Falling Litigation Rates in the US: Could Ireland Adopt Similar Measures

Abstract:

Medical litigation has halved in the US over the last 10 years. Rates of paid claims have decreased from 18.6 to 9.9 per 1000 physicians between 2002 and 2013. The median payment awards have reduced from $218,400 to $195,000 between 2007 and 2013. The consequence of this in the medicolegal environment is that the insurance premiums for doctors have lowered. In some states the premiums for obstetricians have dropped by as much as 36%. The 4 factors that appear to have effected this dramatic change in American malpractice rates are raising the barriers to bringing lawsuits, placing limitations on the sums awarded, the introduction of interim payments rather than lump sums, and Safe Harbors.

The barrier to frivolous lawsuits has been strengthened. Pretrial expert screening panels review the case at an early stage and determine whether the claim has enough evidence to proceed. If the plaintiff still decides to proceed the panels negative opinion has to be submitted to the court. At the initial filling of the allegation the plaintiff must submit an expert witness report stating that there is a reasonable justification for the suit. The expert witnesses must be licensed in the state that the case takes place. Clearly set limits are placed on the attorneys fees.

Caps are placed on the quantum of money that can be awarded. Particular emphasis is placed on reducing the amounts paid out for pain and suffering. The introduction of the collateral-source rule reform means that compensation obtained from other sources (eg. health insurance) is deducted from the amount that the defendant has to pay out. Insurers pay interim sums of money rather than the total amount. Insurers are able to retain any amount of money that is not collected during the plaintiffs lifetime. When there are multiple defendants, the final liability of each defendant is limited to the deemed percentage of his fault. No single defendant can be pursued for the total claim.

Safe Harbors are directives that give doctors a protection against litigation if they can demonstrate that they followed a recognized, agreed guideline when caring from their patient. Safe Harbors were introduced as a way of reducing the uncertainty created by the employment of a vague standard such as recklessness. They insulate the standard of care from external interference. To be considered for Safe Harbor status the clinical guideline must be reliable, valid and clearly defined. There are many advantages to this process. It provides caregivers with a clearer picture of what is expected of them in most clinical situations. Doctors are less likely to practice defensive medicine by including tests and treatments that are not recommended by the guideline. It favours the patient because he receives better, evidence-based, care. The Safe Harbors Act 2014 proposes that US doctors subject to a medico-legal claim have the option of a review by an independent review panel who determines whether an acceptable guideline was adhered to. The process has been back ed by President Obama who stated that the broader use of evidence based guidelines could scale back the excessive defensive medicine reinforcing our current system of more treatment rather than better care.

The hurdles experienced with Safe Harbors are the time and expense of producing guidelines, the difficulty in keeping guidelines up to date and doctor resistance to following guidelines. The other point is that guidelines can aid in the planning of the investigations and treatment. They cannot protect the caregiver when there are problems in the execution of therapy such as inadvertent cutting of an artery during surgery or a drug dose miscalculation.

Sage points out that a crisis is about danger and opportunity. The 1970s through to the early 2000s represented a crisis in US medical practice due to malpractice litigation. Insurance premiums for doctors had become increasingly unaffordable and unsustainable. He places particular emphasis on money and time. While injured patients should be compensated, in the case of less serious cases the covering of the cost of additional medical care is sufficient. Communication and resolution initiatives should be instituted at an early stage. Conventional litigation thrives on delay. The protracted legal transactions exacerbate the actuarial uncertainty for the defendant and his insurer. Valuable time is lost over many months or years.

This reform of malpractice litigation in the US is very welcome. It would be great if it could be translated to the Irish heath-care with its increasing malpractice crisis. The MPS recently stated that of the 10,000 cases it handled worldwide, 600 were from Ireland. In 2012 the number of claims had increased 2.5 times compared with 2007. In addition significantly higher. A legal claim costing 1.26m in 1998, now costs 2.5m.

Malpractice claims in primary care are understudied. Wallace et al in a systematic review of 34 studies found that the annual prevalence rate for GPs was 5.2%. By age 65 years 76% of GPs would have been sued. One third of the claims resulted in compensation being awarded. The 2 commonest causes for litigation were delay in diagnosis and drug prescribing- errors. It would appear that the majority of Irish doctors can expect to be sued. The experience is distressing and challenging. There are emotional, reputation, and economic consequences.

The US has adopted far-reaching, radical measures to control the rising rates of litigation that it faced in the early 2000s. The
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