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Mandatory pre-suit mediation: Local malpractice reform benefiting patients and healthcare providers

By Randall C. Jenkins, JD,
Director Self-Insurance Programs
Lindsay A. Warren, JD,
and Nikolaus Gravenstein, MD

INTRODUCTION

This article outlines the systematic process and early success of the Florida Patient Safety and Pre-Suit Mediation Program (FLPSMP) as a pro-patient and pro-provider solution to the high costs, lengthy delays, and uncertainty plaguing the existing medical malpractice litigation process.

Problem: Costs, delay, and uncertainty with medical malpractice litigation

The cost of healthcare has been consistently increasing for decades. The average payment per malpractice claim rose from about $95,000 in 1986 to $323,306 in 2007.(1) Although the cost per claim resulting in payment to the patient has increased, the rate of claims has remained relatively constant. Each year, about 15 malpractice claims are filed for every 100 physicians. Furthermore, since 1986, legal defense costs have grown by about 8% annually. Claims that did not lead to payments incurred average defense costs of $22,000 in 2002, compared with $39,000 for claims that resulted in payments.(2) Thus the total cost to defend a claim (defense expense plus payment to patient) went from approximately $103,036 in 1986 to approximately $350,500 in 2002.

A 2009 University of Michigan report called overhead costs associated with malpractice litigation "exorbitant" and demonstrated that "for every dollar spent on compensation, 54 cents went to administrative expenses (including those involving lawyers, experts, and courts)."(3) In other words, patients retain only about 46% of payouts when their claim is successful. Complicating the issue is the length of time it takes for a patient to be compensated after injury. In Florida, Missouri, and Texas, medical malpractice claims were filed with insurance companies an average of 15 to 18 months after an injury. (4) It took on average another 26 to 29 months to close a claim. On average, it took close to 3.5 years after an injury for patients to receive compensation.

Solution: University of Florida Health Science Center Pre-Suit Mediation and Patient Safety Program

To provide more compensation directly to deserving patients and address the rising healthcare liability legal expenses, the University of Florida Health Science Center instituted the FLPSMP on January 1, 2008 and has data to support how the consistent use of the FLPSMP meets its objectives of:

- Compensation of patients in a fair and timely manner
- Encouragement of better communication between doctors and patients
- Reduction of frivolous lawsuits

The systematic process that has been implemented provides a template to be followed that ensures patients and their counsel are fully informed, that mediations are scheduled in a timely way, and, when mediations are successful, that patients receive their compensation quickly.

Because the cost of malpractice insurance premiums for physicians is related to the number of claims filed, an expected future benefit is the long-term reduction in liability premiums.

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Process:

As part of the consent process and prior to receiving medical care, patients sign a form that includes an explicit agreement to mediate unless they are unable to sign due to an emergent condition.

FLPSMP provides a trained, neutral medical malpractice mediator to facilitate candid, confidential communication in a structured setting between the patient and the healthcare provider during a pre-suit mediation. If the claim does not resolve at pre-suit mediation, the patient preserves the right to file a formal lawsuit.

Through a systematic approach to early and confidential communication and apology, the FLPSMP minimizes legal expenses to patients, providers, and healthcare facilities; maximizes the amount of compensation patients with successfully mediated claims receive; and preserves patients' full legal rights to file a lawsuit should they choose to do so.

FLPSMP results:

Timely resolution of claims.

From 2000 to 2007, claims using the traditional litigation process took on average 33.8 months from filing a notice of intent to resolution, and claims using the FLPSMP were, on average, resolved in 6.2 months.

FLPSMP resolved claims in less than one-fifth the time it took to resolve claims using the traditional litigation process. An obvious benefit to the patient is earlier closure and expedited compensation. When claims are resolved quickly, patient safety and quality improvement techniques learned from each claim and possible medical error can be implemented more swiftly.

Reduction of medical liability costs for patients and providers

Formal litigation processes do not provide the injured patient with the full awarded amount, as claimants are required to pay for legal expenses associated with litigating the claim. Of particular interest to this discussion, 37% of the claims examined in the 1999 IOM study not involve medical errors. Claims not involving errors accounted for between 13% and 16% of the system's total monetary costs, a meaningful percentage. (5)

Fair compensation for meritorious claims

FLPSMP data for the first two years of pre-suit mediation indicate that patients using the program receive at least as much compensation as they would have received had they used the traditional legal system. Claims resolved using the FLPSMP mediation system provided patients with statistically greater net recovery because a large majority of the legal fees and costs incurred by the traditional litigation system were avoided.

