

**AMERICAN COLLEGE OF RHEUMATOLOGY  
POSITION STATEMENT**

**SUBJECT: Medical Liability Reform**

**PRESENTED BY: Committee on Government Affairs**

**FOR DISTRIBUTION TO: Members of the American College of Rheumatology  
United States Congress  
The White House  
Medical Societies**

**BACKGROUND:**

1 Any meaningful health care reform should address medical liability. The ever escalating costs of  
2 medical malpractice insurance premiums adding to costs of practicing medicine have forced some  
3 specialists to avoid providing service in certain states, denying patients access to medical care.  
4 The threat of lawsuits has forced physicians into the costly practice of “defensive medicine,”  
5 performing many unnecessary additional tests to “defend” diagnoses. The American College of  
6 Rheumatology recognizes that medical errors do occur and that those who are injured should be  
7 fairly compensated. With the goal of patient safety at its center the American College of  
8 Rheumatology supports medical liability reform at both the National and State levels.

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10 The ACR recommends:

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12 A. Evidence – Based Standards of Practice:

13 Government should provide funding so that such evidenced-based guidelines can be developed on  
14 a national or state-by-state basis in consultation with the AHRQ, Medical professional societies  
15 and noted experts. Providers following evidence based guidelines should not be held liable from  
16 medical malpractice but not necessarily to deny that medical injury has occurred. In addition not  
17 following the guidelines does not *a priori* mean that substandard or negligent care was rendered.

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19 B. Early Disclosure and Compensation:

20 Health care providers including hospitals and physicians should voluntarily disclose  
21 medical errors to patients, next of kin, their respective health system and patient safety  
22 organizations as soon as they occur. Payment schedules should be developed to assure fair  
23 awards for medical injury and avoid the “lottery” system of medical compensation.  
24 Providers offering disclosure and compensation should be held harmless from subsequent  
25 liability claims. Such offers cannot be used as an admission of guilt in any subsequent legal  
26 claim. Thus the cost savings by malpractice insurance companies in avoiding costly court  
27 litigation should be applied to reducing malpractice insurance costs.

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32 C. Arbitration and Medical Liability Courts:  
33 Prior to any litigation, the parties should have an opportunity to arbitrate the grievance. If it is  
34 unsuccessful at resolving the issues, then the claim can be adjudicated in special Health Courts.  
35 These courts should be established in each state to determine medical liability. The members of  
36 the courts should include physicians, lawyers and lay people. These courts can adjudicate cases  
37 and award damages. The court can also establish compensation limits for fees charged in  
38 preparation and defense of cases. Arbitration by these courts would be final and preclude  
39 additional liability claims.

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41 D. Development of Standards for Experts Witnesses:  
42 National standards for expert witnesses should be established with guidance from the Medical  
43 Professional Societies in each area of specialization. The expert witness's testimony should be  
44 limited to their area of expertise.

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46 E. Non economic damages:  
47 There should not be a limit on economic damages. For economic damages there should be  
48 established an administrative body to establish a compensation model to set compensation  
49 schedules and to determine the net economic loss due to injuries with offsets for payments made  
50 by insurance and other entities. However, non-economic damages should be limited to \$250 000.

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52 F. Joint & Several Liability:  
53 Medical malpractice suits should no longer be filed with joint and several liability.  
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55 The American College of Rheumatology believes that adoption of these reforms would improve  
56 patient safety and reduce the ancillary costs of delivering Health care.

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58 Approved by Government Affairs Committee: September 2009  
59 Approved by the Board of Directors: May 2010