HEALTHCARE RISK MANAGEMENT™

THE TRUSTED SOURCE FOR LEGAL AND PATIENT SAFETY ADVICE FOR MORE THAN THREE DECADES

INSIDE

Advice for reducing your liability with diagnosis . . . . . Cover

Increase in public data might mean trouble for your facility. . . . 54

Electronic, anonymous system improves reporting 55

Triple Aim brings benefits to health system. 56

EHR failures hit several facilities . . . 58

$10 million settlement for allegation of kickbacks 59

Enclosed in this issue:

- Legal Review & Commentary
- HIPAA Regulatory Alert
- 2015 Reader Survey

AHC Media

MAY 2015 Vol. 37, No. 5; p. 49-60

Costly diagnosis delays can be avoided with good practices

Delays in diagnosis are the most common and most costly malpractice claims, yet healthcare organizations still struggle to ensure that patients are properly diagnosed and notified in a timely manner. Patient safety experts are finding that system failures are more responsible for diagnosis errors than simply mistakes by individuals.

The risks posed by delays in diagnosis are clear. According to PIAA in Rockville, MD, the five types of cases that most commonly result in malpractice lawsuits for family physicians all involve errors in diagnosis due to delays in diagnosis. The PIAA also has data showing that the most expensive and common claim against physicians is a delay in the diagnosis of breast cancer. PIAA is an insurance trade association representing domestic and international medical professional liability insurance companies, risk retention groups, captives, trusts, and other entities. *(For more on the incidence of delay in diagnosis and the resulting liability, see the stories in this issue.)*

"IF YOU LOOK AT THE TOP FIVE DIAGNOSIS CLAIMS, THEY WERE ALL FOR FAIRLY COMMON ILLNESSES LIKE BREAST CANCER."
— DAVID B. TROXWEL, MD, THE DOCTORS COMPANY

Data collected by The Doctors Company, a malpractice insurance provider in Napa, CA, indicate that reducing delays in diagnosis can have a significant impact on patient safety and malpractice-related costs, says Medical Director **David B. Troxel**, MD. Troxel is a researcher on the issue of delays in diagnosis causing malpractice suits. In a recent article, "Diagnostic error in medical practice by specialty," he analyzes the types of diagnosis-related errors that are most

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.

HEALTHCARE RISK MANAGEMENT™

Healthcare Risk Management™,
ISSN 1081-6534, including HRM Legal Review & Commentary™ is published monthly by
AHC Media, LLC
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326.

Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.
GST Registration Number: R128870672.

POSTMASTER: Send address changes to:
Healthcare Risk Management
P.O. Box 550669
Atlanta, GA 30355.

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
customerservice@ahcmedia.com.
www.ahcmedia.com

SUBSCRIPTION PRICES:
U.S.A., Print: 1 year (12 issues) with free CE nursing contact hours, $519. Add $19.99 for shipping & handling. Online only, single user: 1 year with free CE nursing contact hours, $469. Outside U.S., add $30 per year, total prepaid in U.S. funds.

MULTIPLE COPIES: Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $87 each. (GST registration number R128870672.) Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.

ACCREDITATION: AHC Media, LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.
This activity has been approved for 1.25 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 1.25 Contact Hours.

This activity is valid 24 months from the date of publication.

Healthcare Risk Management™ is intended for risk managers, health system administrators, and health care legal counsel.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

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.

common in each specialty. *(The article is available online at http://tinyurl.com/qhfpavq.)*

Of the 7,500 claims in the database filed between 2007 and 2013, a quarter of them involved a diagnosis delay or error. The problem occurs most frequently with non-surgical physician practices because those practices are where most diagnoses are made, he notes. For family practice physicians, almost 40% of their claims involved misdiagnosis, and 20% involved missing breast cancer.

When Troxel and his colleagues drilled down to see why the errors were made, they found that they could be placed in several categories: the assessment of the patient, such as the breast exam that can detect breast cancer; type of test ordered; the notification of the patient; and the follow-up process. "If you look at the top five diagnosis claims, they were all for fairly common illnesses like breast cancer," Troxel says. "They weren't exotic or unusual diagnoses that you might understand why any physician missed. They were fairly common issues like a heart attack, something most physicians should be able to diagnose."

Patient notification and follow-up are where risk managers might make the most difference, Troxel says. The other factors involve physician decision-making, but risk managers can influence the policies and procedures concerning patient notification and confirming whether a patient has followed up on treatment and diagnostic tests, he says. "Obviously risk managers can't do very much about the provider's original assessment of the patient, but risk managers can lead the way in assessing and improving processes," he says. "This involves the systems you have in place for ensuring that the patient doesn't fall through the cracks or that a diagnosis documented in the hospital or physician practice was not conveyed to the patient."

A little known risk related to diagnosis error involves trauma patients. **Akram Alashari,** MD, a trauma surgeon and surgical intensivist in the Surgical Critical Care department at the University of Florida in Gainesville, explains that a delay in diagnosis occurs frequently with trauma patients. "This is because the trauma patient often has multisystem organ injury and multiple fractures, inevitably leading to a missed injury," Alashari explains. "In addition, we often see incidental findings on imaging studies such as previously unknown tumors that can be overlooked and can also lead to a delay in diagnosis."

With the trauma care overriding all other concerns until the patient is stabilized, those findings can be

EXECUTIVE SUMMARY

Delays in diagnosis are the most common allegation in malpractice claims. They carry the potential for significant liability because the delay can inflict great harm on the patient.

- Delays in diagnosis claims are among the most expensive.
- Trauma patients might require a specific plan to reduce missed diagnoses.
- Policies and procedures must require an immediate, well-documented notification for abnormal results.

ignored or not properly noted in the record, he says. Then the newly discovered tumor, for example, is not addressed when the patient survives the trauma.

"One of the techniques we use to mitigate the risk of a delay in diagnosis is to perform a tertiary review of every imaging study with radiology and make sure that there is an established plan for every injury as well as incidental finding," Alashari says. "In addition, we make sure that the appropriate consult is in place for the specific entities such as orthopedic surgery or cardiology and confirm that they have left their documentation in the chart. We also make sure that their recommendations were implemented. This all must occur before the patient is discharged from the hospital."

