In the Literature

"HEALTH COURTS" AND ACCOUNTABILITY FOR PATIENT SAFETY

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Milbank Quarterly
September 2006
84(3):459–92

Full text is available at:
http://www.milbank.org/quarterly/8403feat.html

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Commonwealth Fund Pub. #997
February 2007

In the Literature presents brief summaries of Commonwealth Fund–supported research recently published in professional journals.

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There is ample evidence that the current medical malpractice system does not work well for physicians or patients. Along with other organizations, the Institute of Medicine has made recommendations for reform, with proposals that focus on moving away from the current tort system to an alternative, known as administrative compensation. In addition to improving accuracy and efficiency, an administrative system could promote efforts to monitor and improve patient safety. Two bills have been introduced in Congress to offer grants and technical assistance to states wishing to try demonstrations of these special "health courts."

In "'Health Courts' and Accountability for Patient Safety" (*Milbank Quarterly*, Sept. 2006), Michelle M. Mello, Ph.D., J.D., and David M. Studdert, L.L.B, Sc.D., of the Harvard School of Public Health, and colleagues describe the current proposals for designing a health court system and outline its advantages. Funding was provided by the Robert Wood Johnson Foundation and The Commonwealth Fund.

What Would Health Courts Look Like?

Health courts would exist outside the regular court system, with specially trained judges making decisions based on a standard of care broader than negligence—the basis for the current tort-based system—but not approaching strict liability, in which all injuries are rewarded. In a health court, claimants would have to demonstrate that their injuries would not have occurred if best practices had been followed. Compensation criteria would be based on evidence and guided by pre-set determinations, enabling speedy decisions.

The authors recommend a small-scale trial of such a system for medical malpractice claims. After an adverse event, a patient could file a claim by completing a simple form. A group of experts would then review the claim and decide whether compensation is deserved. If the patient is unhappy with either the decision or the amount of damages, the process would continue on to the health court. In most cases, say the authors, the claimant could easily proceed without the assistance of legal counsel. The judge, assisted by court-appointed medical experts, would make a decision within a few weeks.

Economic damages would be awarded, subject to a few conditions. To control the number and costs of claims, patients would need to pass an eligibility threshold—for instance, losing four weeks of work time or $4,000 in medical expenses. In addition, settlements from other sources, such as medical insurance, would offset the awards.

Advantages of Health Courts

Health courts promise several advantages over the tort system, say the authors. First, compensation decisions would likely be faster and more reliable, and the use of decision-making tools—like a database of previous decisions—would make payouts more consistent. Though health courts would be more accessible to a broader range of patients, they could help to control costs, with the size of average awards considerably lower than in the tort system.

Most important, the courts would provide a mechanism for systematically examining—and preventing—medical errors. Patients who sue for malpractice say that they are motivated by the desire to prevent similar events from happening again. However, the silence surrounding malpractice litigation effectively impedes safety, with doctors reluctant to share information. Instead of promoting a culture of blame, health courts could promote a culture of safety, the authors maintain, in which all parties share information about injuries and help promote analysis and learning.

Safety Analysis at Hospital and State Levels

The administrative system would enhance hospitals' capacity to analyze the root causes of errors and develop systems to prevent them. It could also provide monetary incentives through liability insurance premiums, indexed to the frequency of a hospital's avoidable injuries.

As repositories of information about medical errors and prevention, health courts could also promote regulation of patient safety. The existence of a centralized database of patient safety information would make an enormous contribution to research and interventions.

Examples from Abroad

Administrative compensation systems in New Zealand, Denmark, and Sweden demonstrate that such a system is feasible. The Danish Patient Insurance Association relies on partnerships with patient-safety researchers to study claims databases and publicize the findings in scholarly journals. The New Zealand Accident Compensation Corporation recently implemented a comprehensive system to improve patient safety. Based on claims data, analysts rate the severity and rarity of each injury and then identify injuries that merit immediate action, those that should be monitored, and those for which more evidence is needed.

Conclusions

While viewed with skepticism from some quarters, health courts hold enough promise to merit a trial demonstration, the authors maintain. "Alleviating the stigma and adversarialism of dispute resolution in tort would likely contribute significantly to building a safety culture," they conclude. "In weighing proposals for health courts, policymakers will continue to debate cost, fairness, and feasibility issues. But when it comes to patient safety, the scale is tipped heavily in favor of a new approach."

Injury Compensation Systems in Four Countries, Selected Features

	United States' Tort System	**New Zealand's Accident Compensation Commission (ACC)***	**Sweden's Regions Patient Injury Insurance (LOF)**	**Denmark's Patient Insurance Association (PIA)**
Use of compensation decisions as data for safety research	No centralized repository for information on all filed claims. Academic researchers have made some use of closed-claim databases, but data fields and access are limited.	Details of all claims are logged in a database. Hospitals may request their own claims data for purposes of analysis; otherwise, data are not externally accessible.	Details of all claims are logged in a database. but have seldom been updated.	Details of all claims are logged in a database. Data are available to external researchers. PIA maintains copies of associated medical records.
Safety analyses performed by compensation system	None.	ACC has a new patient safety division to identify priority areas for safety improvement and to perform safety analyses using the database. ACC writes reports and distributes them to hospitals. Injury prevention is now viewed as ACC's primary goal.	LOF analyzes claims data and prepares presentations of patient safety issues for hospitals and regions. LOF sends facility-level comparisons of claims rates, injury types, etc. to hospitals. LOF does no root-cause analysis but gives hospitals data and economic incentives to do so. It also permits researchers to access the data.	PIA does no safety analysis itself but has joined external researchers to publish several safety-related articles in scholarly journals.
Information sharing with patient safety regulators	None.	If a safety threat is identified, ACC must report it to the relevant regulatory authority. When ACC identifies a clearly effective and low-cost safety improvement, it may ask the government to order providers to adopt it.	None.	PIA shares information about drug-related claims with the national regulatory body.

* Current practice under reform legislation passed in 2005. Before 2005, there was more frequent reporting to disciplinary bodies and little data aggregation and patient safety analysis.

Source: Adapted from M. M. Mello et al., "'Health Courts' and Accountability for Patient Safety," *Milbank Quarterly,* Sept. 2006 84(3):459–92.