Tort Reform in the Emergency Room

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The high bar adopted as the emergency room standard of care in Texas has come at a great cost to Texan patients, making it very difficult and many times impossible for those grossly injured by medical error to be justly compensated. Section 74.151 of the Texas Civil Practice and Remedies Code was amended in 2003 to read, “A person who in good faith administers emergency care, including using an automated external defibrillator, is not liable in civil damages for an act performed during the emergency unless the act is willfully or wantonly negligent.”1 Texas courts have held the “willful and wanton” standard to mean that emergency room patients must establish that their emergency room physician or staff not only put them in extreme risk but also knew they were putting the patients in extreme risk, which is a nearly impossible threshold to meet.2 Many pieces of literature state that this new standard has deterred frivolous claims against emergency room doctors from being brought forth.3 While this may be true, it goes even farther in preventing many legitimate emergency room claims from going forward. Patients who visit the emergency room deserve to hold physicians and staff accountable for some degree of care.

A. The Injured Are Left With No Recourse

The leg pain Connie Spears felt was excruciating and familiar; she had had blood clots before, and doctors had installed a filter in one of her heart’s main veins.4 At a Christus Santa

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1 TEX. CIV. PRAC. & REM. CODE § 74.151.
Rosa hospital in San Antonio, where Spears went seeking help, the emergency room doctor disagreed. He ran some tests and discharged her with “bilateral leg pain.” He told her to follow up with her primary care physician. Three days later, delusional and with legs the color of red wine, Spears called 911 and was taken to a different area hospital. This time, doctors determined the 54-year-old’s vein filter was severely clotted and had led to tissue death in her legs and kidney failure. Weeks later, Spears regained consciousness only to find that she could hardly handle her new reality: doctors had amputated both legs to save her life.

Spears’s outrage over the first ER doctor’s diagnosis and the loss of her legs has been compounded by her inability to find a medical malpractice attorney to represent her. One after another, they have rejected her telling her that she had a great case but not in Texas. Spears’s story is only one of many in Texas.

Malpractice attorneys say that unless the doctor comes to work drunk or high, the willful and wanton threshold effectively requires the plaintiff to be able to read the doctor’s mind. Furthermore, consumers are complaining that medical malpractice caps prevent injured patients from getting their day in court. As described in InjuryBoard’s “Medical Malpractice and the Legal Process” article, most attorneys are unable to take on cases that are not financially viable. With caps in place, claimants in Texas can recover only $250,000 in a lawsuit against a

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5 Id.
6 Id.
7 Id.
8 Id.
9 Id.
10 Id.
11 Id.
12 Id.
13 Id.
After the costs of the case are deducted from this award, many injured parties are left with almost nothing to compensate them for their injuries or pay their medical bills. As a result, many lawyers refuse to take these cases knowing that the injured party will have gone through the hardships of a trial only to receive little or nothing for that effort.

Therefore, many malpractice attorneys are switching specialties. Astonishingly, Houston, home of the world’s largest medical center and the fourth most populous city in the nation, has only a handful of firms left that specialize in plaintiff medical malpractice.

Tort reform advocates disagree, noting that patients in Texas continue to sue doctors and hospitals over emergency care. And, they say, the “willful and wanton” language, as well as the damage caps, have driven down malpractice insurance rates by nearly 30% and attracted more emergency room doctors to Texas.

Plaintiffs’ lawyers say these developments have come at the expense of patients. They argue that the “willful and wanton” rule means emergency room care in Texas is some of the most dangerous in the country. A preliminary study shows that malpractice claims dropped by 60% between 2003, when the law was enacted, and 2007. There are surely a lot more legitimate claims, but because of the ER standard, and the damage caps, attorneys just will not take them.

**B. Texas Courts and the Impregnably High Standard for Liability in the ER**
While the willful and wanton standard should be a tough one to establish, it should not be a nearly impossible threshold to meet. If that was what Congress intended, then it would have granted immunity to the ER department in the Texas Medical Liability statute.

*Turner v. Franklin* was a case of first impression in the Texas Court of Appeals to define “willful and wanton negligence” for purposes of section 74.153. The court concluded the legislature intended “willful and wanton negligence,” as used in section 74.153 of the civil practice and remedies code, to mean “gross negligence.”