Monitor referrals closely

Of all breast cancer claims in The Doctors Company database, about 90% were related to diagnosis errors, Troxel says. Misdiagnosis is not common, but failure to diagnose and delay in diagnosis account for most breast cancer claims, he says. But what were the root causes of those diagnostic errors?

Troxel found that a third of those claims could be traced to communication problems between the doctor and patient, the doctor and the mammography provider, or the doctor and the specialist to whom the patient was referred.

"I was surprised to see also that roughly 30% of the time the problem was traced to the patient failing to follow up with an appointment or failing to get the testing that was advised," he says. "That indicates a need for better systems to ensure that a referral actually takes place and to be notified if it doesn't. When a woman is told that the lump is small and she is at relatively low risk for breast cancer, a surprising number are so relieved that they don't follow up with the mammography."

In addition to systems that notify the physician if a patient does not follow through, risk managers also should implement a process for ensuring that the physician actually sees the report, Troxel notes. Sometimes a report can get filed in the patient's chart without the doctor ever seeing it, he says.

"... ROUGHLY 30% OF THE TIME THE PROBLEM WAS TRACED TO THE PATIENT FAILING TO FOLLOW UP WITH AN APPOINTMENT OR FAILING TO GET THE TESTING THAT WAS ADVISED."

"It seems that shouldn't happen often, but we know it does occur because we see the resulting claims," Troxel says. "A mammogram came back with suspicious calcifications, a biopsy was recommended, and the doctor never saw the report. Imagine how hard it would be to defend that claim."

The solution can be as simple as having a master suspense file for the practice or hospital outpatient center, he explains. Patients sent for testing are entered in the suspense file as pending, and the file is checked every day to see whose exams should have been received already. If it seems the report is late, staff can follow up to confirm that the test was performed and find out when the results will be available.

Some electronic health records (EHRs) can automate that process, but Troxel cautions that they are not foolproof. EHRs have been known to file lab and other test reports in the wrong part of the patient's electronic record, rather than the place where the physician typically will look for them, he says. That mistake results in the report becoming part of the record without the physician ever having a chance to act on it.

Policies should require that test results be sent directly to the physician who ordered the test, says **Ann Whitehead**, RN, JD, vice president of risk management and patient safety at the Cooperative of American Physicians (CAP), a malpractice insurance provider in Los Angeles. Particularly with some large physician practices or hospital-based clinics, results might be funneled to another person who is responsible for charting them or sending them on to the ordering physician. That system introduces an opportunity for the results to be misdirected or filed without the doctor's knowledge. *(See the story in this issue for more of Whitehead's advice on reducing diagnostic errors.)*

"It also is important to have direct physician-to-physician contact any time there is an abnormal or unusual diagnosis," she says. "Those results should not just be put in the pipeline for delivery like everything else."

Another simple strategy is to have a rule that all mammography and other critical reports cannot be filed in the patient's chart until it has been initialed and dated by the physician, Troxel suggests.

"It's surprisingly simple things that can counter such a common problem and one that has such a negative impact on a healthcare organization," he says.

SOURCE

- Ann Whitehead, RN, JD, Vice President of Risk Management and Patient Safety, CAP, Los Angeles. Email: ann.whitehead@capphysicians.com. ■

Process is key to reducing diagnosis claims

Policies, procedures, and processes are some of the tools most commonly used by risk managers, and nowhere are they more important than in avoiding claims related to delays in diagnosis.

Having the proper processes and procedures in place can greatly reduce the chance of a diagnosis being missed or delayed, says **Ann Whitehead**, RN, JD, vice president of risk management and patient safety at the Cooperative of American Physicians (CAP), a malpractice insurance provider in Los Angeles.

"A physician's failure to diagnose in a timely manner tops the chart as the most common allegation in medical professional liability lawsuits," she says. "This is why it is very important for every physician, clinic, or hospital to establish a consistent process for tracking results." Whitehead suggests focusing on these key areas to strengthen the diagnosis monitoring process:

- **Clear communication:** Devise a system that notifies every patient of every result. Never allow clinicians to use the "no news is good news" policy, in which the patient is told he or she will be contacted only if the test result is problematic.
- **Notification:** Establish a simple, standardized system for notifying patients of normal and abnormal test results, and document that communication process clearly. Every attempt to contact the patient should be documented in the record.
- **Legible notes on lab sheets:** For normal or non-urgent abnormal results, physicians should initial, date, and provide instruction for the patient follow-up on the actual laboratory result sheet.
- **Immediate action on abnormal results:** All urgent abnormal results should be immediately directed to, and followed-up by, the physician. These reports also should be dated and initialed by the physician or an advanced practice professional.
- **Empower patients:** Empower patients to serve as a double check system. Patients should be educated about what tests are being ordered, the purpose of the test, and when and how the results will be relayed. Give them a specific timeframe to expect the results, and direct them to call the office if they haven't received their results. ■

PIAA: Most commonly missed or delayed diagnosis: breast cancer

The most common allegation in breast cancer claims was errors in diagnosis, according to a 2014 study from PIAA in Rockville, MD.

Diagnostic errors resulted in a payment 44% of the time. The total indemnity exceeded $220 million of the $297 million total paid out for all breast cancer claims during the study period.

Overall, 70% of claims reported to the PIAA closed with no indemnity payment, with a 30% paid-to-close ratio (the percentage of closed claims that resolved with a payment to the plaintiff).

From 2002-2011, a total of 2,157 closed claims naming female breast cancer were compiled in the PIAA Data Sharing Project (DSP), the world's largest independent research database on malpractice litigation. With an average 33% paid-to-close ratio, breast cancer claims had the largest total indemnity payment, which was $297 million. The data come from the *PIAA Breast Cancer Study, MPL Cancer Claims Miniseries: Volume 1*.

Specialty-specific data were analyzed in terms of the average and largest indemnity payments made in breast cancer claims. An indemnity payment to a claimant includes an amount that might be deemed equivalent to the costs required for economic recovery and for damages incurred during the resolution of a claim. Claims were further characterized by noting the presence of one of 28 possible chief medical factors.

Radiologists were named as the top physician specialty for breast cancer claims, with mammography cited as the top procedure involved. Diagnostic errors ranked as the top alleged error associated with breast cancer, with a relatively high (44%) payment ratio. In more than half of the breast cancer claims (59%),

patients presented with something other than breast cancer as their initial reason for the medical visit, but the resulting medical condition was breast cancer.

