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INSIDE

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Harsh claims as nurse sues hospital where she contracted Ebola

She alleges insufficient precautions, deceit by the hospital

In scathing allegations that paint a picture quite different than what the hospital has portrayed publicly, the nurse who was the first person to contract Ebola in the United States is suing her employer for thrusting her into danger without training or proper equipment. She also claims that the hospital lied about her volunteering to care for the patient and tried to use her to create positive press during the Ebola scare.

The hospital, of course, is at a disadvantage in defending itself publicly from the claims. Texas Health Presbyterian Hospital Dallas Spokesman **Wendell Watson** says that hospital officials still support 26-year -old Nina Pham but cannot comment on claims in the lawsuit.

"IT IS A PR NIGHTMARE. THE BIGGEST ISSUE FACING THAT HOSPITAL SYSTEM IS THAT IT WAS THE ONLY HOSPITAL WHERE A SECONDARY INFECTION OCCURRED."
-- ROBERT FULLER, JD, NELSON HARDIMAN

"Nina Pham served very bravely during a most difficult time as we all struggled to deal with the first case of Ebola to arrive in a U.S. hospital's emergency room. Texas Health Resources has a strong culture of caring and compassion, and we view all our employees as part of our family," Watson says. "That's why we have continued to support Nina both during and after her illness, and it's why she is still a member of our team. As distressing as the lawsuit is to us, we remain optimistic that we can resolve this matter with Nina."

The lawsuit is indeed distressing. It claims Pham still has nightmares, body aches, and insomnia as a result of contracting the disease from Thomas Eric Duncan, the first person in the United States

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EXECUTIVE EDITOR: Joy Daughtery Dickinson (404) 262-5410 (joy.dickinson@ahcmedia.com).
DIRECTOR OF CONTINUING EDUCATION AND EDITORIAL: Lee Landenberger.

EDITORIAL QUESTIONS
Questions or comments?
Call Editor **Greg Freeman**, (770) 998-8455.

diagnosed with Ebola. She claims the hospital's lack of training and proper equipment and violations of her privacy made her "a symbol of corporate neglect — a casualty of a hospital system's failure to prepare for a known and impending medical crisis."

Seventy-six healthcare workers who helped treat Liberian Ebola patient Thomas Eric Duncan at Texas Health Presbyterian Hospital Dallas were monitored for potential Ebola exposure after his first visit on Sept. 24, 2014. Pham and another nurse contracted the disease, but both of them recovered. Duncan died. Healthcare workers involved in Duncan's treatment complained at the time that inadequate education, training, and equipment put them at risk of infection. *(For more information on Ebola and the Duncan case, see "Ebola prompts changes, creates new risk management challenges,"* Healthcare Risk Management*, December 2014.)*

PPE, training criticized

The Centers for Disease Control and Prevention (CDC) confirmed claims that the Dallas nurses and physicians had to learn on the fly how to avoid infection. They initially used CDC protocols that left the caregiver's neck exposed to the patient's copious amounts of highly infectious vomit and diarrhea. The nurses treating Duncan worked for days without proper protective gear and faced constantly changing protocols, according to a statement released by National Nurses United, the largest United States nurses' union.

The main allegations in the lawsuit concern what Pham says was a failure to develop policies, train staff for treating Ebola patients, and provide proper protective gear. Other claims delve deeper into what the nurse says was a purposeful effort by the hospital to mislead the public and use her to bolster the hospital's image in a time of crisis. *(For more on the allegations in the lawsuit, see story in this issue. For information on how the hospital allegedly misled Pham for public relations purposes, see story in this issue.)*

"Nina brings this case to hold Texas Health Resources accountable for what happened to her and to send a message to corporations like it that the safety of all patients and health care providers comes first," the lawsuit says. "So when the next viral outbreak occurs — and it will occur — these hospitals will be prepared and those health care providers will

EXECUTIVE SUMMARY

A nurse who contracted Ebola after treating a patient with the disease is suing her hospital. She claims the hospital failed to provide adequate training and protective gear, among several other charges.

- The nurse says she still suffers physically and mentally from the experience.
- She alleges that the hospital used her for public relations efforts against her will.
- Staff members allegedly resorted to Googling information on how to protect themselves.

be protected."

Pham is asking for unspecified damages for physical pain and mental anguish, medical expenses, and loss of future earnings. The hospital confirmed recently that it had settled with Duncan's family regarding his delayed diagnosis. The family attorney said the settlement was for a "substantial amount."

'A PR nightmare'

Much of the legal liability in Pham's case might be addressed by Texas workers' compensation laws, but those laws still might leave unresolved issues related to her treatment as a patient and disclosure of her medical records, says **Robert Fuller**, JD, who headed a 199-bed acute care hospital in Los Angeles from 2001 to 2013, when he joined the law firm of Nelson Hardiman in Los Angeles.

Fuller notes that if the substantial allegations in the lawsuit prove to be true, they would suggest that Texas Presbyterian Dallas was not just the unlucky hospital that received the first Ebola patient when no other hospital was adequately prepared either. Other hospitals apparently *were* prepared, he says.

"It is a PR nightmare," Fuller says. "The biggest issue facing that hospital system is that it was the only hospital where a secondary infection occurred. Emory, NIH [National Institutes of Health], Nebraska, Bellevue, all successfully cared for their Ebola patients without incurring infections to staff members. That shows that U.S. hospitals could and did handle Ebola successfully."

The allegations in the lawsuit raise multiple questions about the hospital's preparations for admitting an infectious disease patient, as well as the hospital's organizational structure, he says. Fuller wonders if hospital leaders misjudged the facility's ability to cope with the unusual case.

"Most importantly, why did the administrator not transfer the patient out to another facility?" Fuller asks. "In other words, did the administrator understand their capabilities and have a realistic assessment of what they could and could not do? Virtually every hospital has its limitations. The administrators have to know them and be prepared to insist on moving patients whose care cannot be accommodated well."

A tough case to fight?

The workers' compensation laws might work to the hospital's benefit, notes **Peter Ticktin**, JD, senior counsel at the Ticktin Law Group in Deerfield Beach, FL. If an employee suffers an injury through simple negligence, the employee's claim would be limited to workers' compensation, he notes. Gross negligence must be proven to go beyond the compensation of workers' comp, he explains.

"It is doubtful that this higher level of negligence could be found, if the level of protection was up to the level of almost all the other hospitals," Ticktin says.

Despite the undeniable PR hit, other legal experts also say the situation it not unwinnable for the hospital. The case should be dismissed, says **Bridget M. Cohee**, JD, in the Martinsburg, WV, of law firm Steptoe & Johnson. A hospital does not have a duty to anticipate what the standard of care will be when confronted with a situation in which the standard has not yet been set, she says.