Furthermore, the FLPSMP data confirmed that the 2008–2009 average payment to the patient per claim was slightly higher than the average patient payment per claim, using the traditional legal system (not adjusted for inflation), from 2000 to 2007. Also, the 2009 Benchmark Analysis conducted by Aon Analytics for the American Society for Healthcare Risk Management reported a national average compensation to patients of $179,833 per claim from 2003 to 2008. (6) The FLPSMP not only provides compensation on par with the contemporary national average for litigated claims, but patients keep a higher percentage of the compensation, as they do not pay for years of legal expenses.

Claims resolved through formal litigation consume at least 54 cents of every dollar compensating patients to pay attorneys' fees and legal expenses.

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(7) The FLPSMP claimant retains much more of the net pay out when not burdened with a 54% to 78% reduction of the settlement awarded that is required to finance the higher legal fees and expenses during traditional litigation. Generally if a claim is settled prior to the filing of a lawsuit, a plaintiff 's attorney compensated on a contingency basis receives 25% to 30% of the patient's compensation. Once formal litigation begins with the filing of a complaint, the plaintiff 's attorney receives about 35% to 40% of the patient's total compensation. This percentage is in addition to any legal expenses incurred in the pursuit of a formal lawsuit.

As healthcare facilities and providers become more informed about the benefits of implementing a consistent and systematic pre-suit mediation program for all claims prior to entering litigation, it will become easier to make the paradigm shift that conducting an early mediation does not have to signal to the plaintiffs that the defendants have concerns about the care provided to the claimant.

Smaller claims

An additional benefit of FLPSMP is that this program encourages patients and related other plaintiffs to bring smaller dollar-value claims—claims that would not be accommodated in the traditional legal system because of the costs of litigation. Plaintiff 's attorneys can benefit from the early mediation process. Although a smaller percentage of the compensation is paid to the plaintiff attorney (typically 25% to 30% as compared to 35% to 40%), the attorney will receive deserved compensation for the patient and himself or herself without years of trial preparation and discovery. Healthcare providers and systems also gain from FLPSMP by saving thousands of dollars in legal defense costs and learning of opportunities to improve patient safety within the first six months of an incident because of much earlier discovery and resolution. This enables healthcare providers the rare opportunity to make quality improvement changes based on small claims that would not have otherwise been brought to their attention.

CONCLUSION

The program has improved patient safety, provided more net compensation per claim to patients with meritorious claims than the traditional litigation process, and reduced legal liability expenditures by an average of $46,008 per claim, saving significant dollars per year.

FLPSMP is a successful, systematic alternative dispute resolution remedy for medical malpractice claims. The success of FLPSMP stems from a mediation environment that promotes open and honest communication, full and frank disclosure, and early apologies. Patients using FLPSMP resolve claims on average 5.4 times faster than those proceeding with traditional litigation, FLPSMP claimants receive equal or more compensation as compared to litigated claims, and allocated legal expenses for both patients and healthcare providers and facilities are reduced by many thousands of dollars.

As more healthcare systems and providers embrace mandatory pre-suit mediation programs similar to FLPSMP, patient care improvements can occur years earlier, and patients and providers will enjoy a significant reduction in legal expenses, which should naturally lead to reductions in liability insurance premiums and reduced medical costs for patients.

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How the Good Samaritan Act Can Minimize the Potential for Claims in the Emergency Room

By Francys C. Martin, Esq.
Claims and Litigation Coordinator
UF HSC Self-Insurance Program

In order to recover damages against a healthcare provider for actionable negligence, a plaintiff must establish that the healthcare provider had a legal duty to provide care and breached that duty. The plaintiff must further prove that their injury was proximately caused by the healthcare provider's breach and that they suffered damages as a result of that breach. That negligence is often defined as a failure to use reasonable care. "Reasonable care on the part of a health care provider is that level of care, skill and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by similar and reasonably careful health care providers." Florida Standard Jury Instructions 402.4(a)

In an action for recovery of damages based on the alleged negligence of a healthcare provider, the plaintiff has the burden of proving by the greater weight of evidence[1] that the alleged actions of the health care provider represented a breach of the prevailing professional standard of care for that health care provider. "The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers." Florida Statute 766.102.