Five medical specialties were named in 87% of all medical professional liability (MPL) breast cancer claims stored in the DSP: radiologists, obstetric/gynecologic (OB/GYN) surgeons, internal medicine physicians, and general surgeons. The average indemnity paid for claims involving radiologists was $433,668. However, for OB/GYN surgeons, it was 2% higher: $443,458. Radiologists were named in 43% of the total of all closed claims, with a 39% paid-to-close ratio, and the highest total indemnity: more than $155 million. OB/GYN surgeons were associated with the second-highest number of closed claims: 16%. The ratio of paid-to-close claims was 29%; the total indemnity exceeded $44 million.

Although errors in diagnosis were linked with the highest reported number of closed claims (1,122), failure to supervise or monitor a case had the highest average indemnity, $519,417, followed by delay in performance, $487,321. The full breast cancer report is available for purchase on the PIAA web site at http://tinyurl.com/l9o6r2l. ■

Assessment failures lead to diagnostic errors

In most cases, a diagnostic error can be traced to a failure in assessing the patient, according to the results of CRICO Strategies' 2014 annual benchmarking report *Malpractice Risks in the Diagnostic Process.*

The report from the Cambridge, MA-based insurer is the product of analyzing more than 4,700 cases filed from 2008 to 2012 alleging malpractice that put patients at risk of a missed or significantly delayed diagnosis. While the majority (58%) of these cases highlight assessment failures, the analysis explores the entire diagnostic process to help identify where breakdowns most commonly occur.

Another 29% of the cases were traced to faults in testing and results processing. Forty-six percent were related to follow-up and coordination of care.

"Relatively scant attention has been paid to errors during the diagnostic process which, according to the data from the Comparative Benchmarking System (CBS), are more common than obstetrical errors, and more costly than surgical cases," Crico President **Mark E. Reynolds** said in a statement accompanying the report. "This analysis opens our eyes to where and when diagnosis-related errors most commonly occur, and furthers discussion about the changes necessary to prevent them."

The full report is available online at http://tinyurl.com/odtsqxu. ■

Jury awards $28.2 million for delay in diagnosis

In a case that illustrates the potential liability of delays in diagnosis, a Los Angeles jury recently awarded a woman $28.2 million in future medical expenses, future loss of earnings, and pain and suffering after a four-week trial in Los Angeles Superior Court that focused on a delay in diagnosis.

The jury ruled that Kaiser Permanente was liable for mishandling Anna Rahm's medical treatment, which resulted in the loss of her right leg, half of her pelvis, and parts of her spine. The case was tried by Michael J. Bidart, JD, and Danica Dougherty, JD, of the Claremont office of the law firm Shernoff Bidart Echeverria Bentley.

In August 2008, at age 16, Rahm began experiencing lower back pain. The pain began radiating down her right leg in January 2009. After unsuccessful chiropractic treatments in February 2009, her chiropractor urged her to go to Kaiser Permanente to obtain an MRI, her lawsuit states. Rahm and her mother went to Kaiser Permanente in Woodland Hills in March 2009 and saw her primary care physician and physical medicine specialist.

Between March and June 2009, the Rahm family repeatedly requested an MRI from their treating physicians at Kaiser Permanente, her lawyers claim. Both doctors refused to order an MRI, failed to document the MRI request in the medical records, and then claimed at trial that Rahm and her mother had never requested the MRI.

After Rahm's mother became incensed, Kaiser Permanente finally relented and ordered an MRI, which was performed on July 2, 2009. Unfortunately, it revealed that she had an extremely aggressive tumor mass in her pelvis known as osteosarcoma. After months of chemotherapy, Anna underwent surgeries lasting a total of 22 hours during which her right leg, half of her pelvis, and a portion of her spine were removed. ■

Increase in public data could prompt litigation against your healthcare facility

When legal changes led to a flood of healthcare-related information being released to the public in the 1990s, a wave of lawsuits against long-term care providers followed. With more data than ever available to the public now, risk managers should brace for the possibility of another increase in litigation that could hit a broader segment of the industry.

The lawsuit surge in the 1990s caused professional liability claim costs to soar from $200 per bed to more than $10,000 per bed in some instances, says **Jeffrey Smith**, senior vice president and healthcare leader with Lockton, a risk management consulting firm based in Atlanta.

Plaintiffs became skilled at using state survey scores against skilled nursing facilities when making claims of malpractice or neglect, which resulted in verdicts of more than $100 million in some cases, Smith says. Healthcare providers responded by improving organizational structure, pushing for tort reform, increasing use of alternative dispute resolution, increasing investment in quality initiatives, and reducing insurance limits. Those strategies calmed the waters for a while, but now the Affordable Care Act (ACA) is providing plaintiffs with more publicly available data.

"It was publicly available quality data that drove a lot of this litigation in the '90s. This information can and will be used by attorneys and other professionals who selectively pick certain damaging details to use against providers," Smith says. "Jury verdict sizes in medical malpractice claims against hospitals could meet the same fate as those against nursing homes."

ACA dramatically increased the amount of regulatory oversight regarding nursing homes and makes regulatory supervision and inspection reports more widely available to the public, Smith explains. As required by the law, the Centers for Medicare and Medicaid Services began adding a vast amount of information to the Nursing Home Compare website, including the outcome of substantiated complaints and links to Internet sites citing deficiencies and plans of correction. More information about hospitals' care of patients is now available to the public through the Hospital and Physician Compare website (http://tinyurl.com/ltulslo) and will continue to increase in the coming years.

> ... THE AFFORDABLE CARE ACT IS PROVIDING PLAINTIFFS WITH MORE PUBLICLY AVAILABLE DATA.

Smith says these are the types of publicly available data that should be of most concern to healthcare risk managers:

- risk-adjusted quality based reimbursements;
- hospital readmissions;
- hospital-acquired conditions;
- patient surveys;
- care transitions.

Some of the information, such as patient surveys, doesn't have a direct role in plaintiff litigation, but Smith says that situation is only because the attorneys haven't figured out a way to use them. It takes only one judge to admit the information as evidence to open the door for other lawsuit, he says. "It's not a question of if, it's a question of when," Smith says. "In the coming years we will find out how this data can be used creatively by plaintiffs' attorneys."