"The lesson is that no hospital is immune from a lawsuit, even when the merits of the claim are questionable," she says.

Even so, the hospital might be well-advised to make the case go away as quickly as possible, says **R. Scott Oswald**, JD, managing principal of The Employment Law Group in Washington, DC. It is possible for the hospital to put up a defense and successfully argue that any oversights did not reach the level of gross negligence, he notes. But what would it gain, really?

"Nina Pham is a national hero, and she makes a tremendously sympathetic plaintiff. I think that anyone opposing her in a lawsuit is risking far more than money. THR's whole image as a caring company is at stake," Oswald says.

A long legal battle will remind everyone of the Dallas hospital's terrible publicity from last fall, Oswald says, and Texas Health Resources might look like it's bullying a role model who has been embraced, literally, by the United States president.

"In that sense, I think THR doesn't have many good options," he says. "It would be well-advised to come to terms quickly with Ms. Pham."

SOURCES

- Bridget M. Cohee, JD, Steptoe & Johnson, Martinsburg, WV. Telephone: (304) 262-3538. Email: bridget.cohee@steptoe-johnson.com.
- Robert Fuller, JD, Nelson Hardiman, Los Angeles. Telephone: (310) 203-2803. Email: rfuller@nelsonhardiman.com.
- R. Scott Oswald, JD, Managing Principal, The Employment Law Group, Washington, DC. Telephone: (202) 261-2806. Email: soswald@employmentlawgroup.net.
- Peter Ticktin, JD, Senior Counsel at the Ticktin Law Group in Deerfield Beach, FL. Telephone: (954) 570-6757. Email: pt@legalbrains.com. ■

Ebola lawsuit claims nurse was thrust into danger without proper training

The Kafkaesque story told in the lawsuit filed by nurse Nina Pham features a woman who innocently shows up for work one day and finds herself trapped in a nightmare, betrayed by those she trusted to protect her.

Hobbled by limitations on how much it can address an active lawsuit, Texas Health Presbyterian Hospital Dallas and its parent company Texas Health Resources (THR) have not rebutted the individual allegations by Pham. Until they can, the lawsuit paints a damning portrait.

These are some of the allegations in Pham's lawsuit:

• Nurse Pham did not volunteer to treat the country's first Ebola patient.

When Pham arrived for her regular shift in the hospital's intensive care unit, the lawsuit alleges, she was informed that she would be caring for patient Thomas Eric Duncan. She did not volunteer to be his nurse, and the lawsuit claims that the hospital promoted a false story of her heroically volunteering to encourage favorable media coverage. She did not refuse because she felt an obligation to treat the patient assigned to her.

"But the myth perpetuated by THR that this was a 'volunteer' health care team obscures the dark reality: Nina was put in the position to take care of Mr. Duncan without any prior knowledge of the risks, dangers, or any training. As with any patient, a nurse can attempt to refuse an assignment, but Nina was not inclined to do that because she saw critical care nursing as a calling, and she had a job to do," the lawsuit states. "Unfortunately, THR was sending her to do it without the necessary qualifications or protections to do it safely."

• Pham was misled about Duncan's condition and the risk of infection.

"She was told Mr. Duncan was in stable condition and could use the bathroom by himself. She was told that she would not have to go in the patient's room much and could just monitor him remotely, all of which turned out to be untrue," the lawsuit says.

> "NINA PHAM WOULD HAVE BEEN BETTER OFF TREATING MR. DUNCAN IN A LIBERIAN EBOLA CENTER THAN IN THR'S SIGNATURE HOSPITAL."

• Pham was completely unprepared to treat an Ebola patient.

"She had never been trained to handle infectious diseases, never been told anything about Ebola, how to treat Ebola, or how to protect herself as a nurse treating an Ebola patient," the lawsuit states. "The hospital had never given her any in-services, training or guidance about Ebola. All Nina knew about Ebola is what she had heard on the television about the deadly outbreak in West Africa."

• The hospital failed to provide even some of the most basic supplies.

"Nina was not even provided disposable scrubs or a change of clothes. She had to wear the scrubs she wore that first day home, taking out of the hospital clothing that was potentially carrying the virus," the lawsuit claims. Noting that Ebola caregivers in West Africa wear full "moon suits," the lawsuit says, "Here, at THR's hospital, the health care providers were given only basic coverings that left them exposed to the highly contagious disease. Despite the claims about our advanced healthcare system, ultimately none of it was brought to bear to protect the healthcare providers here. "Nina Pham would have been better off treating Mr. Duncan in a Liberian Ebola center than in THR's signature hospital."

• Pham's supervisors had to Google information on how to avoid Ebola infection.

When Pham asked her manager what she should do to protect herself from the deadly disease, either her manager or her supervisor went to the Internet, searched Google, printed off information regarding what Pham was supposed to do, and handed her the paper, the lawsuit alleges. The ICU did not have any written polices or manuals about treating level 4 infectious disease patients generally or Ebola specifically, according to the lawsuit.

• The hospital defied Pham's wishes to remain anonymous and violated her privacy.

On her way to her hospital's emergency department with possible Ebola symptoms, Pham called the

hospital and asked to be registered as a "no information" patient, a method used to protect a patient's privacy so the patient's name is not visible to others accessing the electronic health record. The strategy often is used for celebrities or others whose records might be of special interest.

Despite her request, severe illness, and the effects of multiple medications, the public relations department of the hospital's parent company called Pham repeatedly, according to the lawsuit. The hospital failed to honor her request for anonymity, and her record was "grossly and inappropriately accessed by dozens of people throughout the THR system," the lawsuit claims. On the day the lawsuit was filed, THR sent a letter to employees saying it had Pham's consent to share the information about her that was released.

• The hospital's chief medical officer lied to Congress about staff training and preparedness.

Daniel Varga, MD, the chief medical officer for THR, testified before the U.S. House of Representative Subcommittee on Oversight and Investigation on Oct. 16, 2014, regarding THR's dissemination of infection control policies related to Ebola. "It must be noted that Dr. Varga made numerous patently false statements to Congress, including falsely claiming the hospital staff was trained to manage Ebola and misrepresenting to Congress what type of personal protective equipment, or PPE, the nurses wore at various times when caring for Duncan," the lawsuit claims.

• The hospital could have easily transferred Duncan to a facility better prepared to treat an Ebola patient.

The Galveston (TX) National Laboratory is a biosafety level 4 (BSL-4) Biocontainment Laboratory, one of only two national BSL-4 laboratories in the United States.