All 50 states have passed some variation of the "Good Samaritan Act" but most of these laws are intended to protect the actions of private citizens assisting others in emergency circumstances where some other injury is inadvertently caused. Unlike many other states, Florida healthcare providers' are fortunate to have additional protections when rendering emergency medical treatment under the Good Samaritan Act.

Florida legislators recognized that extending protection to healthcare providers rendering care under emergency circumstances would encourage the treatment of emergency patients. Subparagraph 2(c)(3) of Florida Statute 786.13 specifically states that "the Legislature's intent is to encourage healthcare practitioners to provide necessary emergency care to all persons without fear of litigation…" In fact, the statute provides for protection of "healthcare practitioners" and does not specify that these be only practitioners of emergency medicine. Therefore, this may extend to physician assistants, nurses, and all other extenders providing emergent care. It is also noteworthy that a previous version of the Good Samaritan Act extended only to patients who entered the facility

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through the emergency room or trauma center. Since an amendment of the Good Samaritan Act in 2003, that is no longer the case.

Under the Good Samaritan Act, (Florida Statute 768.13(2)(a), a healthcare practitioner providing emergency services, "shall not be held liable for any civil damages as a result of such care or treatment or as a result of any act or failure to act in providing or arranging further medical treatment where the person acts as an ordinary reasonably prudent person would have acted under the same or similar circumstances." The Good Samaritan Act also requires a higher burden of proof and the Plaintiff must show that the healthcare provider acted with "reckless disregard for the consequences so as to affect the life or health of another" (Florida Statute 768.13(2)(b).) The Good Samaritan Act defines reckless disregard as, "conduct that a health care provider knew or should have known, at the time such services were rendered, created an unreasonable risk of injury so as to affect the life or health of another, and such risk was substantially greater than that which is necessary to make the conduct negligent." Florida Statute 768.13(2)(b)(3).

The immunity provided by the Good Samaritan Act extends to any act or omission of providing medical care or treatment, including diagnosis. This immunity includes care or treatment rendered before the patient is stabilized and capable of receiving care as a non-emergency patient. In fact, if surgery is required as a result of the condition with which the patient presented, then the immunity extends up through and including the care provided until the patient is stabilized following the surgery. Florida Statute 768.13(2)(b)2.a.

Whether or not the Good Samaritan Act applies to a given situation can be a matter of law, but often times it is a question of fact. These questions of fact are often left to the jury and there are specific jury instructions that may assist the jury in its determination. One of the many potential factual disputes is whether the patient was actually receiving emergency medical treatment. In Florida, a jury may be instructed to view emergency circumstances as care provided pursuant to a sudden event resulting in a condition demanding immediate medical attention, for which the plaintiff initially entered the hospital through the emergency department , before they were medically stabilized and capable of receiving care as a nonemergency patient." Supreme Court of Florida Standard Jury Instruction, 658 So. 2d 97. These jury instructions also elaborate upon the definition of "reckless disregard" and appear to provide a greater appreciation for the emergency setting and all the considerations made by the healthcare provider. These jury instructions provide that reckless disregard will be found where the healthcare provider knew or should have known their action would result in injury or death, "considering the seriousness of the situation, the lack of a prior physician patient relationship, time constraints due to other emergencies requiring care/treatment at the same time, the lack of time or ability to obtain appropriate medical consultation, and the inability to obtain an appropriate medical history of the patient." 658 So. 2d 97. This definition very clearly takes into account the emergency department environment, the patient population and the need to triage patients.

Another facet of the Good Samaritan Act for which the jury may be utilized is determining when a patient is stabilized and capable of receiving medical treatment as a nonemergency patient. Similar

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to the Federal EMTALA law, Florida Statute § 395.002(29) defines "stabilized" by stating that, "with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the patient from a hospital." In conjunction with Florida Statute 768.13(2)(b)2.a., one may argue that if the patient was never deemed to be stable prior to a surgery, undergoes that surgery and is still not stabilized, then the protections of the Good Samaritan Act extend past the care provided in the emergency department, the operating room and the unit, until the patient is stabilized, if ever. If the patient is stabilized prior to surgery, these protections may still be extended through and including the surgery, if that surgery occurs within a reasonable time after the stabilization.

Despite its importance and its ability to completely eliminate liability for a healthcare provider, there is little case law interpreting its application.

