AHA: Ban Self-Referrals To Specialty Hospitals

BY MARY ELLEN SCHNEIDER
Senior Writer

The American Hospital Association is calling on Congress to permanently ban the practice of self-referral of patients to new physician-owned specialty hospitals.

Congress placed an 18-month moratorium on the construction of new physician-owned specialty hospitals under the Medicare Modernization Act of 2003. The moratorium is set to expire in June.

In a new report, the American Hospital Association (AHA) contends that physician-owned specialty hospitals have led to increased costs and the increased use of health care services, forced cutbacks in other services at full-service hospitals, and placed access to emergency and trauma services at risk.

'These physician-owned limited service hospitals seem to be experts at choosing patients and services that are most financially rewarding ...'

"This practice strips full-service hospitals of critical resources needed to provide a full array of services that the community expects," George Lynn, chairman of AHA's Board of Trustees and president of AtlantiCare in Atlantic City, N.J., said at a press conference.

AHA examined the impact of specialty hospitals on patients, communities, and full-service hospitals in Lincoln, Neb.; Oklahoma City; Wichita, Kan.; and the Black Hills region of South Dakota.

When these hospitals entered a community, access to emergency and trauma care was put at risk, the report found. And full-service community hospitals made cuts in areas such as behavioral health care, outpatient clinics for low-income patients, health education and awareness, and medical education.

In addition, investments in new technologies were delayed or cut altogether, Mr. Lynn said.

The report also found physician-owned specialty hospitals focused on higher-reimbursed services. "These physician-owned, limited-service hospitals seem to be experts at choosing patients and services that are most financially rewarding and steering them to their own facilities," he said.

But Randolph B. Fenninger, Washington representative for the American Surgical Hospital Association (ASHA), the trade group for physician-owned specialty hospitals, said continuing the moratorium is unnecessary.

Instead, Mr. Fenninger said the ASHA supports making changes to the diagnosis-related–group prospective payment system to better reflect the cost of care. The Medicare Payment Advisory Commission recently recommended that Congress extend the moratorium another 18 months, to study the impact of the hospitals and implement payment changes.

However, the payment changes alone won't be enough to alter current incentives, Mr. Lynn said. AHA plans to continue to work with members of Congress to make the moratorium permanent. ■

New Legislation Is Expected To Limit Class-Action Lawsuits

BY JOYCE FRIEDEN
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WASHINGTON — People who have suffered adverse outcomes due to drugs or medical devices may face more delays in suing manufacturers for damages now that federal class-action lawsuit legislation has been signed into law.

The law—the Class Action Fairness Act of 2005—would move from state court to federal court any class-action lawsuit in which the amount of damages claimed was greater than $5 million and involved citizens in different states. The law outlines circumstances in which federal courts can decline to hear class-action cases.

Proponents of the law, which passed in both the House and Senate in record time, say that it will help decrease the number of "junk lawsuits" that are clogging up the state courts.

"America's employers and consumers are the big winners," Tom Donohue, president and CEO of the U.S. Chamber of Commerce, said in a statement. "Reform of the class-action lawsuit system will reduce frivolous lawsuits, spur business investment, and help restore sanity to our nation's legal system."

Critics of the bill, however, say that it will deprive citizens of their right to sue when they are injured by a defective product. "There are only 678 federal trial judges in the system, but there are 9,200 state judges in courts of general jurisdiction," said Jillian Aldebron, counsel and communications coordinator for Public Citizen's Congress Watch, a citizen watchdog group. "So you're talking about cases ordinarily divided up among 9,200 judges and squeezing them into the courtrooms of 678 judges. Even if they are willing to hear the cases, it's going to take years, and these cases take years in state court" already.

Many physician organizations, including the American Medical Association, have declined to take a stand on the bill; their efforts are more focused on tort reform legislation affecting medical malpractice cases. But a few consumer groups, such as the Campaign for Tobacco-Free Kids, lamented the effect the bill would have on health care-related cases.

