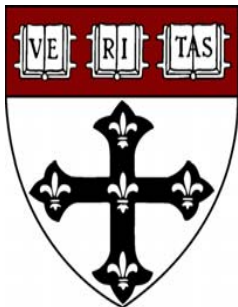


Health Courts

Opportunities for Patient Safety Enhancement



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The Health Courts Model: Core Principles

1. Compensation decisions are made outside the regular tort system.
 - Exclusive remedy, with appeal options.
2. To facilitate reliable decision-making, adjudicators use:
 - “Evidence-based” judgments on clinical questions
 - Record of decision making in similar cases
 - Some *ex ante* determinations about preventability of common medical adverse events



Core Principles - continued

3. Eligibility for compensation is broader than negligence, but does not approach pure “no fault”
4. Explicit, rational guidelines are used to determine noneconomic damages
5. System incentivizes, reinforces, and empowers improvements in patient safety



Advantages of Health Courts Over Tort

- Speed and reliability
 - Explicit decision aids; use of presumptions and precedent
- Expanded compensation
 - Eligibility for compensation extends beyond negligence standard
- Cost control
 - Calibrated to reflect social choices

○ Patient safety



Deterrence of Medical Error

- The tort system has generally failed in its deterrence function
 - Uncertainty about the negligence standard
 - Physicians think litigation outcomes are unrelated to case merits
- Deterrence-enhancing features of health courts:
 - Explicit compensation criteria
 - Larger proportion of injuries become claims



Improving Patient Safety: Foundations

- Culture of safety
 - Open communication with patients
 - Open communication, information sharing, and learning among providers
 - Complementary legal culture
- Science of safety
 - Reporting of adverse events
 - Data aggregation and analysis
 - Design of interventions
 - Feedback and implementation



How Would Health Courts Improve the Situation?

1. **Move to avoidability standard**

- Suboptimal, but not substandard
- Fewer moral connotations than negligence
- Lower barriers to disclosure and reporting
- No automatic threat of disciplinary action



How Would Health Courts Improve the Situation?

2. Analysis of claims data

- **Hospital level:** All filed claims receive root-cause analysis
- **State level:** Health court as centralized repository for claims information
 - Connected office would compile and publish aggregated statistics



How Valuable Are Claims Data in Patient Safety Research?

- Triage point for vast number of patient encounters
- Relatively large numbers of rare events, especially when pooled across institutions
- Emphasis on errors that cause most severe injuries
- Rich information set
- Alignment of risk management and quality improvement perspectives



Examples of Possible Analyses

- What are the top 20 most common avoidable injuries that occur in hospitals?
- What are the most costly avoidable injuries that occur?
- What characteristics of patients are associated with a higher risk of preventable injury?
- What individual and systems problems are evident in cases of preventable medication-related injuries?



Avenues of Dissemination

- Direct feedback to hospitals
 - Deidentified individual root-cause analyses
 - “Patient Safety Alerts” with recommendations
 - Benchmarking
- Contributions to public knowledge base
 - Partnerships with external researchers
 - Publicly available summary reports (deidentified)



Are These Plans Realistic? Evidence From 3 Foreign Models

- New Zealand
 - Accident Compensation Corporation (ACC)
- Denmark
 - Patient Insurance Association (PIA)
- Sweden
 - Regions Patient Injury Insurance (LOF)



New Zealand ACC

- Comprehensive database to collect and analyze claims data
 - Nature of the event, surrounding circumstances, and how it could have been avoided
- All events graded for severity and rarity
 - Priority for follow-up by safety improvement team
 - Effective and low-cost solutions may be mandated



Denmark PIA

- Maintains a comprehensive database
- Patient safety analysis is conducted by external researchers
- Researchers apply for permission to study and publish their findings in scholarly journals



Sweden LOF

- LOF conducts descriptive analyses of claims data
 - Findings are disseminated to hospitals
 - Provides hospital-specific comparisons and ranking
- Encourages hospitals to conduct root-cause analyses

Patient Safety Research in 4 Systems

	US
Data options	<ul style="list-style-type: none">• No centralized repository• Limited fields• Tightly held
Safety analyses performed by system	None
Information sharing with regulators	None

Patient Safety Research in 4 Systems

	US	New Zealand	Sweden	Denmark
Data options	<ul style="list-style-type: none"> • No centralized repository • Limited fields • Tightly held 	<ul style="list-style-type: none"> • Detailed claims database • Hospitals may request their data 	Detailed claims database	Detailed claims database, including associated medical records.
Safety analyses performed by system	None	<ul style="list-style-type: none"> • Identifies high-priority areas for safety improvement • Writes and disseminates reports. 	<ul style="list-style-type: none"> • Prepares presentation • Sends facility-level information to hospitals. 	Analyses performed by external researchers.
Information sharing with regulators	None	ACC must report safety threats.	None	Shares drug-related claims.

Woman Set On Fire While Giving Birth

August 19 2002

A woman was set on fire during a caesarean delivery at the maternity unit of Waitakere Hospital in New Zealand at the weekend.

The fire left the woman, who was giving birth, with burns to the lower part of her body.

Hospital authorities and the fire service have launched separate investigations into how the fire started in the operating theatre on Saturday morning. Investigators said it was possible an alcohol based swabbing solution, used to sterilise parts of the body for surgery, may have ignited.

The woman was resting in a comfortable condition in Middlemore Hospital on Saturday night. Her baby boy was not hurt and is with her at the hospital.



Obstetric Fire - Causal Analysis

- Fire was caused by ignition of alcohol vapour arising from run-off skin disinfectant (chlorhexidine in 70% alcohol)
- Two years before accident, sponge applicator changed and colour removed from solution leading to five-fold increase in run-off
- At least ten different human factors aligned
- No deviation from standard practice compared with 14 other surgical units



Obstetric Fire - Action Taken

- System was changed to prevent future occurrence
- National and international alerts issued
- Positive media coverage



Prospects for a US National Adverse Event Database

- In a health court system, state databases could be integrated into a national dataset
- Barriers under the current system:
 - Malpractice claims represent a skewed sample, tending toward the most serious injuries
 - Claims information is too fragmented and not standardized
 - Culturally antithetical!



Relationship to Disciplinary Processes

- Public needs to know that “bad apple” doctors will be held accountable
- Physicians need to know they can report injuries without triggering disciplinary proceedings

How can we balance these interests?



Lessons From Foreign Systems

- Success of the system depends on physician participation
- Physicians will hesitate to report if they fear disciplinary action
- A paid claim in an avoidability-based system is not usually cause for discipline
- Discipline can be handled through an independent body with a separate complaints process



Health Courts and Disciplinary Processes

- No information leakage to disciplinary processes except in cases of imminent safety threat
- But hospitals' investigation processes will be buttressed
 - Hospitals will receive detailed feedback about claims
 - Can pursue their own investigations or report to an external disciplinary authority

Will hospitals be willing and able to police physician competence?



Conclusions

Health courts hold promise for:

- Fostering a culture of safety
- Stimulating hospitals to conduct more safety analysis
- Improving injury deterrence
- Improving the science of injury prevention