In one recent Florida case[2] , an anesthesiologist was called into his facility for an obstetric procedure. While there, the anesthesiologist received another call seeking his assistance in the emergency room, though he did not provide on-call services to the emergency room. When the anesthesiologist arrived in the emergency room, he found the patient presented with tongue and throat swelling. The anesthesiologist refused to perform an oral or nasal intubation because the patient was on blood thinning medications that could have caused additional care issues. While waiting to be airlifted to another hospital, the patient died. The patient's estate filed a wrongful death suit against the doctor. The District Court of Appeal found that there was no patient/physician relationship and even though he had volunteered to assist, the Plaintiff failed to demonstrate the anesthesiologist had a responsibility to patients in the emergency room. In this case, the anesthesiologist had no relationship with the patient, failed to act and was not an emergency room physician, but the Good Samaritan Act was found to be applicable. There is no requirement that there be a physician/patient relationship to be protected under the Good Samaritan Act.

Most recently, Florida's First District Court of Appeal undertook the task of interpreting the Good Samaritan Act and notably, acknowledged that there is little case law interpreting the Good Samaritan Act but proceeded to provide a very thorough analysis of the legislative history and intent of the Good Samaritan Act. [3] In this action, the patient presented to the ED with severe stomach pain and vomiting. He was evaluated there and deemed to require surgical intervention at another facility and transfer was arranged. Before the transfer was completed, the accepting facility requested a CT scan and the patient was diagnosed with gastric outlet obstruction. Shortly thereafter, he was transferred via ambulance to the accepting facility. He was admitted to the medical/surgical unit of the hospital and a surgical consultation was ordered for the following morning. That evening, the patient arrested and was transferred to the ICU. He arrested again the following morning and expired.

In this case, the parties disagreed as to whether "emergency services" were being provided under the terms of the Good Samaritan Act. Appellant University of Florida Board of Trustees argued that the Good Samaritan Act should apply because the patient was suffering from an emergency medical condition when he arrived to the accepting facility. Appellee Stone argued that the patient was stable when he was transferred. The trial court ruled that

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the Good Samaritan Act did not apply as a matter of law and did not allow the question of its application to be presented to the jury for determination. The First DCA concluded that emergency services are "those provided for the diagnosis or treatment of an emergency medical condition prior to the time the patient is stabilized and capable of receiving treatment as a non-emergency patient." They also found that there were a number of factual disputes as to whether the patient was stabilized and able to receive non-emergent care. Because of these questions of fact, the trial court erred in granting Appellee Stone's Motion for Directed Verdict as to whether the Good Samaritan Act applied. The First DCA reversed and remanded for a new trial. To read the entire opinion follow this link: http://opinions.1dca.org/written/opinions2012/06-21-2012/11-1951.pdf

Florida's Good Samaritan Act allows healthcare providers to render care in high tension situations without the fear of litigation looming over their heads.

Another benefit of the Good Samaritan Act and Florida Statute § 766.118(4) is the limitation on the award of noneconomic damages actions for injuries caused by the negligence of a practitioner while providing emergency care and services. Under Florida Statute § 766.118(4), regardless of the number of practitioners found liable, each claimant is entitled to an award of no more than $150,000 for noneconomic damages, and the total award recoverable by all claimants is limited to no more than $300,000 for noneconomic damages. Where the provision of emergency medical services is not involved, noneconomic damages may be limited to between $500,000 and $1 million.

The protection from liability and high damage awards that the Good Samaritan Act provides makes it more likely that healthcare providers will help even when they have no obligation to do so and therefore, positively impact the lives and well-being of patients.

References:

[1]The greater weight of the evidence is defined as the more persuasive and convincing force and effect of the entire evidence in the case. Florida Standard Jury Instructions 401.3.

[2]Harris v. Soha, 15 So.3d 767 (Fla. 1st DCA 2009)

[3] University of Florida Board of Trustees v. Stone ex rel.Stone, 2012 WL 2345115 (Fla.App.1 Dist.), 37 Fla.L. Weekley D1476.

Martin Smith, SIP Director, Retires

W. Martin Smith, Director and Founder of the Florida Board of Governors Academic Self- Insurance Programs (SIP) retired effective June 30, 2012.

In honor of his 41 years of dedicated service and commitment to patient safety, risk management and loss prevention, the Clinical Quality Award Program was officially renamed the W. Martin Smith Interdisciplinary Patient Quality and Safety Awards Program (IPQSA) on June 22. To learn more about SIP, IPQSA and available online educational programs, log onto http://www.flbog.sip.ufl.edu/cqap/index.php

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