In addition, Smith says, plaintiffs are attempting to bring in conditions of participation (CoPs) applicable to hospitals in negligence per se claims, as evidence of the standard of care. Courts have been inconsistent in deciding whether to allow CoPs as

EXECUTIVE SUMMARY

The amount of healthcare-related data available to the public is increasing at a rapid pace. Some analysts are concerned that the newly available data could lead to more litigation for healthcare providers.

- The Affordable Care Act is resulting in more data being available to the public.
- A similar increase in litigation occurred after state survey scores were released.
- Conditions of participation are a particular area of concern.

evidence, but Smith says he fears the trend is to admit them as the standard of care. That trend means health system risk managers must bolster their basic knowledge of CoPs and understand the extent of their expertise to manage those risks.

"Areas such as data monitoring, strategic ties to public data, hiring considerations, and survey readiness preparations are some of the starting points for risk managers to assess," Smith says. "This can help create a baseline in preparation for the potential landslide of lawsuits that appear to be on the horizon."

The availability of data is closely tied to the use of social media, which poses additional risks, notes **Angela Matney**, JD, an attorney with the law firm of Hirschler Fleischer in Richmond, VA. The patient who uses social media and has a question about the available data, for example, could put healthcare professionals in a difficult position. "Healthcare providers want to take advantage of social media to promote patient satisfaction and facilitate communication, but at the same time, they have to take precautions," Matney says. "Contact through social media shouldn't happen until you have written consent from the patient, and then you should also document any interaction you have with the patient through social media."

Matney also urges healthcare organizations to educate employees about the dangers of posting information on social media sites.

"They need to be educated and reminded often about how easy it is to post protected health information and violate someone's privacy," she says. "A lot of times people think that they have deleted names and other information, so that makes it safe, or they think it's not going to be seen because they marked it private. Those misconceptions can lead to serious problems for both the employee and the healthcare organization." *(For more on social media, see "Sexting in surgery, Facebook post among latest problems,"* Healthcare Risk Management*, August 2014, p. 79.)*

SOURCES

- Angela Matney, JD, Hirschler Fleischer, Richmond, VA. Email: amatney@hf-law.com ■

Study up on conditions of participation, public data

The increasing amount of public data on healthcare organizations might bring lawsuits using that information against you, so it would be wise to prepare yourself for how those claims might take shape.

For example, plaintiffs' attorneys are eager to admit into evidence conditions of participation (CoPs) as the standard of care, so risk managers should study them now, suggests **Jeffrey Smith**, senior vice president and healthcare leader with Lockton, a risk management consulting firm based in Atlanta.

Risk managers will need a basic knowledge of CoPs and need to understand whether and to what extent they have the expertise and authority to manage those risks, Smith says.

Regarding other types of publicly available data, he suggests risk managers answer these questions as a way to prepare for the lawsuits they might produce:

• Who within the organization monitors the publicly available hospital and physician data and the Hospital Compare and Physician Compare websites?

• Are the quality or performance improvement strategies of the organization tied to the public data?

• Is physician data taken into account when hiring or credentialing physicians?

• Is risk management involved in survey readiness preparations? ■

Electronic reporting, anonymity improve reporting

Incident reporting appears to improve when employees are provided an anonymous method, according to the experience of Montefiore Medical Center in Bronx, NY.

The use of the anonymous reporting system grew out of the hospital's adherence to the Agency for Healthcare Research and Quality's Common Formats method of incident reporting. Patient safety organizations — Montefiore is a member of one — are required to collect and analyze data in a standardized manner, and the Common Formats method helps providers uniformly report patient safety events and aims to improve healthcare providers' efforts to eliminate harm.

One of the options included in the Common Formats is anonymous reporting, and Montefiore included that method when it implemented the MIDAS+ incident reporting system from Midas+ Solutions in Tucson,

AZ, in 2012. Among other features, the system enables hospital staff to submit anonymous incident reports of patient safety issues for analysis and improvement. The previous process at Montefiore had employees filling out a one-page paper form.

A big increase

Transitioning to the electronic reporting system greatly increased the quantity and quality of reporting, says **Jason Adelman**, MD, patient safety officer at Montefiore. Adelman did not specify specific numbers but said the increase was more than he expected and made him realize that many safety concerns had gone unreported in previous years.

The quality of the reports improved because the anonymity, and the ease of reporting electronically, prompted people to share their concerns more fully, with details that typically were not provided in earlier reports.

Not all of the reports are anonymous, and Adelman says it is unclear how much of the increase in reporting was due to that feature. However, he says he suspects the anonymous feature has led to the reporting of some incidents that might have gone unknown. "The message we send is that we are interested in finding out what the system problem was that allowed that error or that near miss to occur, not to punish the person who made a human error," Adelman says. "Anonymous reporting is a way to encourage that."

Protocol at Montefiore requires the staff member who becomes aware of a safety issue to complete a written report through the MIDAS+ system, from which trending and investigation reports are produced. Incident reporting is required for unsafe conditions, near misses, and adverse events resulting in actual harm to a patient. Montefiore's data is shared with the ECRI Institute's web-based Patient Safety Organization (PSO), where it is merged and compared to the error reports from healthcare institutions nationwide. Data from the ECRI PSO is used by Adelman and colleagues in developing and testing appropriate interventions, such as efforts to reduce wrong-site errors and medication mistakes.

> "WITH EVERY MEDICAL ERROR ROOT CAUSE WE IDENTIFY, WE ARE SAVING LIVES, AND OUR PHYSICIANS ARE A CRITICAL LINK ..."

"With every medical error root cause we identify, we are saving lives, and our physicians are a critical link to helping us identify those causes," Adelman says. "There are many vendors and systems you can use for incident reporting, but my main recommendation is to use the Common Formats in whatever system you choose." *(More information on AHRQ's Common Formats is available online at http://www.pso.ahrq.gov/common.)*

SOURCE:

- **Jason Adelman**, MD, Patient Safety Officer, Montefiore Medical Center, Bronx, NY. Email: jadelman@montefiore.org. ■

EXECUTIVE SUMMARY

Reporting of adverse events, near misses, and patient safety concerns might be improved by providing a way for employees to report anonymously. One hospital has seen significant improvements after employing such a system.

