LAW & MEDICINE

This 'Sleeping Dog' Never Gets Any Rest

On Dec. 12, 2007, Sen. Judd Gregg (R-N.H.) offered an amendment to a major farm-aid bill in the Senate, but it had nothing to do with aid to our nation's farmers. Sen. Gregg's amendment was called the "Healthy Mothers and Healthy Babies Rural Access to Care Act." This bill would have limited exposure to obstetricians and gynecologists who practice in towns of 20,000 people or fewer. One provision in the bill would have capped noneconomic damages—also known as "pain and suffering"—at $250,000 for a physician and $250,000 for a health care institution. The amendment was voted down 53-41.

BY MILES ZAREMSKI, J.D.

On Dec. 27, the Ohio Supreme Court upheld a law limiting the amount of pain and suffering damages a person can collect because of a defective product. The case involved Cincinnati property manager Melisa Arbino, who claimed that the Ortho Evra Birth Control Patch made by Johnson & Johnson caused permanent physical damage and jeopardized her fertility. According to press reports, Ohio Supreme Court Chief Justice Thomas J. Moyer said the Ohio law did not violate an injured person's right under state law to trial by jury or to a remedy for their injuries. One of the law's provisions caps awards at either $250,000 or three times the amount of economic damages, whichever is greater, up to an overall limit of $350,000. There is an exception to the cap if the person suffers permanent disability or loss of a limb or bodily organ.

On Nov. 13, 2007, trial judge Diane Larsen of the Circuit Court of Cook County (Chicago) ruled as unconstitutional the Illinois statute on capping noneconomic damages (*LeBron et al. v. Gottlieb Memorial Hospital et al.,* No. 2006 L 012109). Because the law containing the cap has a provision that says no part of it can be considered separately from other parts, Illinois' entire medical malpractice statute was ruled unconstitutional. The defendants appealed this decision directly to the Illinois Supreme Court; a decision is expected late this year.

Judge Larsen ruled that a cap on noneconomic damages in medical malpractice cases violates the constitutional principle of separation of powers. She noted that having the Illinois legislature cap noneconomic damages "unduly encroaches upon the fundamentally judicial prerogative of determining whether a jury's assessment of damages is excessive within the meaning of the law." In other words, the legislative branch should not interfere with the judicial branch's ability to award and determine damages; that would encroach on the powers and authority left to the judicial branch by the state constitution.

These events reflect ongoing efforts to reform medical malpractice law over at least 4 decades. Attempts in Congress to legislate damage caps have been made several times by members on both sides of the aisle.

All such legislation has failed, and will no doubt fail again if attempted in the future. The reason is simple: Regulating medical malpractice is a state-based function—part of a state's ability to regulate health care—and the federal government is an interloper in this arena.

Most of the action on caps has occurred at the state level. California was one of the first to enact caps with its Medical Injury Compensation Reform Act (MICRA), which became law in 1975 and is still in place. Under MICRA, noneconomic damages are capped at $250,000. Other states have enacted caps either through the state legislatures or by voter referendum, such as occurred in Texas in 2003. The Texas law, like California's, also caps noneconomic damages, such as pain and suffering and loss of companionship, at $250,000, although lawyers can still sue for punitive damages.

Despite these successes, other states have seen caps thrown out on various grounds, often for being in violation of a state's constitution. The fact that these caps have been so controversial lends itself to considering why we have caps in the first place.

I have spent 35 years serving as a lawyer representing health care providers, policy makers, and legislators, and also doing research and writing in this subject area. In light of this experience (which did not include any work as a plaintiff's attorney), my conclusion is that the driving force behind capping noneconomic damages is the perceived link between enacting caps and lowering physician malpractice insurance premiums. The theory goes that without a cap, malpractice premiums would continue to rise, forcing some physicians to leave a geographic area, or even to retire early.

Research has shown, however, that caps in some states have not had an effect in lowering premiums; premiums have also increased within reason, or have stayed relatively flat, in jurisdictions without any caps. There is also a cyclical element at work: Premiums have increased dramatically, over short periods of time, once every decade since the 1970s.

It is clear that the success of and need for caps have varied. The question then becomes, has it been prudent for various state legislators to enact such caps if there has been no real proof that high verdicts and settlements are the reason that physician premiums have increased so dramatically?