"One of the two places in this country and one of the handful of places on earth with qualified and trained experts on the containment and treatment of Ebola was only a phone call and an hour's flight away," the lawsuit states. ■

Nurse: Hospital lied, tricked her for PR benefit

One of the more shocking allegations in the lawsuit nurse Nina Pham filed recently against Texas Health Presbyterian Hospital Dallas involves what she says was a deceitful attempt to help bolster the hospital's public image during a frenzy of media coverage about Ebola.

After Amber Vinson, a second nurse at Presbyterian also was confirmed to have Ebola, the hospital's parent company Texas Health Resources (THR) went into full crisis mode, the lawsuit states. Public perception was that the hospital was incompetent, and it was in need of good news.

"Desperately, THR issued a press release that announced Nina's condition had been upgraded from stable to good in hopes that the public would think THR was doing something right. However despite publicly claiming Nina was in good condition, Nina's medical records tell another story," the lawsuit says.

Pham's medical records show that while Texas Health Resources was publicly proclaiming her improved condition, healthcare providers were at the same time having end-of-life discussions with her in which they tried to convince her not to require lifesaving measures, the lawsuit claims. Her physicians specifically documented in the record that Pham was in such critical condition that she could not make decisions for herself.

"Perhaps the act most indicative of THR's callousness in the pursuit of good PR happened on the day Nina finally got transferred to the National Institutes of Health (NIH) in Bethesda, Maryland. THR desperately wanted to claim credit for making Nina better so that the public would not believe that Nina was being transferred because she was not receiving proper medical care," the lawsuit claims.

Before she departed for the National Institutes of Health, one of Nina's physicians entered her hospital room with a tiny GoPro camera under his hood filming everything in the room, according to her lawsuit. The physician tried to get Nina to say good things about Presbyterian and to get her to say that she was feeling well and wished she was not being transferred, Pham claims.

"Nina, unclear as to what was occurring, did not give the answers THR was looking for. The physician tried to tease out any good sound bites he could get but mostly failed. Finally at the end of the discussions, he made Nina tear up a little bit and then respond with optimistic statements," the lawsuit alleges. "THR immediately edited the video to make it look as good as possible for THR. Then THR released it to the press and published it on the THR YouTube site." ■

Experts warn: Patient passports need review by risk management department

Risk managers know better communication with patients and family members can reduce errors and improve the overall quality of care, and some hospitals are now adopting "patient passports" to facilitate a better exchange. Proponents laud the benefits of the passports, but risk managers also must consider any potential liability or documentation issues.

The patient passport is a document that covers basic patient data, including some information found in traditional medical records. Patients can write in additional information such as how they deal with certain health conditions, what type of activities they might need help with, and any requests they might have after discharge. They also can update the passport with changes in their conditions or medications prescribed.

The National Quality Forum (NQF) in Washington, DC, has developed a patient passport modeled on one used at the Mattel Children's Hospital in Los Angeles. It can be customized for specific patient groups, such as cancer patients or palliative care patients. *(The passport is available at no charge online at http://www.qualityforum.org/Patient_Passport.aspx.)*

Written in the patient's voice, the patient passport uses pictures and simple language to start conversations and to help providers see their patients as people with stories beyond their illnesses, the NQF explains. The content and style are intended to make frontline staff's work simpler and more effective by presenting critical information about the patient, such as medications, conditions, and what works or doesn't work to cope with health conditions, in a concise and meaningful way, the Forum explains.

Mattel developed the passport after leaders there recognized that when children are taken outside the pediatric ward, other physicians and nurses might be unaware of conditions such metabolic issues or weak immune systems. Griffin Hospital in Derby, CT, recently began a similar program for its patients.

One goal with patient passports is to "fill in the gap between best intentions and patient outcomes," says **Jim Kinsey**, director of member experience with Planetree, a not-for-profit hospital membership organization that works with the corporate parent of Griffin Hospital.

"There is a disconnect between what providers believe the patients want and what the patient actually wants," Kinsey say. "The passport helps patients be more active in their care and to have their voices heard more clearly."

Before signing on to the patient passport idea, Kinsey investigated potential risk management issues with colleagues at Griffin Hospital. He found that by far the most direct risk management effect from patient passports should be positive. Many malpractice cases can be traced back to a misunderstanding between what the patient wanted and what the provider thought, or to mistakes in the patient's assessment or medications, he notes.

"We think we're actually avoiding problems by having the patient passport," Kinsey says. "Researchers have shown that having the patient more involved in their own care improves outcomes and can even reduce costs."

The legal status of the patient passport is not clear. At Griffin Hospital, administrators do not consider the passport to be part of the medical record, mostly because they encourage patients to continually update it as their wishes or situations change. Medical records are more of a static document that is never altered, Kinsey says.

Patient passports do not have to be incorporated into the medical record, but they probably should be, says **Sarah E. Coyne**, JD, partner in the Madison, WI, office of the Quarles Brady law firm. The legal community has not yet addressed the issue because patient passports are so new, but Coyne says the safe approach is

EXECUTIVE SUMMARY

Patient passports are gaining in popularity, but risk managers should consider legal and documentation issues. The patient passport is a document that covers basic patient data. A key question is whether the passport becomes part of the medical record.

- Passports can benefit patient safety by improving communication between the patient and caregivers.
- The safe strategy is to consider a patient passport part of the medical record.
- Patient passport templates are available to all hospitals.

to consider them part of the record because they are used to determine care.

"My advice is to incorporate it, because otherwise you can have an informational gap if the patient doesn't bring it back," Coyne says. "Once you've asked the patient to use this as a means of communication, I could see providers being held responsible for not knowing what was in the document or not adhering to it."

Coyne also wonders about the risk of inconsistency between the passport and the patient's record. If the patient passport notes an allergy, for example, but that information is not recorded in the patient's record, the patient then can say the passport is proof that the information was communicated. But what if the patient did not bring the passport to the next visit after noting the allergy on it? Can the hospital claim that its medical record is the official document and that the passport was not provided?

Another concern is that the passport will contain protected health information (PHI) and probably will not be subject to the security precautions in place for electronic or paper medical records, Coyne says. If the patient is responsible for keeping the passport secure, there is still a possibility that the healthcare organization could run afoul of the Health Insurance Portability and Accountability Act (HIPAA.)

"To the extent that it has sensitive information, such as behavioral health treatment or medications, HIPAA can be enforced on that," she explains. "There also can be additional restraints on a state level, and I would want any hospital I'm working with to have some sort of system that keeps the passport secure."