- Electronic reporting might significantly increase the quantity and quality of incident reports.
- Anonymous reporting encourages reports that otherwise might be unknown.
- Using Common Formats helps improve patient safety across all organizations.

Hospital meets Triple Aim goal, improves safety

In its efforts to achieve the Triple Aim quality goal, Lafayette (LA) General Health has implemented flexible systems, along with standardized equipment and monitoring solutions that improve patient safety and overall quality at the health system.

The Triple Aim is a framework for healthcare improvement based on three primary goals: improving the patient experience, improving

the health of populations, and reducing the per capita cost of healthcare. *(See the story in this issue for more information on Triple Aim.)* Implementing a new electronic record and electronic monitoring system from Welch Allyn was a significant step forward for the Lafayette hospital, says **Jamie Gonzales**, RN, BSN, clinical educator at Lafayette General Health.

The new monitoring system was only part of the effort, Gonzales says. One task was to gain a better understanding of the patient experience and to improve that experience. A better interaction among staff also was desired, so Lafayette asked employees to define what they expect from their coworkers. The health system educated frontline staff on the importance of small gestures such as introducing themselves properly to patients and coworkers.

"It was the little tiny things that overall made a huge impact on the perceptions of both patients and employees," Gonzales says. "Our quality measures weren't what we wanted, so we started making rounds daily through every single floor, even on the weekend, to ensure that every single core measure was met and no one was left behind."

Much of the improvement effort focused on empowering nurses. Lafayette also implemented hourly rounding by nurses, which reduced falls and improved outcomes overall, Gonzales says. The clinical education department was completely rebuilt to provide more thorough and ongoing education beyond initial orientation.

The new electronic system provides more real-time monitoring to detect early changes to vital signs, bed exits, pressure ulcers, and respiratory failure. This monitoring has led to 75% reduction in mortality rates and 40% reduction in cost of care. Custom alarms also alert staff before the trouble occurs, such as when a patient is trying to exit the bed. Vital signs errors have been reduced by 75%.

For a typical 200-bed hospital, this change alone can equate to savings of $2 million in operational costs, says **Garrison Gomez**, senior director of vital signs and cardiology for the United States and Canada at Welch Allyn in Skaneateles Falls, NY.

SOURCES

- Jamie Gonzales, RN, BSN, Clinical Educator, Lafayette (LA) General Health. Telephone: (337) 289-8665. Email: jdgonzales@lgh.org.
- Garrison Gomez, Senior Director of Vital Signs and Cardiology, U.S. & Canada, Welch Allyn, Skaneateles Falls, NY. Telephone: (315) 554-4049. Email: garrison.gomez@welchallyn.com. ■

EXECUTIVE SUMMARY

Improved monitoring has helped Lafayette General Health improve outcomes. The effort was part of the hospital's goal to achieve the Triple Aim.

- Vital sign errors were reduced by 75%.
- Infection control has improved.
- The patient experience has improved, partly through a reduction in vitals documentation.

Triple Aim pursues higher quality, lower costs

The possibility is high that you will be hearing more about Triple Aim as hospitals adopt this approach to quality improvement. The Triple Aim is a framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimizing health system performance.

It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, which it calls the Triple Aim:

- improving the patient experience of care (including quality and satisfaction);
- improving the health of populations;
- reducing the per capita cost of healthcare.

In most healthcare settings today, no one is accountable for all three dimensions of the Triple Aim, IHI notes.

"Because the IHI Triple Aim entails ambitious improvement at all levels of the system, we advocate a systematic approach to change," IHI writes. "Based on six phases of pilot testing with over 100 organizations around the world, IHI recommends a change process that includes identification of target populations, definition of system aims and measures, development of a portfolio of project work that is sufficiently strong to move system-level results, and rapid testing and scale up that is adapted to local needs and conditions." More information about IHI's Triple Aim is available online at http://tinyurl.com/ozb49nd. ■

Medical malpractice payout amounts increase

For the second consecutive year, medical malpractice payouts increased more than 4% from the previous year, according to an analysis Diederich Healthcare conducted of the medical malpractice payout data provided by the National Practitioner Data Bank. Diederich Healthcare is a division of Diederich Insurance Agency, which provides comprehensive medical malpractice insurance and consulting services.

After seeing a steady decline in medical malpractice payout amounts from 2003 through 2012, malpractice payouts started to rise in 2013 and continued to rise at a steady pace in 2014, which marks a trend of increased medical malpractice payouts in the United States.

The National Practitioner Data Bank (NPDB) data in 2014 saw an increase of 4.4% in total payout amounts, which brought the total closer to the $4 billion mark. In fact, if the trend continues, 2015 could be the year that the United States crosses the $4 billion threshold.

Several states saw a decrease in medical malpractice payout amounts, such as California and much of the western area of the United States. However, most states saw an increase, particularly states in the South and the Northeast.

New York is again the highest state in terms of per capita payouts at $36.15. The Northeast as a whole had a per capita payout rate of $28.20, which is more than three times greater than the next highest region (the Midwest).

The full payout analysis is available online at http://tinyurl.com/nh2q5dw. ■

EHR failures create havoc for hospitals

The wide adoption of electronic health records (EHRs) and other electronic systems inevitably means that healthcare facilities will have to cope with outages. Several facilities recently have experienced how much the failure of one of those systems can cripple a hospital.

Registered nurses at Antelope Valley Hospital in Lancaster, CA, have asked the Los Angeles County Department of Public Health (DPH) to investigate the failure of an electronic health records system at their hospital, which they say led to the closure of the hospital emergency department and multiple other problems that put patients at risk.

In a message to the Los Angeles DPH office, Antelope Valley nurse **Maria Altamirano**, RN, reported that "our entire electronic and data system failed." She was speaking on behalf of other nurses who are members of the California Nurses Association/National Nurses United.

Antelope Valley Hospital issued a statement confirming that the hospital experienced a "rare information system outage" but said the issue was quickly identified and did not compromise patient safety. The emergency department continued to treat patients during the outage, the hospital stated.

The nurses' union contends that the outage created problems with properly dispensing medications; verifying physician orders; reviewing patient labs, MRIs, and other diagnostic procedures; and led to an inability for clinicians to review patient records.