"Class-action lawsuits have been an important tool in efforts to hold the tobacco industry accountable," the group's president, Matthew L. Myers, said in a statement. "This bill will deprive citizens of a state of the right to have their cases heard in their own courts, further overburden the federal courts, and make it more difficult for tobacco companies to be held accountable."

Senior citizens' lobby AARP also opposed the bill. "We felt that there wasn't an adequate basis for consumers no longer having the option of bringing a multistate case in state court," said Larry White, senior legislative representative. "We acknowledge there are abuses on both sides in the system, but when you in essence say that the federal courts will have jurisdiction of these cases . . . knowing the federal courts oftentimes don't certify those cases, you're in essence saying people who have been genuinely harmed don't have options."

According to the Bush administration, the law will help consumers. "The bill will remove significant burdens on class-action litigants and provide greater protections for the victims," the administration said in a statement.

The new law would only affect cases filed after the legislation was signed, according to Ms. Aldebron. ■

Ethicist Says Medical Records Now Open for Patient Requests

BY CHRISTINE KILGORE
Contributing Writer

The long-held perception that medical records should never be altered at a patient's request is quickly becoming erroneous, according to health lawyer and ethicist George Annas.

"We can delete (items from the record), as long as we note that something has been deleted and who did it," said Mr. Annas, chairman of the department of health law, bioethics, and human rights at Boston University.

In a Webcast sponsored by the National Institutes of Health, he braced physicians for a future in which patients will increasingly ask to have items corrected, deleted, or changed that are errors or that they are concerned may pose harm to them.

"The real reason patients don't ask to make deletions [now] is because most people don't look at their records," he said. But with the advent of the Health Insurance Portability and Accountability Act (HIPAA), "there's a federal right of access" to records.

Moreover, President Bush's emphasis on electronic medical records (EMRs) embraces "the idea that patients should be in control," and patients are generally more concerned about the content of electronic records than paper records, said Mr. Annas, who is professor of sociomedical sciences and community medicine at Boston University.

The Bush administration has not addressed, in the context of its EMR proposals, whether "a patient [should] be able to delete accurate, factual information [from medical records]," he said.

There are "lots of mistakes in medical records," making it likely that in the future, many changes will address errors. Debate about other types of alterations will ensue, but under this new climate "you could argue that patients should be able to change anything," he told the physicians.

HIPAA addresses the issue of corrections to records, saying "patients have a right to request corrections in the record, and if there's no response, they can write their own letter and have it added," Mr. Annas explained.

The physicians who attended the NIH session reviewed a case in which a patient presented at the National Institute of Neurological Diseases and Stroke to enroll in a sleep study. He had a complaint of insomnia but, during a visit with an NIH clinical social worker, he also reported symptoms of severe depression and a history of drug use.

The day after the social worker evaluated the 37-year-old unemployed man, he requested that the information in the computerized record be deleted. "He was vague in his request, but he was concerned that someone would illegally obtain access ... and use [the information] against him," said Elaine Chase, of the social work department at the NIH Clinical Center, Bethesda, Md.

Mr. Annas said that if he were the provider faced with this request, he would agree to delete the information most disconcerting to the patient. "And if he wanted it out of a paper record, I'd still say yes," though, in the interest of research integrity, the patient should then be excluded from the NIH study, he said.

He offered his verdict on the case example after a free-ranging discussion in which some physicians voiced concern that a move from "physician's record" to "patient's record" would hinder communication among providers.

"Part of the purpose [of the medical record] is it helps individuals plan care," said one physician. "So from this standpoint, you can't just delete things. ... Or if there's going to be a patient medical record, maybe there needs to be another record [for providers]," she said.

It's true, Mr. Annas said, that "defense attorneys still say today that your best defense is a complete medical record."

Still, physicians, overall, "take the record too seriously" and, although questions remain, they are going to have to be more willing to consider patient requests to alter the medical records, Mr. Annas told this newspaper.

Theoretically, at least, the doctor and patient should review the content of the record before the visit ends, he said. "It makes sense that when you take a history, you should go over it with the patient and ask, 'Is this what you tell me? Is it right?' " ■

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