SOURCES

- **Sarah E. Coyne**, JD, Partner, Quarles Brady, Madison, WI. Email: sarah.coyne@quarles.com.
- **Jim Kinsey**, Director of Member Experience, Planetree, Derby, CT. Telephone: (610) 733-5140. Email: jkinsey@planetree.org. ■

Hospital reduces falls 75% with bundle of strategies

A hospital in Atlanta has reduced falls by 75% with interventions that were implemented by a performance improvement team. Raising awareness among staff members about the risk of falls was a major component of the effort.

Like all hospitals, Grady Memorial Hospital continually addressed falls as a patient safety and liability risk, and in 2011 the fall rates seemed under control, explains **Rosiland Harris**, DNP, APRN, RNC, ACNS, BC, director of professional nursing education, practice, and research for the Grady Health System. Then the number of falls with injuries doubled between 2011 and 2012.

That increase was a red flag that something was seriously wrong, Harris says. She determined that fall prevention efforts had relaxed and Grady was not using many of the best practices. Grady's fall rate was still under the average when compared with national benchmarks, but the rate continued to rise.

Harris and Patient Safety Officer **Donise Musheno**, RN, MS, CPHQ, worked to secure support from senior leadership and established a multidisciplinary fall team at the hospital with members from risk management, quality, nursing, education, medical staff, and physical therapy. One of the first actions the team took was to ensure that Grady complied to the letter with the universal falls precautions. That effort meant using signage, color-coded socks and arm bands, bed alarms, nurse telephone connections directly to the bed alarms, and a strong focus on hourly rounding to assess the patient's need to use the bathroom.

"Research has demonstrated over and over again that one of the main reasons people fall is trying to get out of the bed to go to the bathroom," Harris says. "We also made a strong effort to assess patients thoroughly for their fall risk and then to take the necessary precautions."

Some of the protocols required substantial purchases for signage, socks, armbands and new telephone systems for nurses, Harris says. Senior leadership support was crucial in

EXECUTIVE SUMMARY

A hospital is reporting a 75% reduction in falls through the use of a performance improvement team. The team uses a "bundle" of strategies to reduce falls.

- Increasing the awareness of hospital staff members was a key component.
- The plan also addressed common fall risks, such as patients trying to go to the toilet on their own.
- Hospital leaders must be willing to invest in fall reduction.

making sure those expenditures were approved, she says. Even simple items such as the socks must be kept in constant supply so that no patient is left at risk because the supply ran out.

In addition, Grady ensured that each patient room had a bedside commode. The paper signage previously used was changed for more durable, but more expensive, permanent signage that could be modified for the patient. Grady also mounted a white board in each room so that the nurse making rounds could check off that he or she asked if the patient needed assistance.

Much of the efforts were not innovative but rather the Grady team focused on ensuring strict compliance with the protocols that are known to reduce falls. That focus required staff education and also working with patients to encourage them to communicate their needs, Harris says.

"It took a host of different measures and interventions, and a very intense focus on them," Harris says. "The hardest thing was to stay focused and not let up. We wanted it to become second nature, and it did because we remained below the national benchmark for nine consecutive quarters, about 27 months."

As a result of the education, the tools provided, and the enhanced awareness, the recorded rate of falls decreased by more than 75% during the first quarter of 2014. The number of patient falls with injury per 1,000 patient days was 15% in 2011 and 28% in 2012. At the end of 2013, the rate was 0.5%. Grady has since had a steady rate of 0.7%.

Musheno notes that reduction in falls was well worth the investment in time and money, from a patient safety and a financial perspective. A fall with injury typically increases costs to the hospital by 60%, and the Centers for Medicare and Medicaid Services (CMS) limits reimbursement for fall-related injuries.

"From a human factor, taking care our patients and keeping them safe, reducing falls has to be a top priority," Musheno says. "From the standpoint of the resources that are devoted to caring for patients after a fall and the limited reimbursement from CMS, a fall reduction program like this is a huge opportunity for the organization." ■

Misplaced NG tubes a major patient safety risk

Every year, nearly 500,000 nasogastric (NG) and percutaneous endoscopic gastrostomy (PEG) tubes and suction tubes are misplaced, which result in severe complications or death, notes **Paul J. Gilbert**, MD, FACEP, an emergency physician who owns a private physician group of seven emergency department physicians in the Scottsdale, AZ, area.

After Gilbert lost a patient due to a misplaced tube, he realized something needed to be done to enhance patient safety. He now focuses on educating physicians and healthcare organizations about the risk of misplaced tubes, and along with colleagues, he has developed three new point-of-care diagnostic devices to provide safer NG tube placement and more accurate gastric acidity measures for critically ill patients. Gilbert's pH indicator tools, which are the RightSpot, RightLevel, and RightSpot Infant, are sold by RightBio Metrics in Scottsdale. Each device costs $10 or $13, depending on the purchase quantity.

RightSpot is a small, non-invasive in vitro diagnostic device that is used to verify gastric acidity to avoid misplacement of nasogastric feeding/suctions tubes and PEG tubes; the infant product serves the same purpose. The RightSpot indicator is placed on the tube and gastric fluid is aspirated; a pH below 4.5 would indicate gastric acidity. The RightLevel is similar but designed to facilitate proper treatment of gastric ulcers and bleeding, which involves administering medication in dosages appropriate for a specific stomach pH level.

Gilbert provides these facts:

• Studies show between 2% and 4% of all tubes are misplaced.

• Misplaced tubes are typically misguided into the lungs, which causes significant morbidity and mortality and costs medical providers millions of dollars.

• From 2001 to 2011, medical

EXECUTIVE SUMMARY

Misplaced nasogastric and percutaneous endoscopic gastrostomy tubes pose a serious threat to patient safety and a liability risk for hospitals. New technology might improve the detection of misplaced tubes.

- Half a million tubes are misplaced every year.
- Between 2% and 4% of tubes are misplaced.
- A misplaced tube can be deadly and can cost providers millions of dollars.

providers in the Chicago area alone paid more than $10 million to resolve lawsuits filed for injuries and deaths caused by misplaced NG feeding and suction tubes.

• Between 1993 and 2014 there were about 1,750 malpractice cases in the United States that were in some way related to placements of tubes; 412 of these cases directly stated that there was a misplacement issue.

• Of the 412 cases that related directly to the misplacement of NG, PEG, or suction tubes, 25 of them showed the settlement costs. NG tubes were involved in 173 settlements for tube misplacement, with an average cost of settlement being $1.07 million. For PEG tubes, there were 81 settlements for tube misplacement, with an average cost of settlement being $3.28 million. There were 119 settlements for suction tube misplacement, with an average settlement cost of about $1 million.