Boston Children's Hospital's system also experienced an outage recently that affected lab orders, pharmacy work, and electronic prescription writing. Digital imaging, patient registration, and scheduling continued to run, according to a hospital statement.

"The outage was quickly identified, and the staff quickly shifted to patient care services that don't rely on electronic systems, such as face-to-face communications, direct hand-offs, read backs and running pharmacy notes from floor to pharmacy," according to the hospital statement.

The Boston Globe reported that the outage was caused by a hardware issue related to storage. **Rob Graham**, a spokesman for the hospital, told the *Globe* that less than five elective medical admissions were postponed, and all surgeries continued as planned. The incident was the longest outage the hospital has experienced with that health record system, he said.

COMING IN FUTURE MONTHS

- Inmate escape highlights armed security
- Stark settlements increasing
- Electronic records and malpractice risks
- Wrong-site surgery still a threat

In August 2013 an EHR system at several Bay Area hospitals operated by Sutter Health went completely dark for hours, which required nurses and doctors to effectively work without any access to patient information, including what medications patients were on or needed, patient history information that informs treatment options, and all other information required for safe patient care delivery.

Rideout Memorial Hospital in Marysville, CA, also reported a system blackout recently that was traced to a burned-out heating unit at an off-site data center. Patient records were not available, and email was not functional during the shutdown. ■

System pays $10M to settle FCA allegations

Robinson Health System has agreed to pay $10 million to settle claims that it violated the False Claims Act (FCA), the Anti-Kickback Statute, and the Stark Statute by engaging in improper financial relationships with referring physicians, the Justice Department announced recently.

Robinson is a nonprofit corporation based in Ohio that operates healthcare facilities in Portage County, OH, including Robinson Memorial Hospital. The settlement involved Robinson's financial relationships with referring physicians that allegedly violated the Anti-Kickback Statute and the Stark Statute, which restrict the financial relationships that hospitals may have with doctors who refer patients to them, said Acting Assistant Attorney General **Benjamin C. Mizer** of the Justice Department's Civil Division in announcing the settlement.

These relationships included management agreements that Robinson had with two physician groups. According to the Justice Department, the physicians allegedly failed to provide sufficient bona fide management services to have justified the payments that they received. Robinson disclosed these issues to the government.

"The Department of Justice has longstanding concerns about improper financial relationships between health care providers and their referral sources, because such relationships can alter a physician's judgment about the patient's true health care needs and drive up health care costs for everybody," Mizer said.

U.S. Attorney **Steven M. Dettelbach**, JD, of the Northern District of Ohio, added that improper financial relationships between hospitals and referring doctors can lead to clouded judgments. ■

HHS targets opioid-drug related overdose, death

Health and Human Services (HHS) recently announced an initiative aimed at reducing prescription opioid- and heroin-related overdose, death, and dependence.

Deaths from drug overdose have risen steadily over the past two decades and outnumber deaths from car accidents in the United States. President Obama's FY 2016 budget includes critical investments to intensify efforts to reduce opioid misuse and abuse, including $133 million in new funding to address this critical issue.

The HHS secretary's efforts focus on three priority areas that tackle the opioid crisis, which is expected to significantly impact those struggling with substance use disorders and help save lives:

- providing training and educational resources, including updated prescriber guidelines, to assist professionals in making informed prescribing decisions and address the over-prescribing of opioids;
- increasing use of naloxone, as well as supporting the development and distribution of the life-saving drug, to help reduce the number of deaths associated with prescription opioid and heroin overdose;
- expanding the use of medication-assisted treatment (MAT), a comprehensive way to address the needs of individuals that combines the use of medication with counseling and behavioral therapies to treat substance use disorders. ■

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™

CNE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:
1. Read and study the activity, using the provided references for further research.

2. Scan the QR code to the right or log on to the new AHCMedia.com site to take a post-test. Go to "MyAHC" and then "My Courses" to view your available CE activities. Tests are taken after each issue. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed.

4. After completing the test, your browser will be automatically directed to the activity evaluation form, which you submit online.

5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly.

CNE QUESTIONS

1. **According to data collected by The Doctors Company, how many malpractice claims stemmed from a diagnosis delay or error?**

   A. 10%
   B. 25%
   C. 45%

2. **Why does Akram Alashari, MD, a trauma surgeon and surgical intensivist in the Surgical Critical Care department at the University of Florida, say delay in diagnosis is a risk in trauma care?**

   A. The trauma patient often has multisystem organ injury and multiple fractures, leading to a missed injury.
   B. Trauma surgeons are neither trained nor skilled in identifying disease in trauma patients.
   C. The physiological effects of trauma can prevent some indicators of disease from showing up in standard tests and scans.
   D. The trauma unit is not properly equipped for the testing necessary for a thorough diagnosis.

3. **According to Jeffrey Smith, senior vice president and healthcare leader with Lockton, why are plaintiffs attempting to bring in conditions of participation (CoPs) as evidence in medical malpractice cases?**

   A. Many states recently have enacted legislation allowing it.
   B. They are trying to introduce them in negligence per se claims, as evidence of the standard of care.
   C. Violation of the CoP automatically results in a higher award.

4. **According to an analysis Diederich Healthcare conducted of the medical malpractice payout data provided by the National Practitioner Data Bank, what is the trend with medical malpractice payouts?**

   A. They decreased 4% for the third consecutive year.
   B. They decreased 2% in 2014, which reversed a three-year trend.
   C. For the second consecutive year, medical malpractice payouts increased more than 4% from the previous year.

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

Failure to diagnose cauda equina syndrome results in $2.5 million verdict from jury

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 (2004-2013)
California Hospital Medical Center
Los Angeles

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

News: The patient, a 19-year-old woman, sought treatment at a local hospital emergency department and was complaining of severe lower back pain and pelvic numbness. The woman had a prior history of bulging disks in her back. While at the emergency department, a nurse practitioner examined the patient and quickly discharged her without a complete diagnosis, but the nurse practitioner attributed the symptoms to common back pain. The physician in the emergency department failed to consult with the patient, but subsequently approved the nurse's actions.

Two days later, the patient returned to the same hospital emergency department and was complaining of new symptoms. At this time, the patient was diagnosed with cauda equine syndrome. However, by this time, the patient had suffered serious and permanent injuries. The patient brought suit against the hospital, nurse, and physician, and she alleged that the condition should have been diagnosed during the initial visit. The defendants all denied liability. The jury found for the patient and awarded $2.5 million in damages.

