



# Health Courts & the Avoidability Standard

*Opportunities for Patient Safety Enhancement*



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## Overview

1. **Case Example**
  - Complexity of Error
  - Relation to Patient Safety and Malpractice Principles
2. Health Courts
3. Avoidability
4. Conclusions

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## Case Example

- 55 YO healthy woman with fevers, headache, and malaise presents to the emergency department
- Seen by the ED resident and attending
  - Extensive evaluation and then home
- Patient returns next day
  - Extensive evaluation and then home again
- Patient returns third day
  - Septic and requires ICU stay
- Recovers fully

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## Case Example: Points for Consideration

- Error in this case had a complex etiology
  - Multiple "misses" & chances to avoid the outcome
- Nobody was particularly "careless"
- Most would agree that this was a mistake, but was anybody here unreasonable?
- We could debate about who was unreasonable
  - Was anyone more unreasonable than the others?
- A better system could have prevented this
  - We need to learn how

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## The Newer Approach to Error and its Clash with Medical Malpractice System

Patient Safety Principle	Malpractice System
Recognize that errors are common and systematic	Errors handled on case by case basis
"No blame" approach	Assign responsibility to a provider
Collective effort to improve	Adversarial process - litigation
Reporting / Disclosure	Can be seen as admissions of liability

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## A Key Need for Science of Patient Safety

- Reporting of medical error needed
  - IOM *To Err is Human* Report
    - Voluntary and mandatory reporting systems
- States increasingly adopting reporting laws
  - Not universal or uniform though
  - Often focus on very serious events only
- We still need a large volume of detailed information on "preventable" error
  - With this epidemiological information, we would be equipped to prioritize and attack error in a systematic fashion

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## Some Common Malpractice Reform Goals and Strategies

- Improving patient compensation
  - Res ipsa doctrine
  - Early offer and disclosure programs
- Reducing “non-negligent” claims
  - Caps
  - Shorter statute of limitations
- Reducing administrative costs
  - Screening panels, ADR/Arbitration
  - Lower contingency fees

**Most strategies focus on management of errors that have occurred and do not create direct mechanisms to reduce error in the future.**

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## Another Approach: Health Courts

1. Compensation decisions are made outside the regular tort system
  - File with administrative agency or health court
  - Exclusive remedy, with appeal options
2. Neutral adjudicators
  - Evidence based judgments + use of precedent
3. Decisions based on avoidability standard (broader than negligence). No assignment of responsibility
  - This is NOT pure “no fault”
  - Causation still also required
4. Explicit guidelines are used to determine economic + noneconomic damages
5. System collects and uses data for two specific purposes of patient compensation and to drive patient safety improvement

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## Advantages of Health Courts Over Tort

- Expanded access to compensation
  - Easier to file
  - Eligibility for compensation extends beyond negligence standard
- Speed and reliability
  - Explicit decision aids; use of presumptions and precedent
- Less administrative overhead
- **Patient safety**

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## How Would Health Courts Improve Patient Safety?

- Function as a robust reporting system
  - Patients with an incentive to report
  - Pooling of relatively large numbers of rare events
    - With aggregate data, stronger analyses possible
      - Detailed reports to hospitals
      - Comparisons to other institutions
      - Case specific details
      - Interventions can be tested
- Foster culture of safety
  - No blame/assignment of responsibility
- Enhance patient-physician relationship
  - Disclosure supported

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## Avoidability and Health Courts

If the structure of the health courts advances patient safety, why use a broader standard?

- Makes it easier for patients to obtain compensation
  - Further encourages reporting
- Lines up more readily with patient safety principles of preventability
  - Other standards would require additional analysis for patient safety use
- Removes the need to make a finding of "substandard" care to provide compensation
  - Supports a no blame systems approach
  - Avoids the "substandard" stigma
  - Furthers reporting, disclosure, culture of safety

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## What is Avoidability?

An avoidable medical injury is one that likely would not have occurred if care had been delivered with the level and skill of the best practitioner (or best system) practicing in similar circumstances.

<p><b>Elements of "avoidable"</b></p> <p>Events that result from care that is not in accord with best practice</p> <p>No use of hindsight</p>	<p><b>Contrast with unavoidable</b></p> <p><u>Unexpected</u> events that happen despite deployment of best or perfect care</p> <p>OR</p> <p>Could have been prevented with benefit of hindsight</p> <p>OR</p> <p>Injuries reasonably expected with proper and necessary treatment (no system seeks to compensate these)</p>
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## Examples of Avoidable Injury

- The "unknown" latex allergy with an emergent surgery
  - Folks may argue re: negligence, but most would agree the best system would likely have caught this
    - Note: Urban vs. rural can have a different answer
- Patient with symptomatic hyponatremia treated with concentrated saline on the general ward instead of the ICU

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## The Systems Approach and the "Bad Apples"

- No information leakage to disciplinary processes except in cases of imminent safety threat
  - International and US experience suggest this is critical to physician support of the compensation process
- What to do about accountability for the "bad apples"?
  - Patient can ask for an investigation with a separate filing to the appropriate disciplinary agency

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## Conclusions

- **Health courts and an avoidability standard hold promise for:**
  - Improving the science of injury prevention (via enhanced reporting and data collection)
  - Fostering a culture of safety (via removing blame)
  - Enhancing physician-patient relationship (via disclosure)
- **An administrative model does not mean no accountability**

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