The common methods for checking tube placement involve X-rays or using pH paper to check the fluid in the tube, but Gilbert's devices provide what he says is a safer and easier way to check the pH of the fluids without removing them from the patient. The pH paper is contained in the plastic housing of the single-use device, so the fluid makes contact with the test strip there. "It's a very hot topic, especially with kids because we don't want to expose them to X-rays," Gilbert says. "There have been some very highly publicized cases of infant death, and that looks very bad for a hospital. It's a topic that risk managers should be involved in, so they can push for improvements on a problem that is occurring more often than they might realize."

Defending an NG tube misplacement malpractice case can be exceptionally difficult because it is widely recognized that the standard of care requires confirmation of proper NG tube placement in some manner, says **Edward McNabola**, JD, a partner with the McNabola Law Group in Chicago. The traditional approach of using auscultation to confirm placement is notoriously unreliable and, therefore, does not satisfy the standard of care, McNabola says.

"I have a vivid memory of a widow coming to speak with me about the tragic loss of her husband and father of her children. In short, the physician inserted the NG tube and assumed that it was in the stomach, based upon auscultation. However, the NG tube was actually in his lung, and they delivered charcoal and other substances into the lung, resulting in cardiopulmonary collapse, anoxic brain injury, and his eventual death," he says. "My firm filed a lawsuit against the healthcare providers and the hospital and successfully resolved the case for settlement in excess of $900,000." ■

$8.5 million verdict is first for concierge medicine

A Palm Beach County, FL, jury recently returned an $8.5 million malpractice verdict against MDVIP, the nation's largest concierge medicine practice company, which has 784 affiliated physicians in 41 states. The award is the first against MDVIP, and it is believed to be the first malpractice award against any concierge management firm.

Concierge practices offer patients who pay a membership fee faster access to a physician, more streamlined service, and higher quality care than practices that participate in managed care plans. A concierge practice is meant to appeal to those who can afford to pay extra in order to avoid some of the hassle typically associated with busy practices and third-party insurers.

The attorneys who won the case say it should signal caution for any hospital or health system that might align with a concierge service because the verdict casts doubt on the entire concierge concept. MDVIP was founded in 2000 to offer members such perks as same-day appointments and more personalized care in exchange for a $1,500 annual membership fee.

The jury found MDVIP liable for the negligence of one of its physicians, who was sued for misdiagnosing the cause of a patient's leg pain, which led to its amputation. The jury also found the firm had falsely advertised its exceptional doctors and patient care.

In 2008, Boca Raton resident Joan Beber, then a recent MDVIP member, sought medical attention for leg pain and was treated by MDVIP primary care physician Charles Metzger Jr., MD. Despite the progressive worsening of her condition, Beber was repeatedly misdiagnosed by Metzger and other MDVIP-affiliated staff members, according to her lawsuit. Orthopedists, to which Beber was referred by Metzger and with whom Metzger was supposed to be coordinating Beber's care, were never given medical records or informed of her worsening symptoms, she claimed. That information should have led to the discovery of a serious circulation problem in Beber's leg that eventually required the above-the-knee amputation. She spent the next four years dealing with serious phantom pain and struggling to learn

to walk on a prosthetic leg before she died of leukemia in 2012.

Significantly, the scope of the case extends beyond medical malpractice, explains one of Beber's attorney, **Karen Terry**, JD, of Searcy Denney Scarola Barnhart & Shipley in West Palm Beach, FL.

During the three-week trial, the plaintiff's lawyers argued that MDVIP misled Beber and her husband, Robert Beber, into paying $1,500 each annually for what they were told, verbally and in writing, would be exceptional care provided by a network of exceptional doctors. They charged MDVIP with making false claims as to the qualifications of their doctors, the availability of specialist physicians, and access to top-quality hospitals.

The jury deliberated for just more than six hours. Metzger and his colleagues settled out of court prior to trial, but those settlements do not diminish the damages for which MDVIP was found to be liable by the jury's verdict. The verdict also carries with it a liability for seven years of attorneys' fees and costs, estimated to add as much as a million dollars or more to the final judgment against MDVIP, notes another of Beber's attorneys, **John Scarola**, JD, of the same firm.

"MDVIP's scheme worked just like most other con games," Scarola says. "MDVIP essentially took money for a service that did not exist and which they never intended to provide. Had Ms. Beber not been duped, she never would have suffered the tragic and traumatic injury that ensued. The jury's unprecedented verdict is a clear indication of their agreement that what MDVIP really stands for is Marketing Deception and Valueless Illusory Promises."

MDVIP's very business model is at issue, Terry adds. Concierge practices promise that a retainer payment will ensure superior service, and they may not be able to fulfill that promise, she says.

"As this landmark case sadly demonstrates, we need to take a much longer and more critical look at how this entire industry actually operates," Terry says. "This verdict will have serious future ramifications for MDVIP, which has now been held to be vicariously liable for its physicians." ■

Med mal reform not lowering healthcare costs

Two papers co-authored by a University of Illinois expert in the regulation and financing of healthcare conclude that tort reform has had relatively little impact on the U.S. healthcare system.

Tort reform advocates have hailed caps on noneconomic damages as a silver bullet for controlling healthcare costs by reducing defensive medicine and for attracting more physicians to a state, particularly those practicing in high-risk specialties. But according to **David Hyman**, JD, the H. Ross and Helen Workman Chair in Law and professor of medicine at the university in Champaign, there is scant evidence to support any of those claims.

"The best evidence is that caps would have, at most, a tiny impact. We find some evidence that caps might actually increase healthcare costs," Hyman says. "It's very hard to see how damage caps bend the cost curve down or materially increase the number of practicing physicians in a state."

According to Hyman, the direct costs of medical malpractice liability are "pretty modest" relative to total healthcare spending in the United States. "Tort reform may be a good idea or a bad idea, but ultimately it's a very small idea," he says. "It's not going to have as big of an impact as many proponents claimed it would."

One paper published in October 2014 in the Northwestern University School of Law's *Law and Economics Research Paper Series* examined the third wave of malpractice reforms, which consisted of studying nine states that enacted tort reform from 2002-05: Florida, Georgia, Illinois, Mississippi, Nevada, Ohio, Oklahoma, South Carolina, and Texas. Thirty-one states covering about 70% of the U.S. population already have adopted damage caps, according to the paper. "We compared what was happening in healthcare spending in those [nine] states before and after tort reform with what was happening in the control states, which were the states that had never enacted tort reform and states that had enacted tort reform during one of the earlier waves," Hyman says. "Some early studies found evidence that enacting

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tort reform made a big difference in healthcare spending. Subsequent studies found more modest effects. Other studies found no effect."