Caps have been enacted because of a persuasive method of advocacy known to many as the KISS ("Keep it simple, stupid") principle. If you want to convince someone (typically, a juror) of a position, keep your point simple and straightforward. Telling legislators that in order to reduce malpractice insurance premiums, noneconomic damages must be capped is an example of KISS at work.

But in reality, increased insurance premiums are a product of complex and interrelated factors, including performance by financial markets, returns on premium dollars invested, and expected profit margins by insurers that invest in the financial markets. It may also be that these companies have a disdain for the legal profession, although it comes at the expense of patient care.

The continuing debate over capping noneconomic damages has yet to be settled, both in state and federal law. This sleeping dog has not found a resting place yet. ■

Update since the last issue: On Jan. 7, the Supreme Court declined to take the case of Adkins v. Christie, which dealt with confidentiality of peer review. That means the lower court's ruling against the defendants will stand.

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Aetna to Refuse Payment for Preventable Errors at Hospitals

BY MARY ELLEN SCHNEIDER
New York Bureau

In a move that could have significant implications for physicians and hospitals, the insurer Aetna has said it will not pay its network hospitals for care necessitated by certain preventable errors.

The announcement follows a policy shift by the Centers for Medicare and Medicaid Services, which has finalized plans to stop paying for eight preventable events as of October 2008.

Aetna Inc. has incorporated language into its hospital contracts that calls for waiving all costs related to a number of serious reportable events. The language comes from the Leapfrog Group's "never events" policy, which includes a list of 28 events considered so harmful that they should never occur. The list, compiled by the National Quality Forum (NQF), comprises events ranging from surgery performed on the wrong body part or on the wrong patient, to stage III or IV pressure ulcers acquired after admission to a health care facility.

The policy instructs hospitals to report errors within 10 days to the Joint Commission, state reporting programs, or patient safety organizations.

Hospitals also are asked to take action to prevent future events and to apologize to the patient or family affected by the error.

Aetna is the first health plan to endorse the Leapfrog policy. "The major goal here is to get hospitals to focus on having the systems in place to prevent these events from happening," said Dr. Charles Cutler, Aetna's national medical director.

Adopting the Leapfrog Group's never events policy is not about saving money, Dr. Cutler said. In fact, many of the never events carry no additional cost. Instead, Aetna is seeking to send a consistent message to hospitals about quality, he said. "The intent here is not to be punitive."

But the Aetna announcement has encountered some skepticism from the physician community.

The NQF list of never events is much broader than the eight preventable events selected under the Medicare policy, said Cynthia Brown, director of the division of advocacy and health policy at the American College of Surgeons (ACS). One reason that many of those events were not included on Medicare's list is that they are difficult to measure with the current coding system, she said.

Another problem with the Aetna approach is that it's hard to affix blame to a hospital or a particular physician. "If there's a problem with blood incompatibility, is it the surgeon's fault?" Ms. Brown asked.

When used properly, the NQF never events list protects patients and directs a patient environment enriched with safety and quality, said Dr. Frank Opelka, chair of the ACS Committee on Patient Safety and Quality Improvement. But he cautioned that if payers drift from the intentions of the NQF never events, the specifications could be lost and overreporting could create unintended consequences.

For example, because of hospital overcrowding and limited resources in a rural environment, a frail patient may be admitted despite the lack of health care resources. If the patient has a pressure ulcer that progresses from a stage II on admission to a stage III, this should not be considered an NQF never event, he said.

Dr. Opelka also questioned whether hospitals would continue to report these types of serious preventable errors if they aren't being paid for the care. "If the reports are generated from a hospital claims system and the payer no longer recognizes the events as payable, isn't the message to stop reporting rather than to prevent the never events?" asked Dr. Opelka, also vice chancellor for clinical affairs at Louisiana State University Health Sciences Center, New Orleans.

The policy is likely to affect all of Aetna's network hospitals over the next 3 years as the company renegotiates its contracts, Dr. Cutler said.

Since Medicare announced its policy shift last summer, other insurers have considered changes to their policies. Officials at Cigna, for example, are evaluating how to implement a similar policy within their hospital network. The insurer plans to have a national policy in place by October 2008, said Cigna spokesman Mark Slitt. ■