Background: The patient had a prior history of bulging disks in her back. On this particular occasion, the patient did not have a bulging disk, but suffered from severe lower back pain and pelvic numbness. She was admitted to a local hospital's emergency department. She relayed these symptoms to a nurse practitioner, who proceeded to examine the woman. After the examination, the nurse practitioner quickly discharged the patient without a complete diagnosis, but the nurse attributed the symptoms to common back pain, despite the patient's history of bulging disks. The physician in the emergency department failed to consult with the patient, but after the discharge, the doctor apparently approved of the nurse's actions. There was no arrangement for an MRI or any neurosurgical consultation before the patient was discharged. The patient returned to the same hospital emergency department two days later. This time the patient was suffering from urinary retention and complete loss of rectal tone. In addition to these new symptoms, the patient also revealed that the numbness from two days prior had continued.

During the second visit, the patient was diagnosed with cauda equina syndrome, a severe neurological disorder that typically is associated with a herniated disc in the lower, or lumbar, region of the back. Cauda equina syndrome is caused by excessive and prolonged compression by a disc on the cauda equina, which is a sack of nerve roots at the end of the spinal cord. The condition is considered a medical emergency, and it can lead to permanent incontinence and paralysis if not promptly treated. Common symptoms of an impending cauda equina syndrome include severe lower back pain, urinary or bowel dysfunction, motor weakness, sensory loss in the lower extremities, and saddle anesthesia, an inability to feel anything in the pelvic area. By the time this patient's cauda equina syndrome was

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.

diagnosed, permanent injury already had been inflicted: The patient suffers from recurring nerve pain, sexual dysfunction, permanent weakness in her foot, and multiple bowel problems.

The patient brought suit against the hospital, nurse, and physician, and she claimed that the failure to diagnose the impending cauda equina syndrome amounted to medical malpractice. According to the patient and her medical experts, if the condition had been diagnosed during the first admission to the emergency department, physicians could have performed surgery to prevent further pressure and compression of the nerves.

Furthermore, the patient alleged that the care providers failed to adequately examine her by performing an extensive motor examination or assessing the sensory function of her lower extremities. The defense and its medical experts attempted to argue that a diagnosis of cauda equina syndrome cannot be made until there is evidence of bowel or bladder dysfunction, and the patient presented no symptoms in line with this evidence during the first admission, thus the diagnosis could not have been made at that time. During trial, the nurse also denied that the patient originally complained of pelvic numbness, but other emergency department records had documentd this numbness. Ultimately, the jury found all the defendants jointly and severally liable, and it awarded the patient $2.5 million in damages.

What this means to you: The healthcare providers' liability in this case arose from a failure to timely diagnose an emergent condition, and this diagnostic failure resulted in serious and permanent injuries to the patient. Liability resulting from a failure to diagnose can arise in any medical context, although in an emergency medicine context, a failure to diagnose can result in far more serious consequences and thus greater damages in any resulting suit. However, a diagnostic error on its own does not necessarily raise the specter of liability. The ultimate question is whether the physician acted within the appropriate standard of care. This question is answered by looking at what a reasonable physician would do given the same or similar circumstances. For example, if a patient presents with a set of symptoms, and a reasonable physician would diagnose it as a certain condition, then a physician who actually diagnoses that condition given this set of symptoms is deemed to be within the standard of care, even if this diagnosis is not ultimately the correct one. The key is if a reasonable physician would make the diagnosis, despite it being incorrect given the knowledge at the time; if so, this case is not medical malpractice. Even skilled physicians make diagnostic errors when exercising reasonable care. The important part is the exercise of reasonable care.

Note also that while nurse practitioners serve an important function in busy emergency departments, they often practice under the supervision of a licensed physician. It varies from state to state whether that supervision is direct or indirect or is required at all, but knowing whether supervision must be provided is important.

Looking at the facts of this case, note that numbness indicates pressure on a nerve. It can be temporary or continual, but it is a critical diagnostic signal that must be investigated. The failure of the nurse to order follow-up diagnostic testing based on the patient's serious complaints indicates that the nurse practitioner chose the path of least resistance and made the dangerous assumption of chronic lower back pain related to a previous history. Any assumption in medicine is always dangerous, which is why there is often an opportunity for a licensed supervising physician to review the medical records of patients seen by a nurse practitioner. Physicians must be mindful of their role when using nurse practitioners. Nurse practitioners do have advanced training and are state certified, but they are not physicians, and their liability likely will be shared by any physicians who supervise their care where state law requires such oversight.

Moreover, it is unfortunate but undeniable that some physicians simply ignore nursing documentation. In such circumstances a physician can be completely unaware of a patient's symptoms otherwise clearly documented by nurses in the medical record. This situation can leave the liability burden solely on the physician in cases in which the hospital and the nurse are jointly named as defendants.

An important element of the diagnostic process, and a critical element to defend against potential liability, is adequate examination and testing of the patient. A healthcare provider cannot make an informed, accurate diagnosis without having access to appropriate information regarding the patient's past medical history and current symptoms. In this case, the care providers failed to properly consider these factors when initially evaluating the patient. The patient's past medical history revealed bulging disks in her back. According to testimony by the plaintiff's medical experts, this factor, along with her

symptoms, should have warned of cauda equina syndrome, which a reasonable physician would have recognized. Proper examination is crucial to evaluate or eliminate potential diagnoses, and a MRI or neurosurgical consultation in this case could have confirmed that the condition was far more serious than the one the nurse originally dismissed it as. Healthcare providers must perform appropriate tests or seek opinions from specialists when necessary to investigate a potential diagnosis. Failure to do such not only prevents the provider from making an accurate diagnosis, but it also opens the possibility of liability for failing to make that diagnosis.

Finally, complete and accurate documentation plays an important role in providing health services and preventing medical malpractice liability. In this case, the nurse specifically denied that the patient complained of pelvic numbness during the first admission, and if true, this situation might have helped defend the delayed diagnosis. However, there were records documenting the complaints of numbness from two other nurses in the emergency department. A difference in documentation versus testimony can easily harm an individual's credibility with a jury, as it might appear that the individual is trying to change the facts to defend later decisions. Synchronizing and verifying that records match up with what a patient states might be necessary, especially given that an emergency department patient in particular can see several nurses, staff members, or physicians, and the patient's symptoms or complaints can change in each instance. Steps should be taken to ensure that a patient's medical record is consistent, accurate, and complete. If there are discrepancies, recording each instance of a complaint by the patient might help to identify and bring these forward in order to verify that the patient's symptoms are changing, and care providers should document and explain these changes as much as possible.