Hyman and his co-authors found enacting a damage cap had no effect on hospital spending, but, somewhat surprisingly, caused an increase in spending on physician services. "It turns out that eliminating liability didn't lower spending; it actually resulted in a slight uptick in spending," he said. "So the argument, 'Just pass tort reform, and you'll save lots of money' was not borne out in our study. The bottom line is you're not going to save a lot of money with tort reform, and there's some evidence that you might actually increase spending."

The second paper, published in February 2015 in the *Behavior & Social Science Research Paper Series* from the University of Illinois College of Law's Program in Law, considered another common claim about medical malpractice reform: States that enact tort reform will become a "magnet" for physicians, especially those who practice in a high-risk specialty. There is a certain plausibility to that argument, Hyman says. "People decide where to live and work based on many factors. If tort reform means that a practicing physician's malpractice premiums are lower, then it might factor into whether they move to your state," he says. "Or it may make some physicians in that state defer retirement. It might also affect physicians deciding where to do a residency and deciding where to set up practice after they finish their residency."

But outside of a slight increase in the number of plastic surgeons, Hyman and his co-authors found no evidence that adopting a cap on damages from medical malpractice increases the total number of physicians or the number of high-risk physicians.

"The economics of attracting and keeping high-risk specialists and those practicing in rural areas are challenging, and so the question is what tools do you have to do that, so they provide needed services," he says. "Tort reform proponents argue quite vehemently that enacting a strong cap on noneconomic damages is a good way to get physicians to move to your state. But what we found contradicts that." *(Both papers are available online at http://tinyurl.com/ka8ewq8 and http://tinyurl.com/p7hotfy.)* ■

Huge increase in hacking of computer systems

Hackers are stealing data from providers at an astounding rate, which reflects the fact that information from healthcare records are worth far more on the black market than credit card numbers.

The number of hacking incidents in healthcare jumped over 1,800% from 2008-2013, according to a study from the Brookings Institution, the think tank in Washington, DC. Reviewing Health and Human Services reports of data breaches in which more than 500 patients were exposed, the Brookings Institution found that the number went from just 13 in 2008 to 256 in 2013.

"The healthcare sector is an increasingly attractive target for hackers," according to the report, which comes on the heels of the recent data breach at Anthem, the prominent health insurer. Thought to be the largest healthcare data breach in history by a wide margin, the insurer reported that the breach affected 80 million people.

Brookings also noted on its web site that hacking in healthcare poses problems not encountered by the same crime in a retail setting. Customers of a department store that has been hacked can choose to shop elsewhere, but it is hard for people to move to a new healthcare provider because of insurance and employer requirements.

Brookings notes that the penalties for a privacy breach might not be large enough to prompt healthcare organizations to pay for adequate security. Healthcare organizations that "knew, or by exercising reasonable diligence would have known" of the privacy violations but did not prevent them could potentially be fined a maximum of $1.5 million," the Brookings blog post states. "To put this in perspective, note that the net income of Anthem in 12 months ending on December 31st, 2014, was $2.5 billion. If Anthem were proven guilty of willful neglect, which is very unlikely, it could lose 0.00058% of its net income," Brooking notes. "Anthem makes that much money in one hour and 15 minutes." ■

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

1. describe the legal, clinical, financial, and managerial issues pertinent to risk management;
2. explain the impact of risk management issues on patients, physicians, nurses, legal counsel, and management;
3. identify solutions to risk management problems in healthcare for hospital personnel to use in overcoming the challenges they encounter in daily practice.

HEALTHCARE RISK MANAGEMENT™

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To earn credit for this activity, please follow these instructions:
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CNE QUESTIONS

1. **In her lawsuit against Texas Health Presbyterian Hospital Dallas and its parent company Texas Health Resources, what does nurse Nina Pham claim about her willingness to treat an Ebola patient?**

   A. She volunteered.
   B. She was assigned the patient and did not refuse the assignment.
   C. She was assigned the patient and tried to refuse, but hospital administration insisted she care for the patient.
   D. She agreed only to fill in briefly for a coworker who was unavailable.

2. **According to Pham's lawsuit, what did her supervisors first do when she asked what precautions to take with the Ebola patient?**

   A. They consulted the unit's protocol for treating a level-4 infectious disease patient.
   B. They called the Centers for Disease Control and Prevention to speak with an expert.
   C. They called a hospital in nearby Galveston, TX, that was better equipped for infectious disease care and asked for advice.
   D. They looked up the question on Google and gave Pham the results.

3. **What does Sarah E. Coyne, JD, partner in the Quarles Brady law firm, advise regarding patient passports?**

   A. The safe approach is to consider them part of the patient record.
   B. There is no reason to consider them part of the patient record.
   C. They have no legal bearing whatsoever and are just the patient's personal documents.
   D. They are too risky, and hospitals should avoid using them.

4. **What was one of the steps taken to reduce falls at Grady Memorial Hospital?**

   A. Patient sitters were assigned to all patients at risk of falls.
   B. Bedside commodes were provided in every patient room.
   C. Administrators authorized a more liberal use of restraints.

LEGAL REVIEW & COMMENTARY
EXPERT ANALYSIS OF RECENT LAWSUITS AND THEIR IMPACT ON HEALTHCARE RISK MANAGEMENT

Failure to diagnose infection causes toddler death and yields verdict of $1.72 million

By ***Damian D. Capozzola****, Esq.*
Law Offices of Damian D. Capozzola
Los Angeles

Jamie Terrence*, RN*
President and Founder, Healthcare Risk Services
Former Director of Risk Management Services
California Hospital Medical Center
Los Angeles

Tim Laquer*, 2015 JD Candidate*
Pepperdine University School of Law
Malibu, CA

News: Plaintiffs' 3-month-old daughter was taken to the hospital with a high fever and elevated pulse rate. The emergency department (ED) physician diagnosed an ear infection and discharged the infant with a prescription for antibiotics. Three days later the girl's father found her cold and lethargic. He took her to a different hospital, where she was diagnosed with pneumococcal meningitis, hypoxic brain injury, and hydrocephalus, which required hospitalization for a month. After discharge, the girl lived for 20 more months, but she was constantly in and out of the hospital and eventually died from respiratory arrest, which the plaintiffs claimed was due to the originally undiagnosed meningitis infection. Plaintiffs sued the hospital and the ED physician, and they won a verdict of joint and several liability for $1.7 million.

