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ADVOCATING FOR MEDICAL LIABILITY REFORM American Academy of Pediatrics Position

Pediatricians are committed to bringing about the best possible health outcomes for children and their families. Because all medical interventions involve known and unknown risks, pediatricians should work with health care teams to create safe patient care environments and prevent medical errors by focusing on a systems approach which seeks to identify and learn from errors. However, the Academy believes that when patients are harmed by medical care they should be compensated fairly without waiting years because of legal maneuvering. Unfortunately, the tort system is unfair to the very people it is supposed to help. Only 43 cents of the awards dollar is retained by patients as compensation; the remainder goes to administrative costs, which include attorneys' fees.

Physicians who take care of children, including but not limited to pediatricians, obstetricians, family practitioners, and surgeons must deal with a unique patient population consisting of minors. They face unprecedented and unique legal challenges related to a long statute of limitations. This has profound medico-legal and actuarial consequences. Unique solutions must be used to address these challenges.

The Academy supports the reforms of the Medical Injury Compensation Reform Act (MICRA), California's 1975 landmark legislation with a proven record of making medical liability insurance available and affordable.

The Academy believes that the following reforms are needed to make sure that patients receive timely, full and fair awards when a wrongful or neglectful medical event occurs:

- The Academy recommends state statutes of limitation of two years with the toll beginning from the occurrence (rather than discovery) of an injury, and establishes a child's majority at age 6 for the purpose of medical liability.
- Periodic payments of future damages exceeding \$100,000;
- Non-economic damages should be capped at a reasonable amount;
- There should be mandatory offsets for collateral sources (with credit for out-of-pocket costs of collateral sources);
- Use of a sliding scale for plaintiff lawyer fees;
- A "fair share" rule that allocates damage awards fairly and in proportion to fault; and
- Punitive damages should be awarded only if there is "clear and convincing" evidence that the injury meets the standard set by each jurisdiction and for acts for which the defendant is directly responsible. In those cases, punitive damages should be limited to a reasonable amount.

For states that have not been able to pass comprehensive medical liability reform laws, we support the allocation of federal grants to enable the exploration of state

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or local-based demonstration or pilot programs that have the potential to improve the current litigation climate through measures that could expedite equitable resolutions of disputes and contribute to the reduction of litigation costs and the practice of defensive medicine.

These alternatives include:

- **Expert Witness Qualifications** as specified in the AAP policy statement “Expert Witness Participation in Civil and Criminal Proceedings” Pediatrics 2009; 124:428-438.
- **Health Courts.** Health courts could provide a forum, through either a bench or jury trial, where medical liability actions could be heard by judges specially trained in medical liability matters and who hear only medical liability cases. The negligence standard would be the minimum threshold for compensation to award damages. The recovery of economic damage awards would be based on a schedule. Medical experts and expert witnesses would have to meet established qualifications.
- **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 non-economic damages would be based on a defined payment schedule developed by the state in consultation with relevant experts and with the Secretary of the Department of Health and Human Services (HHS).
- **Administration of a Determination of Compensation Model.** A state’s administrative entity would be charged with setting a compensation schedule for injuries, resolving claims for injuries, and establishing compensation based on the patient’s net economic loss, subject to periodic payment and offset by collateral payments from sources such as insurance.
- **Liability Protections for Use of Evidence-Based Medicine Guidelines.** Develop a pilot program at the state level relating to evidence-based medicine guidelines, including defining the scope of the program, types of liability protections and/or defenses, and measures for evaluation the effectiveness of the program. The pilot program would be developed and overseen by a multi-stakeholder group that must include significant physician participation. The evidence-based guidelines, including justifications for departure from the guidelines, would be developed, evaluated, reviewed, updated, and promulgated by national medical specialty societies to other public or private groups that provide physicians

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with substantial representation on oversight committees and with central decision-making roles in the development of the guidelines. Physicians who elect to participate in the program would utilize evidence-based guidelines and those participating physicians who follow evidence-based guidelines would receive liability protections for diagnosis and treatment in compliance with the guidelines. There would also be no presumption of negligence if a participating physician does not utilize the guidelines. Physicians would receive legal protection for using evidence-based medicine guidelines and/or their clinical judgment based on their patient's particular care and needs.