Gross negligence, in turn, is comprised of two elements—one objective and one subjective. Circumstantial evidence is sufficient to prove either element of gross negligence. First, viewed objectively from the actor's standpoint, the act or omission must depart from the ordinary standard of care to such an extent that it creates an extreme degree of risk of harming others, considering the probability and magnitude of the potential harm to others. Under the objective element, the defendant's conduct must create “an extreme degree of risk,” which is a “threshold significantly higher than the objective ‘reasonable person’ test for negligence.” Extreme risk is more than a remote possibility of injury or even a high probability of slight injury; the defendant's conduct must involve “the likelihood of serious injury” to the plaintiff. To meet the subjective element, the actor must “have actual, subjective awareness of the risk involved and choose to proceed in conscious indifference to the rights, safety, or welfare of others.”

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22 *Supra, note 2.*
23 *Id.*
24 *Id.*
25 *Id.*
26 *Id.*
27 *Id.*
28 *Id.*
welfare, and safety. In other words, the plaintiff must show that the defendant knew about the peril, but his acts or omissions demonstrated that he didn't care.”

This is the latest published opinion that reviews a jury verdict or survived summary judgment in a claim for emergency room medical malpractice, which suggests that consumers and medical malpractice attorneys are correct in saying that the willful and wanton barrier is so high as to prevent medical malpractice attorneys from bringing even legitimate claims to court and to hinder plaintiffs from getting their rightful day in court. This conclusion not only hurts injured patients but society as a whole.

When plaintiffs are not fully compensated the burden is placed on the taxpayers in the form of Medicare, Medicaid and other assistance programs. In the battle for compensation in medical malpractice cases, who should be responsible for the future care of the disabled? Should the doctor who caused the disability be responsible or should responsibility fall on the taxpayers? What tort reform advocates are not telling you is that the “tort reform” shifts the burden to the taxpayers and we all pay that “hidden” tax.

C. Where the Real Problem May Exist

An ongoing study, currently being peer reviewed, finds evidence supporting that Texas had a below-average physician-to-population ratio before tort reform and has a slightly worse ratio today. Therefore, the mantra that tort reform is an important consideration for physicians is belied by the fact that physicians neither flock to states implementing tort reform nor flee states that have not done so. Some people speculate that the real reason Texas does not have more doctors is related to the number of Texans who lack health insurance.

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29 Id.
31 Id.
services from insured patients is a strong lure for physicians.\(^\text{32}\) With this study in mind Governor Rick Perry may want to reconsider opting Texas out of Medicaid expansion under the Affordable Care Act in order to attract more physicians to the state.

\textbf{D. An Acceptable Solution}

One of the problems with the vast majority of tort reforms is that they reflect the self-interest of one group or another. A better solution, a possible compromise, would be proposed "early offers."\(^\text{33}\) Under early offers, physicians would receive the benefit of an increased burden of proof, but only after offering to pay the economic losses of the claimant.\(^\text{34}\) Under early offers, an ER physician would have a given number of days in which to offer to pay a claimant for their economic losses (but not pain and suffering).\(^\text{35}\) The physician must also pay the claimant's reasonable attorney's fees (10\% of the recovery, which reflects the reduced amount of work necessary in the shortened process).\(^\text{36}\) If no offer is made, traditional common law principles apply.\(^\text{37}\) If an offer is made and accepted, a settlement has been reached quickly and the claimant's basic economic losses have been restored.\(^\text{38}\) If an offer is made and rejected, however, the burden of proof increases (to either "clear and convincing" or even "beyond a reasonable doubt") and the physician's standard of care decreases to gross negligence.\(^\text{39}\) This obviously provides the claimant with strong incentives to accept an early offer. Under this scheme, the financial savings would be enormous. Furthermore, the physicians get a higher burden of proof,
but only after they have offered to pay the claimant's economic losses. Both parties receive a benefit.

Another possible solution is as simple as retaining the liability limit for the emergency department, but holding ER physicians and nurses to their own standard of care. This means that, when establishing the negligence of an ER doctor, a claimant would have to prove that the doctor breached the standard of care taken by a reasonable ER doctor rather than be held to the standard of a reasonable physician within the same specialty. Therefore, the urgency and speed of the circumstances and the lack of a deep physician-patient relationship will all be accounted for in determining an ER physician’s liability.

As mentioned above, if we cannot hold ER physicians to even this level of accountability then essentially we are protecting ER doctors from all liability. Such a scenario, which we are in now, releases ER doctors and staff from any incentive to practice with caution aside from their own consciousness, and if everyone was left to his or her own consciousness then we would have no legal system to enforce.