Background: The plaintiffs' daughter was born as a full-term baby with no material health problems or birth defects. She enjoyed normal development for the first 15 weeks. On Dec. 16, 2007, the plaintiffs' daughter began to suffer from a high fever, and she went to the ED. The baby initially was observed by the nurse with abnormal vital signs of elevated pulse of 190 beats per minute, elevated respiratory rate of 33 breaths per minute, and a high temperature of 103 degrees. The ED physician noted that he reviewed the nurse records and documented a history of fever, but nothing else. He then conducted and reported a normal exam, but he circled the preprinted finding of "abnormal tympanic membranes." He did not describe any findings in either of the baby's ears, nor did he even indicate which ear he suspected to be infected. He diagnosed the baby with a middle ear infection but otherwise joked with the parents that she was essentially too healthy to be in the ED. He discharged the baby with an antibiotic prescription, with the instruction to the parents to follow up with their regular pediatrician on an "as-needed" basis.

Three days later, the baby's father found her lethargic, cool to touch, and very pale in her crib. The baby's pediatrician sent her to a different hospital immediately, where she was diagnosed with pneumococcal meningitis and a hypoxic brain injury and hydrocephalus, caused by her infection. After discharge a month later, the baby suffered constantly and eventually died just after her second birthday due to respiratory insufficiency.

Plaintiffs sued and contended that the hospital and the doctor were negligent because the doctor had failed to evaluate the likelihood of a serious bacterial infection and did not exclude the possibility of bacteremia and meningitis. Plaintiffs alleged that a reasonable doctor would have at least ordered a complete blood count and a urinalysis, which were not done, and that abnormal test results would have caused additional evaluation, resulting in a correct diagnosis. The plaintiffs alleged that the doctor should have followed up with the patient in person within 24-48 hours.

Financial Disclosure: Financial Disclosure: Author Greg Freeman, Executive Editor Joy Daughtery Dickinson, and Nurse Planner Maureen Archambault report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Damian Capozzola, Jamie Terrence and Tim Laquer, co-authors, have no relevant relationships to disclose.

The defense position was that neither the hospital nor the doctor were negligent because the doctor had acted within the proper standard of care given the facts before him at the time, especially evidence suggesting that the most likely ailment was a simple middle ear infection. The defense maintained that plaintiffs could not prove that their daughter was suffering from meningitis at the time of treatment, and that the baby contracted meningitis after leaving the ED.

The jury rejected the defense arguments and found for plaintiffs in the amount of $1.7 million, representing $860,000 for economic damages and $860,000 for the baby's pain and suffering.

What this means to you: This case is an unfortunate lesson in not being complacent when confronted by what might seem to be routine presenting symptoms. Many fussy babies who present with high fevers do have a simple ear infection, and one can speculate that this doctor made up his mind upon learning the symptoms. Certainly the fact that the doctor didn't specify why he concluded as he did or even indicate which ear was likely infected suggests that he believed this was a routine case that did not warrant further investigation. Thus, one lesson here is that each case must be analyzed with the idea that it could be the outlier. Care must be taken to rule out the unlikely, and conclusions even of the likely diagnosis must be documented with an eye toward having a solid record for use in defending against any subsequent litigation.

Another lesson is that what likely seemed a jovial comment at the time that the baby didn't belong in the ED likely looked horrible and probably was repeated for dramatic effect (with sarcasm) again and again by the plaintiffs' lawyers. In the context of treating patients, every spoken word might someday be repeated with a life of its own. While a physician can have a cheerful bedside manner, it does caution in favor of thinking twice before giving a stray comment.

Note in particular that sepsis often is overlooked in all age groups because older adults might be essentially asymptomatic while young infants, the most vulnerable, often have very high fevers from relatively common viral or bacterial infections. However, sepsis always must be ruled out on all patients presenting to an ED with symptoms. It has become a standard of care in most hospitals.

The emergency physician in this case picked the easy path toward a simple diagnosis and never looked back, even though the infant presented with the three most common signs of sepsis: high fever, rapid heart rate, and rapid respiratory rate. In addition to inadequate documentation of what he saw and where he saw it, he did not make any attempt to support his assumption with diagnostic tests. A simple white count, blood cultures, and a serum lactate should have been ordered.

More generally, there is no place in medicine for untested assumptions. Where there is uncertainty, there must be continued probing and questioning. A second or even a third opinion from an expert often can bring clarity and alleviate doubt. Had the physician ruled out sepsis, the defense's argument that the infant contracted meningitis after discharge might have been relevant.

A final issue in this case was the discharge instructions given to the parents. Prescribing antibiotics indicates that the patient was suspected of having a bacterial infection. Follow-up to ensure that the correct antibiotic has been prescribed and that the patient's condition is improving rather than deteriorating is critical. Telling the parents to follow-up with their pediatrician "as needed" rather than "within 24 hours" or some other very short timeframe could well have directly contributed to the death.

REFERENCE:

D.O. No. 09-9629 (Berks Cty. Ct. of Common Pleas, PA, June 14, 2013). ■

$21.9 M award in elective steroid injection procedure

News: The patient, a 54-year-old woman, suffered from chronic and severe back pain, and she sought treatment at a medical facility. Under the advice and direction of a physician, she underwent an elective epidural steroid injection (ESI) aimed at relieving pain. However, while sedated, the patient's airway became blocked, which resulted in oxygen deprivation for as long as 10 minutes. Multiple electronic monitors indicated that the patient was not breathing properly, but the physician continued the procedure despite these indications. Emergency assistance was not called for more than an hour, and the physician failed to report to a subsequent treating hospital that the patient was deprived of oxygen for several minutes. As a result of the oxygen deprivation, the patient suffered severe brain damage, and she died six years after the procedure from complications related to the brain injury. The patient's surviving spouse and estate brought suit. They

alleged that the physician and his employer, as well as the medical facility and lead nurse, were negligent. The defense claimed a sudden stroke or other unforeseeable cause was the source of injuries. The jury awarded the widower and estate $21.9 million in damages.

Background: The patient chose to undergo an elective ESI, which is a routine, minimally invasive procedure designed to relieve pain. The patient was given propofol, a sedative which the patient had taken twice without issue. However, during this procedure, the patient's airway became blocked, and the patient's blood-oxygen levels became critically low. Two electronic monitors indicated the dangerous condition the patient was in, and nurses and operating staff warned the physician that the patient was not breathing. The physician continued the procedure. The patient was deprived of oxygen for as long as 10 minutes. Beyond this oxygen deprivation, the patient's blood pressure had dramatically dropped, and there was no detection of a pulse.

