



Position Statement on Medical Liability Reform

The North American Spine Society (NASS) is a multidisciplinary medical organization dedicated to fostering the highest quality, evidence-based and ethical spine care by promoting education, research and advocacy. NASS is comprised of more than 6,200 members from several disciplines including orthopedic surgery, neurosurgery, physiatry, neurology, radiology, anesthesiology, research, physical therapy and other spine care professionals.

The Cost of Defensive Medicine

Currently, the medical liability climate creates a financial burden on the health care system and promotes inefficiencies that fail to protect patient access to quality care. The costs of our liability system are borne throughout society. Defensive medicine, medical practices designed to avert the future possibility of malpractice suits, adds billions of dollars to the cost of health care each year, resulting in higher health insurance premiums for patients and skyrocketing increases in the amount of funding necessary to secure Medicare benefits for our nation's seniors.¹

Studies have shown that thousands of patients each year undergo unnecessary testing and treatments, solely because the treating physician has concerns about the medical liability climate in their state. These tests and treatments are done to minimize litigation risks or avoid frivolous lawsuits. A 2006 Harvard School of Public Health study estimated that 28 percent of all tests and procedures and 13 percent of all hospitalizations were performed to avoid lawsuits.² Further, a 2003 Department of Health and Human Services (HHS) report estimated that between \$70 and \$126 billion per year was spent on unnecessary tests and procedures³, driven in large part by the treating physicians concerns about malpractice liability if these were not carried out.

Defensive medicine takes other forms as well, shifting costs and responsibilities and restricting access to much needed care. Studies show that medical liability concerns have forced 44 percent neurosurgeons and 55 percent of orthopedic surgeons to stop treating some complex cases.^{4, 5} This has caused many physicians to refer patients, many of whom who can be treated in the office, to the emergency room where the cost of providing care is more expensive. Three out of four emergency rooms report diverting ambulances due to shortages of specialists in emergency rooms and more than 25% of hospitals report losing specialist coverage because of medical liability concerns.⁶

The Impact of Medical Liability on Physicians and Patients

Medical liability raises the cost of providing health care in the United States. In a 2009 analysis of proposals to limit costs related to medical malpractice, the nonpartisan Congressional Budget Office (CBO) estimated the effects of incorporating a comprehensive package of tort reform proposals. These included a cap of \$250,000 on awards for noneconomic damages, a cap on awards for punitive damages and a statute of limitations from the date of discovery of an injury (one year for adults and three years for children). The CBO's analysis concluded that incorporating the package of proposals nationwide would reduce national health care spending by roughly five percent. Reduced spending in health care brought about by these proposals would increase federal tax revenues by roughly \$13 billion and reduce federal budget deficits by approximately \$54 billion over the first 10 years. Moreover,

¹ Berenson R., et al. Center for Studying Health System Change, *Medical Malpractice Liability Crisis Meets Markets: Stress in Unexpected Places* (2003).

² Melo, M. *Medical Malpractice: Impact of the Crisis and Affect of State Tort Reforms*. The Robert Wood Johnson Foundation. Research Synthesis Report 10. (2006).

³ Office of the Assistant Secretary for Planning and Evaluation, U.S. Department Of Health and Human Services, *Dressing the New Health Care Crisis: Reforming the Medical Litigation System To Improve the Quality Of Health Care* 11 (2003).

⁴ American Association of Neurological Surgeons and Congress of Neurological Surgeons, 2004 Survey, cited in "Federal Medical Liability Reform," Alliance of Specialty Medicine, July 2005.

⁵ American Association of Orthopaedic Surgeons, cited in "Federal Medical Liability Reform," Alliance of Specialty Medicine, July 2005

⁶ The Schumacher Group, 2004 Hospital Emergency Department Administration Survey, cited in "Federal Medical Liability Reform," Alliance of Specialty Medicine, July 2005.

mandatory spending for Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and the Federal Employees Health Benefits program would be reduced by approximately \$41 billion over the same period of time. The CBO estimate points to evidence which suggests that Medicare would experience the greatest decline in spending among those programs.⁷

Although opponents argue that tort reform adversely affects health outcomes, recent studies have found evidence to the contrary. For example, studies in recent years have concluded that tort reform would not adversely affect patient's health in a significant way.⁸ The Congressional Budget Office, in a December 2009 letter to Senator John Rockefeller, stated that current evidence did not sufficiently demonstrate that tort reform would adversely affect health outcomes.⁹

