Jury Out on Health Courts for Malpractice Suits

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WASHINGTON — The concept of using administrative law judges instead of civil jury trials to settle malpractice suits has gained some admirers in the U.S. Congress and generated interest among state legislatures. But it is uncertain whether such a system is the solution to skyrocketing malpractice premiums and jury awards, according to academics, attorneys, and consumer and legislative representatives who met at a meeting sponsored by Common Good and the Harvard School of Public Health, Boston.

Under the "health court" concept, fleshed out earlier this year by Michelle Mello and David Studdert of Harvard, specially trained judges would make compensation decisions according to whether an injury was "avoidable" or "preventable" (Milbank Quarterly 2006;3:459-92). The plaintiff would have to show that the injury would not have happened if best practices were followed. Impartial experts would help set compensation, based on scientific evidence and what's known about avoidability of errors. Decisions would be made quickly.

Such a system would likely increase the number of people eligible for compensation, but decrease the size of awards, Ms. Mello said.

Unlike the current tort system, a health court system also could help deter medical errors by collecting data that would then be given back to hospitals and practitioners for root-cause analyses, she explained.

In 2005, Sen. Michael Enzi (R-Wyo.) and Sen. Max Baucus (D-Mont.) introduced the Fair and Reliable Medical Justice Act (S. 1337), which would provide money for demonstration projects on alternative methods to address malpractice, including health courts. The Senate Health, Education, Labor, and Pensions Committee held a hearing on the bill in June 2006, but there has been no further action.

At the symposium, Stephen Northrup, the health policy staff director for that committee, said it is not clear whether the newly Democratic-controlled Congress will consider alternatives such as health courts. Because Democrats are unlikely to approve of caps on damages as a tort reform, he said, it is incumbent on physicians to promote alternatives.

The National Committee for Quality Assurance supports the move toward an administrative court, said NCQA general counsel Sharon Donohue. But there is no evidence that rewards will decrease, and with an expanding number of claimants, malpractice premiums might still increase because they are based on the number of claims paid, she said.

Some consumer groups oppose the idea. Linda Kenney, president of the advocacy group Medically Induced Trauma Support Services, said patients should not have to start the claims process, as is proposed under the health court system. An audience member representing Consumers Union said her group did not like the idea of taking away a patient's right to a jury trial.

Dr. Dennis O'Leary, president of the Joint Commission on Accreditation of Healthcare Organizations, also said he saw some basic impediments to using the courts to improve patient safety. Overall, 85% of errors are due to systems issues; only 15% are competency-related, so solutions should focus on systems design, Dr. O'Leary said.

Despite JCAHO's voluntary reporting requirements of the last 10 years, there are few reports of adverse events—maybe 450-500 a year, he said. Most reports concern errors that are not easy to hide, such as patient suicides—the top category—and surgical misadventures, the number two category, Dr. O'Leary said. Surprisingly, at least eight cases a month of wrong-site surgery are reported, he added.

Several states have looked at or adopted "I'm sorry" statutes to address malpractice. Under the 2003 law, physicians can apologize, admit fault, and explain the cause of an error without it being held against them in court. The law has reduced the number of cases going to trial in Colorado.

So far, 2,835 of the 6,000 physicians covered by the COPIC Insurance Co., a malpractice insurer, have participated in a program implementing the law, said George Dikeou, a legislative consultant to the company. Participating physicians have had at least 3,200 discussions with patients, and in about 2,000 cases, the discussion was all that was needed to close the case, he said.

The insurer is authorized to pay up to $30,000 per case; the average payout over 711 cases has been about $5,300, Mr. Dikeou said. Of 116 cases that went to court, 54 cases were closed without payment and without attorney involvement. Six cases were closed with payment, 40 are still open, and 16 have gone to trial. ■

REINVENTING YOUR PRACTICE

Saving Time and Money With Computerized Dictation

If you're frustrated with the expense and delays of Dictaphone transcriptions, Dr. Jonathan Krant's solution may be just what the doctor ordered.