Emergency assistance was not called for more than an hour, even with the patient's critical condition. The patient eventually was transported to a different nearby hospital, which attempted treatment. The physician in charge of the ESI, however, did not report to the subsequent hospital that the patient had been deprived of oxygen for several minutes. As a result of the oxygen deprivation and other issues with the procedure, the patient suffered severe brain damage. She was unable to move or communicate except for blinking her eyes for "yes" or "no." This condition persisted for six years until the patient died of complications related to the brain injury.

The patient's surviving spouse and estate brought suit against four parties involved with the procedure: the lead physician, the physician's employer, the medical facility, and the lead nurse at the medical facility. The widower and estate alleged that the physician incorrectly decided to continue the procedure given the patient's lack of breathing and other warning signs and that this decision caused the severe oxygen deprivation and resulting brain damage. The plaintiffs argued that the patient likely suffered an adverse reaction to the sedative, which led to hypoxia, or dangerously low blood-oxygen levels, within minutes of the procedure's start.

Testimony during trial revealed that the physician arrived late to the procedure and that he appeared to be "impaired," both of which were reported to be common occurrences. The physician reportedly was diagnosed with cancer in 2005 and was taking medication at the time of the procedure. The defense's primary contention was that the patient suffered a sudden stroke or that another unforeseeable event caused the injury. Based on the patient's two prior uses of propofol without any complications, the defense claimed that the physician could not have reasonably predicted a complication with the sedative. The plaintiffs challenged the credibility of the defense's expert, an anesthesiologist who was a friend and colleague of the lead physician, as the expert had no experience with ESI procedures. The jury found three of the four defendants liable: 50% for the physician, 30% for the first medical facility, 20% for the physician's employer, and no liability for the lead nurse. The jury awarded $21.9 million but did not award punitive damages.

What this means to you: The primary cause of liability in this case for the physician was inflexibility. The physician failed to heed signs that indicated that a change was required. Providers must be conscious of warning signs that might indicate that a procedure is not going normally or within acceptable bounds. Some deviation is likely acceptable, but ultimately the question with medical negligence becomes what would a reasonable physician have done in the same or similar circumstances. If there are minor warning signs that oxygen levels are low, but not to critical points, a reasonable physician might continue and watch the monitoring systems closely to determine whether or when to discontinue the procedure and instead stabilize the patient. This step might be particularly relevant to elective procedures such as ESI. The patient is not in an emergency situation in which halting the procedure itself might cause even more serious injury, so delaying treatment might be the best solution. In this case, the monitors as well as the OR staff and nurses trained to assess the patient's condition during the procedure all warned the physician that the patient was in respiratory distress.

A temporary drop in blood pressure might be tolerated for a short time by a relatively young and healthy patient. However, a compromised airway, whether caused by a blockage or the drug-induced depression of the patient's respiratory drive, is an emergency situation that must be immediately corrected. Resuscitation procedures were more important than continuing the epidural injection.

Federal and state laws require that a crash cart be within easy reach of the surgical team and that there are

individuals present who are trained to use it. The crash cart has emergency equipment including a defibrillator to correct lethal cardiac arrhythmias and supplies to intubate and mechanically ventilate the patient. Finally, once the physician realized that this patient's medical condition had deteriorated to a point beyond his ability to deal with it, the delay to get the patient to a higher level of care was very problematic, especially when complicated by his purposeful or unintentional failure to notify the receiving facility of the circumstances surrounding the patient's condition.

There is also a chain of command that most nurses are trained to use in the event that a physician is engaged in unsafe practices. Sometimes the very act of threatening to inform a person in authority is enough help the physician recognize and correct the dangerous situation, and physicians need to be trained to accept such situations gracefully. The facility staff members here likely should not have stopped with just the verbal warning to the physician, which might be why the facility also was found liable.

Another lesson from this case is be on time, and be physically and mentally prepared for an operation. We all inevitably have some time when we go to work with something else on our minds, and this situation is difficult to prevent. For providers, though, this circumstance might lead to a dangerous situation. A physician who is distracted might not be completely dedicated to the patient and, instead, might be thinking about a personal matter. This physician reportedly was distracted and might have been impaired, which raises more serious concerns as to the fitness of a physician to perform his responsibilities. Personal issues clouding judgment or distracting providers can cause serious, even fatal, injuries. Impairment, including narcotic impairment, results in seriously compromised decision-making and reflexes that can be disastrous in any medical context, but especially in a surgical procedure that is difficult even without unnecessary handicaps. Once again, the surgical team, upon recognizing a physician's possibly compromised physical or mental condition, had an opportunity to intervene and convince the physician to postpone the procedure. While canceling operations might not be viewed with favor, it is a far better option than attempting them while impaired or seriously distracted to a level that compromises a physician's decision-making or reflexes. Performing while impaired is a recipe for disaster and liability.

Expert witnesses are a critical element of almost all medical malpractice cases. Experts must be chosen wisely. An injured plaintiff, via his or her counsel, potentially will challenge the credibility of your experts, which makes choosing a likeable, believable, and credible witness all the more difficult. The physician chose a friend as his expert, and this friend didn't perform ESI (epidural) procedures. Both of these conditions created an easy target for the plaintiff's counsel to attack and point out to the jury that this expert might simply be trying to protect his physician friend, and with little actual knowledge as to the medical standard of care expected during ESI procedures. If the physician had looked outside his circle of friends for a third party who was familiar with the ESI standards used in this case, he might have had a better likelihood of persuading the jury that he met the appropriate level of care. Juries are invariably suspicious of experts who often can be seen as "hired guns," individuals paid to say what needs to be said on the stand and who are handsomely compensated for these words. Convincing the jury that your expert is honest and not simply spinning a smooth story is often critical to a successful defense, and working with counsel to choose the right expert for a particular case can be complicated. Also, it is critical to retain the right expert or experts as early in the case as possible so they can help shape discovery and pretrial efforts. They should not have to write an expert report or give expert testimony at deposition or trial without all of the necessary information.

Finally, legal treatments of punitive damages for medical malpractice vary by state, but the general requirement focuses on intentionality. Punitive damages seek to punish an offender for what is viewed as willful misconduct. It is a difficult burden to achieve for a plaintiff, particularly because medical malpractice focuses on negligent behavior rather than intentional behavior. Negligence does not require any intent to cause harm, but it relies upon an individual's duty to another which is breached and causes harm. However, if a plaintiff can prove that the care provider intentionally caused harm to the patient, then punitive damages might be warranted.

The jury initially stated that punitive damages were warranted, but awarded zero dollars. The attorneys for the patient and the defense speculated that this zero award was caused by the high compensatory award of nearly $22 million, thus perhaps the jury viewed the $22 million as sufficient.

REFERENCE:

State Court of Fulton County, GA. Case Number 10EV010621. Jan. 26, 2015. ■