Despite the fact that a majority of medical malpractice claims never come to trial, the size of jury awards and settlements has risen rapidly over the past several years. The Physician Insurers Association of America has very strong data demonstrating this fact. From 1997 to 2006, the median medical liability jury award more than tripled from \$157,000 to \$487,500. The average award increased from \$347,134 in 1997 to \$637,134 in 2006.¹⁰ Staggering growth has not only occurred with jury awards, but also with settlement amounts. Average settlement amounts increased from \$212,861 to \$335,847 between 1997 and 2006.¹¹ Unfortunately, some awards greatly exceed these amounts. In Illinois and Massachusetts, 17 percent of claims paid were at or above \$1 million, as were 8.5 percent of claims in Nevada according to a 2007 Bureau of Justice Statistics report.¹²

A crisis in malpractice insurance has directly resulted from a rise in jury awards and settlement amounts. In some states, malpractice insurance is simply unaffordable, forcing some physicians (especially in rural areas) to close their practice and switch careers or retire altogether. States without liability reform that include caps on noneconomic damages, such as Arkansas and Connecticut, have experienced insurance premium rate hikes from 30 to 113 percent in the early 2000s.¹³ Data from the same HHS report shows states such as Indiana and South Dakota with caps on noneconomic damages did not experience similar rate increases in the early 2000s.¹⁴ A 2006 study by Kilgore, Morrissey and Nelson demonstrated an association between tort reforms and medical liability premiums between 1991 and 2004. Depending upon medical specialty, premiums in states with liability caps were 17.3 to 25.5 percent less than states without caps. The study also found that lowering damage caps by \$100,000 reduced premiums by 3.9%.¹⁵ The 2009 CBO study estimated that providers incurred approximately \$35 billion (two percent of total health care expenditures) in medical malpractice liability costs in 2009. Implementing the package of tort reform proposals outlined in the 2009 CBO study would result in lowering premiums for medical liability insurance by 10 percent and reduce national health care costs by two percent.¹⁶

Medical liability insurance premiums are at or near all-time highs. According to a NASS survey conducted between March and April of 2008 the average estimated annual liability premium between 2002-2006 rose from just under \$50,000 in 2002 to just under \$60,000 in 2006. This increase may have been higher were it not for drastic premium cuts for physicians practicing in states that have implemented medical liability reforms. For example, a respondent from Texas saw a rate drop of \$9000 or 25 percent between 2006 and 2008 after reforms were enacted in that state.¹⁷

⁷ United States Congressional Budget Office. Letter. October 2009. Print.

⁸ Sloan F, Shadle J. "Is There Empirical Evidence for Defensive Medicine? A Reassessment." 28 *Journal of Health Economics*, 481-491 (2009).

⁹ United States Congressional Budget Office. Letter. December 2009. Print.

¹⁰ Physician Insurers Association of America, PIAA Claim Trend Analysis: 2006 ed. (2007).

¹¹ Physician Insurers Association of America, PIAA Claim Trend Analysis: 2006 ed. (2007).

¹² Bureau of Justice Statistic, *Medical Malpractice Insurance Claims in Seven States, 2000-2004*, Department of Justice (March 2007).

¹³ Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, *Special Update on Medical Liability Crisis* (2002).

¹⁴ Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, *Special Update on Medical Liability Crisis* (2002).

¹⁵ Kilgore M, Morrissey M, Nelson L. "Tort Law and Medical Malpractice Insurance Premiums." *Inquiry* 43 (Fall 2006): 255-270.

¹⁶ United States CBO (Congressional Budget Office). Letter. October 2009. Print.

¹⁷ NASS Membership Survey conducted 03/27/2008-04/31/2008.