REFERENCE:

Circuit Court for Anne Arundel County, MD. Case No. 02-C-13-191807. March 10, 2015. ■

Complications post-thyroid surgery lead to patient death, $1.3 million verdict

Verdict against doctor and hospital includes damages for negligent infliction of emotional distress

News: A patient undergoing thyroid surgery was accompanied to the hospital by her sister and daughter. After surgery and upon transfer to the medical-surgical unit, the patient began to struggle with her breathing. The patient's sister and daughter observed the surgeon and a team of nurses work on the patient for more than 30 minutes, during which time the patient's condition continued to deteriorate until the patient stopped breathing and lost her pulse, which led to permanent brain injury. The patient died 10 days later when life support was withdrawn.

Background: On Sept. 26, 2008, a patient underwent surgery on her thyroid gland. The patient's sister and daughter accompanied her to surgery. At approximately 6:45 p.m., the patient was transferred from a post-anesthesia care unit to a medical-surgical unit. A nurse, observing that the patient's breathing was "noisy" and possibly obstructed, called for an evaluation by the hospital's rapid response team (a respiratory therapist and a nurse from the intensive care unit), which arrived in three minutes and suctioned the patient's mouth. The patient's surgeon arrived roughly 10 minutes later, tried to reposition her, and suctioned her mouth and nose. While the bandages were being removed and the sutures on the patient's incision were being removed to relieve pressure, the patient stopped breathing. The surgeon called a Code Blue at 7:23 p.m., which summoned a team of doctors and ancillary personnel to deal with the emergency. The patient lost her pulse for some minutes and, as a consequence of her blocked airway and subsequent anoxia, suffered permanent brain injury. The patient was transferred to the intensive care unit, but died 10 days later when she was removed from life support.

The patient's daughter saw her mother immediately after surgery while she was on a gurney waiting to be brought to her room. She later testified that her mother "didn't look herself," as her skin appeared gray, she was sweating, and she appeared to be very uncomfortable and in distress. The patient's daughter also stated that she observed that her mother could not speak and was making a gurgling sound when she breathed. After

the initial suctioning, the patient's daughter thought her mother still appeared to be uncomfortable, and she requested that the nurse summon the surgeon because her condition was not improving. When the surgeon arrived, the patient's daughter watched him begin to examine the site of the surgery. The daughter then saw her mother's eyes roll back and her arm go up, and she heard the surgeon call a Code Blue. The daughter was frustrated and upset because she felt there was no sense of urgency among the staff to determine why her mother was in distress. She thought that the nurses and others were not moving quickly enough. The patient's sister gave similar testimony. Both were extremely upset by the developments they observed, especially given the highly adverse outcome.

The patient's daughter and sister, along with another daughter of the patient who had not observed the developments immediately after the surgery, filed a complaint for damages against the surgeon and the hospital. They alleged causes of action for wrongful death and negligent infliction of emotional distress. Prior to trial, the plaintiffs settled their claims against the surgeon, and the settlement was found to be in good faith. The case proceeded to trial against the hospital. At the conclusion of the trial, the jury awarded the patients' daughters $1 million on their wrongful death claims, which was an amount later reduced pursuant to state medical malpractice limitations. The jury awarded the patient's daughter $175,000 and the patient's sister $200,000 on their claims for negligent infliction of emotional distress based on what they observed at the hospital. On appeal, these awards for negligent infliction of emotional distress were upheld.

What this means to you: State laws vary, but as a general rule there are three requirements that a plaintiff must satisfy to recover on a claim for negligent infliction of emotional distress to a bystander:

- the plaintiff must be closely related to the injury victim;
- the plaintiff must have been present at the scene of the injury-producing event at the time it occurred and then be aware that it was causing injury to the victim;
- as a result, the plaintiff must have suffered serious emotional distress.

There is no dispute that the daughter and the sister were closely related to the patient and that they were with the patient from the time she began exhibiting difficulty breathing until her surgeon called the code. The hospital's lawyers argued that there is no substantial evidence, however, that the sister and daughter were aware at that time that the defendant's negligence was causing injury to the patient.

This argument was rejected. The patient's daughter and sister were present when the patient had difficulty breathing following surgery. They observed inadequate efforts to assist her breathing, called for help from the respiratory therapist, and essentially ordered him at one point to suction her throat. They also requested hospital staff to call for the surgeon to return to the patient's bedside to treat her breathing problems. These facts sufficed to demonstrate that the patient's sister and daughter were contemporaneously aware of the patient's injury and the inadequate treatment provided to her by the defendants.

The lessons from this case are that bedside manner matters. The patient's sister and daughter fixated on their impression that there was a lack of urgency to determine what was happening to the patient and to intervene. Whether that lack of urgency was the situation or not, it was their impression. It almost certainly drove a significant portion of their decision to file suit. Also, many providers might not be aware that a family member observing treatment might subsequently be a plaintiff in a lawsuit alleging that the manner of treatment negligently caused emotional distress to that family member. Removing family members from difficult treatment situations might not only spare the family members a lifetime of painful memories from watching the ultimate demise of a loved one, but it also might avoid the prospect of liability, whether warranted or not.

Finally, while it would have been appropriate for a staff member to ask family to leave during emergencies to allow response teams access to the patient and the necessary equipment required, the decision to place the patient on a non-monitored unit after thyroid surgery might have been a bigger problem. It seems that the staff members were unable to recognize post-thyroid surgery complications such as bleeding into the neck causing swelling and airway compromise.

Noisy breathing is a post-anesthesia warning that there is an obstruction. It should not be the responsibility of the family to call for help. The best surgeons will tell you that their practices and outcomes are only as good as the postoperative staff. All the efforts of the surgeon are for naught if the caregivers are not trained to handle untoward events.

REFERENCE:

Superior Court of Alameda County, CA. Case No. RG09478812. July 11, 2013. ■