"Until 5 years ago, I utilized a Dictaphone with off-site transcriptions, a process that resulted in chart and referral consultation notes taking a week or longer to get to the referring physician," said Dr. Krant, a rheumatologist in Pittsfield, Mass. Adding insult to injury was the $3,000 monthly cost of the Dictaphone transcriptions. There had to be a better way.

So he invested $4,000 in an off-the-shelf version of Dragon Systems Medical Suite and a Dell computer system. "Over the course of the next several months, I customized the voice recognition software with a rheumatology lexicon of about 10,000 words and corrected mistakes in real time on screen," he said.

'There are no charts on my desk. ... I can send either faxed notes or dictated copy with a keystroke' with 99.5% accuracy.

"Now, 5 years later, there are no charts on my desk. Follow-up appointments and new patient consultations are dictated at the time of service into either a portable handheld unit or a microphone connected to the computer. I can send either faxed notes or dictated copy with a keystroke [with] over 99.5% accuracy," said Dr. Krant, noting that he has no financial interest in the technology.

His practice has saved $180,000 ($3,000 a month for 60 months). "Physician satisfaction cannot be overstated," he said.

"The Dictaphone is awful technology that multiplies medical errors," he said. He looked into voice recognition software, and learned that the Dragon Systems Medical Suite had a tolerable error rate and could be modified to fit his needs. After several thousand entries and corrections, it became a valuable tool. "Entire phrases and chart notes can be set up using templates that have assigned identifier numbers, so all I have to do is say the number and there's the phrase or chart, lickety-split."

Dr. Krant receives referral patients from about 200 primary care physicians. He's now able to get his notes to them within 10 minutes of seeing a patient.

"If I've got a patient with leg swelling and his physician thinks he's got an effusion in the knee because of arthritis, but I'm concerned about a clot in a lower extremity, I have an ultrasound waiting to be performed and an admission pending for deep vein thrombosis lined up within 15 minutes of the patient's examination," he said. ■

'Black Bag' Internist Takes His Practice to His Patients

About 300 people in the Fort Lauderdale, Fla., area are fortunate to be in the care of self-described patient advocate Dr. Randolph J. Swiller, an internist and psychiatrist who ministers to his patients in their homes.

In fact, Dr. Swiller's practice is made up almost exclusively of home visits. "I find that I can be of greater help to my patients this way. Many are bedridden or homebound due to advanced age, physical impairment, or mental problems such as social phobia and panic disorder," he said in an interview.

"Also, some patients are just plain uncomfortable sitting in a doctor's office. So I closed my office 2 years ago and started doing patient rounds in my car full time, 7 days a week," said Dr. Swiller, who began his solo practice 24 years ago.

'I'm not interested in making a lot of money. ... I'm only interested in taking care of people and making them feel comfortable.'

He now sees patients within a 50-mile radius of Fort Lauderdale. His wife, Tina, helps with bookkeeping and patient records. "Our visits are quite productive. I learn about my patients' lives at home, and I have an easy time monitoring their medications," he explained.

Dr. Swiller's "black bag" contains just about everything he needs to conduct a basic physical exam, draw blood, or get an ECG. When further tests are required, he sends patients to an imaging center or hospital.

When he has to provide therapy to a patient who lives in a family setting where privacy is hard to come by, he sees the patient in office space that he sublets from another physician. This same office space is used when a patient's insurance won't reimburse for home treatment.

Uninsured and low-income patients are allowed to pay Dr. Swiller what they can afford, on a sliding scale spread over weeks or months. "I'm not interested in making a lot of money. … I'm only interested in taking care of people and making them feel comfortable."

Dr. Swiller makes a point of contacting patients at least 1 day before going to their homes. "One of my patients is an 86-year-old woman who was robbed by two men posing as meter readers, and now she's afraid to let anyone in her house. I call her and her friends in advance, and the friends join me at her house," he said.

Home visitation is one way physicians can reclaim the high ground in medicine, said Dr. Swiller, who added that he believes the profession has become time-centric and impersonal. ■

By Bruce K. Dixon, Chicago Bureau. Look for the next installment of this column in the Feb. 1, 2007, issue.