A survey conducted by the Council of State Neurosurgical Societies found that between 2000 and 2002 the national average of professional liability insurance premium rates for neurosurgeons increased 63 percent, from \$44,493 to \$72,682.¹⁸ A joint study by the American Medical Association and the American Association of Neurological Surgeons confirmed those findings and estimated that rates for neurosurgeons between 2001 and 2003 continued to rise to an average of \$55,500 to \$84,100. The study also reported that professional liability premiums for neurosurgeons were as high as \$400,000 in some states.¹⁹

The Impact of Frivolous Claims

A study by Harvard University examined New York State hospital medical professional liability claims data to estimate the incidence of adverse events among hospitalized patients and to characterize the relationship between adverse events and medical liability claims. The study found that, "... a substantial majority of malpractice claims filed are not based on actual provider carelessness."²⁰ They discovered that negligence had occurred in only one-sixth of filed claims.²¹ The authors also reported that "in its initial filing stage the tort system is even more error-prone than the medical care system."²² The Physician Insurers Association of America has shown similar findings. A majority of claims filed have no basis, and their study found that 74 percent of all medical liability claims in 2004 were closed without payment to the plaintiff. Plaintiffs lost the majority of the cases that went to a jury. Of the six percent of claims that went to a jury verdict, the defendant won 91 percent of the time.²³ Of greater concern are the significant costs of defending against these claims. Physicians spent an average of \$18,887 to defend a claim that was ultimately dropped or dismissed. Average defense costs for physicians who are victorious at trial are \$94,284.²⁴

Ultimately, physicians are being forced to make difficult decisions, including altering or limiting their services. According to the 2008 NASS survey, 62 percent of NASS members believe that the medical liability climate in their state affected their ability to practice medicine. Sixty-three percent of members responded that they had ordered unnecessary tests while 50 percent had referred a high risk patient to another physician and 44 percent had stopped performing certain treatments or procedures due to current medical liability laws.²⁵ In Pennsylvania, a state with high medical liability claims, 42 percent of specialists have reduced or eliminated high-risk aspects of their practice, and 50 percent are likely to do so over the next two years, due in large part to professional liability costs.²⁶ Patients then suffer due to the diminished access to care. According to a survey of high-risk specialty physicians in Pennsylvania, 25 percent of obstetrician/gynecologists often avoid caring for high-risk patients.²⁷

Medical Liability Reform (MLR) in the States

The states best exemplifying the successes of liability reform are California and Texas. The caps California instituted in 1975 have stabilized the malpractice premiums of physicians in that state for the past 30 years. Prior to the institution of caps, the number of medical liability claims doubled in California between 1968 and 1974. The number of claims paid exceeding \$300,000 increased from 3 to 34. Losses exceeded premiums paid by a ratio of 1.8:1. Most commercial insurers stopped writing policies for physicians as they felt the risk class was uninsurable, and refused to provide medical liability insurance at any price. This threatened access to care and an emergency legislative session was called to enact the Medical Injury Compensation Reform Act of 1975 (MICRA).²⁸

¹⁸ Council of State Neurosurgical Societies, 2002 Survey, cited in Federal Medical Liability Reform: Neurosurgeons Plan to Preserve Patients' Access to Care. American Association of Neurological Surgeons Bulletin. 2003; 12 (3): 7-8, 10, 17.

¹⁹ American Medical Association 2003 Survey, cited in Federal Medical Liability Reform: Neurosurgeons Plan to Preserve Patients' Access to Care. American Association of Neurological Surgeons Bulletin. 2003; 12 (3): 7-8, 10, 17.

²⁰ Weiler, P et al., A Measure of Malpractice: Medical Injury, Malpractice Litigation and Patient Compensation 140 (Harvard University Press 1993).

²¹ Id. at 18.

²² Id. at 18.

²³ Physician Insurers Association of America, PIAA Claim Trend Analysis: 2006 ed. (2007).

²⁴ Id. at 21.

²⁵ NASS Membership Survey conducted 03/27/2008-04/31/2008.

²⁶ Melo M et al., Effects of a Malpractice Crisis on Specialist Supply and Patient Access to Care. 242 Annals of Surgery, 621-628 (November 2005).

²⁷ Studdert, D et al., Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment. 293 The Journal of the American Medical Association, 2609-2617 (June 1, 2005).

²⁸ Anderson, R. Commentaries Defending the Practice of Medicine, 164 Archive of Internal Medicine. 1173-1174 (June 14, 2004).

