additional information go to: http://www.fda.gov/oc/po/firmrecalls/medtronic02_05.html.

CDC Report Shows Limited Use of EMRs (cont'd)

to help accomplish that goal. Senate Majority Leader Bill Frist (R-TN) and other GOP leaders have said that the government should focus its resources on creating electronic information-sharing standards. According to Senator Frist, promoting "interoperability" would do more to encourage the use of health care information technology than distributing federal grants to hospitals, physicians, and other health care providers to install health care information technology systems.

The States: Medical Malpractice Update

✓ **GA Governor Signs Malpractice Bill**

On February 17, 2005, **Georgia** Governor Sonny Perdue (R) signed into law a major tort reform bill – Senate Bill 3 – that limits jury awards for pain and suffering in medical malpractice cases to \$350,000, or \$1.05 million in multi-defendant cases. According to the **Georgia** Hospital Association, the malpractice reforms in the bill “could be the strongest in the country.”

After falling one vote short of adopting the sweeping tort reform bill that had been approved by the House on February 10 by a vote of 136-34, the Senate did an abrupt about-face and approved the House version of the bill on February 14 by a vote of 38-15. The bill became effective upon Perdue's signature.

The new law **limits liability for emergency services providers**, eliminates a legal principal known as "joint and several liability" in all tort cases by making juries decide what share of the blame multiple defendants should be liable for, and reforms the laws regarding expert witnesses and venue. The law also allows health care providers to offer statements of apology and sympathy without the threat of such statements being used against them in court. In addition, it requires plaintiffs to file medical authorization forms with their complaints authorizing their attorney to disclose protected health information and be able to discuss the information with their physicians.

One of the major civil justice reforms included in the law **raises the malpractice standard in cases against hospital EDs and ED doctors** to gross negligence, where previously the standard had been simple negligence. That provision has been bitterly opposed by some lawmakers, and is condemned by the **Georgia**

Trial Lawyers Association which is looking at a legal challenge to the law.

✓ **Missouri Tackles Medical Malpractice**

In **Missouri**, the House Judiciary Committee, on February 9, endorsed legislation – House Bill 393 – that would impose a flat \$250,000 cap on what victims of medical malpractice could receive for noneconomic damages. The next day, Governor Matt Blunt (R) praised the legislation and specifically lauded the \$250,000 cap. The cap would be a dramatic reduction from **Missouri's** current \$579,000 limit, which rises annually with inflation and can be applied against each act of malpractice committed by the health care providers who are sued.

While the cap does not affect awards for economic damages, such as the cost of medical care, and it is only one part of House Bill 393, which also would restrict the filing and trial of all forms of tort cases, it is the medical claims – and specifically the financial limits – that have been the focus of debate in **Missouri**. House Bill 393 now goes to the Senate.

✓ **CT Governor Proposes Liability Reform**

Under **Connecticut** Governor M. Jodi Rell's proposed plan for medical liability reform, medical caps on awards would come up for discussion only if reforms fail to reduce medical malpractice insurance rates by at least 15% in three years. The highlights of Rell's proposed plan include: a detailed medical opinion from a doctor from the same area of expertise as the defendant filed with the court; consideration of all additional payments received by the plaintiff for the same injury when assessing damages; jury awards of \$200,000 or more be paid over time; prior approval from

the state insurance commissioner prior to a malpractice insurance rate increase of 10 percent or more; development of patient safety protocols by hospitals; and expedited processing of medical malpractice complaints, updated disciplinary protocols that focus on patient safety and clarification of existing physician profile data by the state's health department.

Senator Christopher Murphy (D-Southington), Co-Chair of the **Connecticut** legislature's Public Health Committee, said Rell's proposals were "a sort of reshuffling" of the elements contained in a bill vetoed by last year's governor. He said the success of the reform movement may depend on whether the state's doctors decide to support a proposal that does not include caps.

✓ **Illinois Legislation Still in Play**

During the week of March 14, a bitter partisan fight erupted in the **Illinois** Senate over medical malpractice reform legislation, prompting the Senate to close its session early. The argument began when Democratic state Senators withdrew an offer to vote on a Republican-proposed malpractice reform bill. The bill (SB 150), sponsored by Senator David Luechtefeld (R), would set a \$250,000 cap on noneconomic damage awards. The Democratic majority last week postponed the bill for a second time and then decided to transfer the legislation from the Judiciary Committee to the Executive Committee (which is expected to defeat it) for further consideration. Republican state senators attempted to force an immediate vote on the bill and then began a series of parliamentary maneuvers to interrupt Senate business. As a result, Senate President Emil Jones (D) adjourned the Senate. Further discussions on the bill are expected to continue in April when the legislature reconvenes.

✓ **VA Governor Signs Liability Reform Bill**

On March 23, **Virginia** Governor Mark Warner (D) signed into law a medical liability reform bill allowing physicians to apologize without admission of wrongdoing and increasing requirements for expert witnesses in malpractice lawsuits. In

addition, the new law requires competency evaluations for certain physicians and also makes some revisions to the state birth injury program, which blocks malpractice lawsuits against certain physicians and hospitals when infants experience severe injuries at birth. State lawmakers also will continue to discuss other medical liability reform proposals, such as a \$250,000 cap on noneconomic damages in malpractice lawsuits. **Virginia** currently caps all damages in malpractice lawsuits at \$1.75 million.

✓ **Maryland Rejects Reform Amendments**

The **Maryland** Senate on March 10 rejected 10 amendments, introduced by Republican senators, to the medical malpractice reform legislation passed in the state last year. The proposed measures would have established caps on awards to injured patients, limited attorney fees, made doctors' apologies inadmissible as evidence of liability in court, and permitted lawsuits against emergency department physicians only in cases of gross negligence. **Maryland** Governor Robert Ehrlich (R), who has called for additional reforms, has appointed a work group to determine what types of changes to earlier legislation might be approved by the House, including a bill that would allow plaintiffs' awards to be paid in installments instead of a lump sum.

✓ **South Carolina House Passes Caps Bill**

On March 3, the **South Carolina** House passed a bill that would cap noneconomic damages in malpractice lawsuits at \$350,000. The Senate, which last month passed a similar version of the legislation, would have to make only "minor tweaks" before a final version could be approved. The House version of the bill would require mediation before plaintiffs could file malpractice lawsuits – rather than before such cases proceed to trial as the state Senate version would require – and provide for some **liability protections for certain trauma center and emergency department physicians** not included in the Senate version. Both versions of the legislation include a provision that would allow plaintiffs in malpractice lawsuits to receive as much as \$1.05 million in noneconomic damages from a combination of as many as three defendants.