The results of malpractice reform in California are well documented. It takes 1/3 less time to settle claims than in states without caps. The cost of litigation has decreased and injured patients receive payment more rapidly.²⁹ Money has been redistributed from trial lawyers to injured patients and insurer payouts have decreased. A RAND Corporation study showed a 60 percent reduction in trial attorney fees while only a 15 percent reduction in awards to injured parties and their families.³⁰ The greatest effect may be that more claims are settled through arbitration and settlement which places more money in the hands of the injured patient. In addition, “premiums for specialists in Los Angeles are substantially less than for specialists in metropolitan areas in states without reforms such as Florida, Illinois and Nevada.”³¹

Texas passed Proposition 12 in September 2003, capping noneconomic medical malpractice damages for individual providers at \$250,000, with an aggregate cap of \$750,000. Thousands of physicians have since moved to the state, improving delivery of health care in underserved areas. In the past five years, Texas has experienced a 12 percent growth rate in orthopaedic surgeons and neurosurgeons practicing in the state. Both specialties were experiencing net losses prior to the passage of medical liability reform in 2004. Overall, Texas has experienced a 31 percent greater growth rate in newly licensed physicians in the past two years, than in the two years preceding reform.³² Early reports show a decrease in the frequency of paid claims, decreased premiums for physicians, and increased physician supply. The Texas Medical Liability Trust, the state’s largest provider of medical malpractice insurance, reduced rates for new policyholders by 12 percent in 2004, five percent in 2005 and five percent in 2006, and paid an “unprecedented” \$10 million in dividends to 2005 policyholders.³³

Federal Efforts at Medical Liability Reform

Despite this progress at the state level, Congress has failed to pass various proposals dealing with the issue at a national level. In the 107th congress, legislation that limited tort claims for medical malpractice won passage in the House but failed to get a vote in the Senate. Legislation addressing medical malpractice reform was considered twice in the 108th congress but died both times in the Senate. More recently, as a candidate for president, then-Senator Barack Obama expressed a willingness to consider alternative methods to medical liability reform that did not include caps on noneconomic damages. After being elected president, he re-iterated his possible support for alternative methods as part of a health care reform package.

Comprehensive health care reform legislation signed into law by President Obama on March 23, 2010 included initial language that provided incentive payments to states that adopted certificate of merit or early offer rules as an alternative to caps on noneconomic damages. The original language introduced by Representative Bart Gordon (D-TN) was altered throughout the course of the health care debate to discourage serious liability reform. In the final language, states only qualify for incentive payments if state law does not limit attorney’s fees or impose caps on damages. Further, appropriations committees in both chambers are still required to appropriate funds to initiate the program.

In a September 9, 2009 address to a joint session of Congress, President Obama announced a medical liability reform state grant initiative administered by the Agency for Healthcare Research and Quality (AHRQ). Under guidelines released by AHRQ, states and health systems may apply for three year grants to implement and evaluate evidence-based patient safety and medical liability demonstrations. Demonstrations must meet certain principles including reduction of preventable injuries, ensuring that patients are compensated quickly and fairly, as well as reducing frivolous lawsuits and liability premiums.

North American Spine Society Recommendations for Medical Liability Reform

- ***Medical liability reform needed at the federal level***

NASS believes medical liability reform is necessary at the federal level. NASS supports federal legislation establishing punitive damage limits and a proportionality requirement to ensure punishments are appropriate to the offenses. Inequity across state lines increases the inefficiencies placed on our health care system by the current status of tort law in our

²⁹ Harming Patient Access to Care: The Impact of Excessive Litigation: Hearing Before the Subcommittee on Health of the Committee on Energy and Commerce, 107th Congress 88 (2002) (E. Anderson, Chairman of the Doctor’s Co. for the Physician Insurers Association of America).

³⁰ Pace, N. et al, Rand Corporation, Capping Non-Economic Awards in Medical Malpractice Trials xxiv (2004).

³¹ National Association of Insurance Commissioners, Profitability by Line by State in 2005 (National Association of Insurance Commissioners Insurance Products and Services Division), at 123-124 (2007).

³² Proposition 12 Produces Healthy Benefits. Texas Medical Association. February 9, 2009.

³³ Selden, J. “Texas Malpractice Insurance Rates Dropping After Proposition 12 Passage.” [Austin Business Journal](#) 7 October 2005.

society. There is robust public support for federal legislation. A 2006 Harris Interactive poll showed that 76 percent of respondents support a law that would guarantee an injured patient full payment for lost wages and medical expenses and place reasonable limits on awards for “pain and suffering” in medical liability cases. There was overwhelming support for legislators to enact medical liability reform. A 2003 Gallup national poll showed 72 percent supported caps on “pain and suffering.” A federal institution of caps on noneconomic damages would reduce frivolous malpractice claims, stabilize malpractice insurance rates nationwide and maintain patient access to specialty care. Federal regulations should also address the reporting of medical errors without the fear of reprisal.

- ***Limits to punitive damage.***

NASS believes that caps on noneconomic damages should be part of any medical liability reform law. Limits on the noneconomic damages (i.e., pain and suffering) awarded in a suit have been shown to have the greatest effects on controlling unnecessary health care expenditures. Noneconomic awards are often excessive, generally bear no proportionality to the offense and can irreparably damage a physician’s practice, character and reputation. NASS supports appropriate controls on malpractice damage awards such as a “liability” trigger, whereby there is a requirement to prove “clear and convincing evidence” of gross malpractice or intentional wrongdoing before punitive damages can attach. NASS membership believes caps on noneconomic damages and limits on punitive damage awards not only reflect common sense, but are needed to rein in unnecessary health care expenditures.

- ***Health Courts***

Medical liability actions could be heard by judges specially trained in medical liability matters. The negligence standard would be the minimum threshold for compensation to award damages. The recovery of economic damages would not be limited, but noneconomic damage awards would be based on a schedule. An abundance of evidence exists demonstrating that alternate systems would be swift, decisive and equitable to all involved parties.

- ***Early Disclosure and Compensation Programs***

Under an early disclosure and compensation model, providers, including physicians, would be required to notify a patient of an adverse event within a limited period of time. Notification does not constitute an admission of liability. Providers offering to compensate for injuries in good faith would be provided immunity from liability. Payments for noneconomic damages would be based on a defined payment schedule developed by the state in consultation with relevant experts and with the Secretary of HHS.

- ***Expert witness qualifications***
NASS supports the creation of a universal set of guidelines required to serve as an expert witness in a malpractice trial. A universal definition must require expert witnesses certifying standards of care and malpractice to be adequately trained and currently practice within the same medical specialty as the defendant. Evidence or testimony must be based on complete and objective findings that are scientifically based on the standards of care in place at the time of the occurrence.

- ***Certificate of merit***

No case should be allowed to proceed unless an expert witness certifies that malpractice may have occurred. This unequivocally reduces the number of frivolous suits filed and lowers the societal costs.

- ***Expansion of Good Samaritan Laws***

Providers should be able to volunteer their services to charitable organizations or those in need without the threat of lawsuits.

- ***Abolition of joint liability***

Providers should not be subject to joint liability statutes, where a physician who is peripherally connected to treatment of a patient with a bad outcome could be found equally as responsible as a physician more directly connected to the outcome.

- ***Statements of apology legislation***

Statement of apology laws allow physicians to express guilt or fault to a patient without fear of such statements being admitted as evidence in an ensuing medical malpractice action. Supporters believe that patients seek open discussions with their physician when medical errors occur and trust that a willingness to admit a mistake to a patient will significantly reduce the number of medical malpractice suits filed against physicians. Statement of apology laws allow physicians to express guilt or fault to a patient without fear of such statements being admitted as evidence in an ensuing medical

malpractice action. NASS believes physicians who express regret for a medical error should have the explicit right not to have this statement used against them in a related malpractice claim.

- ***Liability Protections for Use of Government Mandated Guidelines***

Medical liability protections should be provided for health care providers who follow practice guidelines that may be established by any government mandated process. There would be no presumption of negligence if a physician does not utilize the guidelines. Physicians would receive legal protections for utilizing evidence-based clinical practice guidelines and/or their clinical judgment in developing a treatment plan based on their patient's particular needs and values.

- ***Offset of collateral payment sources.***

Offset of collateral payment sources would ensure physicians are limited to the liability for which they are responsible. In many states, a defendant is prohibited from introducing evidence to show that a plaintiff's losses have been compensated from other sources. Permitting the admissibility of collateral source payments at trial or requiring the awards to be offset by the amount paid to plaintiffs by these collateral sources would help ensure that physicians are only punished to the extent that they are liable and prevents plaintiffs from being compensated twice.

NASS is committed to providing high quality care to all spine patients, using education, research and advocacy to accomplish this goal. In pursuit of the highest quality of care, liability reform should be included as part of any governmental efforts to further reform the healthcare system. It is at the heart of NASS' mission to advance quality spine care for our patients. To this end, NASS is committed to working with a broad range of stakeholders to ensure proper design and implementation of medical liability reform.

Approved by NASS Board of Directors, June 2010.