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INSIDE

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Providers must tread carefully if patient objects to caregiver

Patients voice opinions on race, gender, religion, or sexual orientation

Recent racial controversies have prompted some risk managers to wonder how to respond if a patient objects to the race, gender, religion, or sexual orientation of a caregiver. The situation is difficult, and labor law experts advise risk managers to step very carefully once the issue is raised.

The dilemma is arising more as healthcare employers hire a diverse staff, says **Tom Harrington**, JD, principal with The Employment Law Group in Los Angeles. The patient's objection might involve the caregiver's religious attire, such as a head scarf, or the person's race or sexual orientation.

Conceding to the demands of the patient can put the hospital at risk of a discrimination claim by the employee, Harrington says. Even if the employer acknowledges that the action is taken only to mollify the patient and there is no endorsement of the discrimination, the employee still might suffer adverse consequences, he says.

"Even when the employer claims that the worker was not denied any hours or pay, and that the discrimination will not affect the employee's status or opportunity for advancement, it still is an inherently untenable position,"

HRM's Ebola coverage wins first place

Healthcare Risk Management has earned First Place in the Best Healthcare Interpretative or Analytical Reporting category in 2015 Specialized Information Publishers Association journalism awards for coverage of the first U.S. Ebola cases. *HRM*'s coverage focused on the lessons learned by the hospitals treating those patients, particularly the potential liability and employee health concerns. See the December 2014 issue of *HRM* for our award-winning analysis of the risk management implications of treating Ebola. It is available at http://www.AHCMedia.com/newsletters/17/issues/71272.

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Harrington says.

Accommodation

Patients do object to their caregivers with some regularity, according to researchers at the University of Michigan Health System, the University of Pennsylvania, and the University of Rochester. In 2010, they published the results of a study that confirmed what they called an open secret among healthcare workers: Patients frequently request providers of the same gender, race, or religion, and their requests often are accommodated.[1]

To study the "culture of accommodation" in the hospital setting, the researchers surveyed 127 emergency physicians from around the United States. Participants reported that patients often request a physician of a race, gender, or religion different from the one assigned, and the facility often complies, especially when the patient is a woman, a racial minority, or a Muslim.

Some requests are related to modesty issues, such as when a woman prefers to be examined by a female nurse or doctor, but the researchers found that black, Hispanic, and Asian patients sometimes believe that they receive better care from doctors of the same race. The decision on accommodation usually falls to the physician, and the study found that female physicians are more likely to say yes.

Civil Rights Act applies

The 1964 Civil Rights Act (CRA) addresses various types of discrimination, and Title VII of the act prohibits employers from making any decisions about job assignments, promotions, or other terms of employment based on the person's status in a protected category, Harrington says. Those protected categories include race, gender, national origin, disability, age, and, in some jurisdictions, sexual orientation.

"That would extend to customer preferences because, ultimately, if the employer gives in to the biased requests of their customers, they are making an assignment based on the discriminatory preferences of their customers," he explains. "They would be ratifying the discriminatory preference and extending that to their employees."

Employees might not even realize they have been discriminated against until some time later, but

EXECUTIVE SUMMARY

Patients might object to particular nurses or other caregivers because of their race or other factors. Hospitals should be prepared to deal with such objections without violating labor laws.

- Patients commonly ask for a caregiver of the same race, gender, or religion, and their requests often are accommodated.
- The Civil Rights Act prohibits discrimination in the workplace, but healthcare providers might be allowed to accommodate requests in some situations.
- Race-based requests can be more difficult to accommodate than privacy-based requests.

that situation does not mitigate the liability risk, Harrington says. Employees who find out after the fact that the hospital barred them specifically, or a person of their race, national origin, or other category, can make a claim that the discrimination adversely affected their job status.

"The question would be what the employee's damages would be. They would have to prove that they suffered economically in some way from the discrimination," Harrington says. "Even if you canvassed all your employees and got them to agree that it's OK to allow the patient to be treated by who he or she chooses, it is still discrimination. Being able to prove that you discussed it openly and there were no objections at the time of the discrimination would not make a lot of difference later when one of those employees takes you to court."

Case holds lessons

The bona fide occupational qualification (BFOQ) defense would be helpful only in limited circumstances, says **Kimani Paul-Emile**, JD, an associate professor of law at Fordham University School of Law in New York City. Title VII permits discrimination on the basis of "religion, sex, or national origin in those instances where religion, sex, or national origin is a bona fide occupational qualification reasonably necessary to the normal operation of the particular business or enterprise." The BFOQ is usually not valid in regard to race discrimination, she explains, but it could be used in the small number of circumstances in which customer privacy is a concern.

"For example, although the BFOQ defense will not serve as a valid justification for an airline to hire only women as flight attendants to comply with male customer preferences, the privacy interests of psychiatric patients can justify a BFOQ for personal hygiene attendants of the same sex," Paul-Emile says. "To this end, courts have held that for certain workers, such as nursing assistants, hospital delivery room nursing staff, and others involved in assisting individuals with dressing, disrobing, or bathing, gender may be a legitimate BFOQ for accommodating patients' privacy or modesty interests."

"EVEN IF YOU CANVASSED ALL YOUR EMPLOYEES AND GOT THEM TO AGREE THAT IT'S OK TO ALLOW THE PATIENT TO BE TREATED BY WHO HE OR SHE CHOOSES, IT IS STILL DISCRIMINATION."
— TOM HARRINGTON, THE EMPLOYMENT LAW GROUP

The most relevant case, however, indicates that race is unlikely to be considered a BFOQ, she says. In *Chaney v. Plainfield Healthcare Center*, the court addressed a situation in which a nursing home had agreed to a patient's request to bar black nurses from her care. The court held that race is not a relevant factor to consider in addressing privacy concerns. *(See the story in this issue for more on that case.)*

Though instructive, the Chaney case is not a direct parallel to the most common scenarios involving racial requests, Paul-Emile says. The decision to accommodate a patient's request is usually made by the treating physician rather than a hospital administrator, she explained in the *UCLA Law Review.* The different roles of physician and administrator are key, Paul-Emile said. *(Her analysis of the case is available online at http://tinyurl.com/pwpr3bm.)*

Accommodating the request can be seen as the physicians deciding among themselves how best to meet each patient's needs, Paul-Emile explains, and courts generally give physicians wide latitude in that regard. Physicians' willingness to accommodate is "likely due to the unique nature of the physician–patient relationship, which contrasts sharply with that of a CNA and nursing home resident," she says.

Harrington says the advice for risk managers is clear.

"It would be a mistake to go along with the patient's demands just to smooth things over," Harrington says. "It would expose you to significant liability."

REFERENCE

1. Padela AI, Schneider SM, Ali Z, et al. Patient choice of provider type in the emergency department: Perceptions and factors relating to accommodation of requests for care providers. *Emerg Med J* 2010; 6:465-469.

SOURCES

- **Tom Harrington**, JD, Principal, The Employment Law Group, Los Angeles. Telephone: (202) 331-3911.
- **Kimani Paul-Emile**, JD, Associate Professor of Law, Fordham University School of Law, New York City. Telephone: (212) 636-7541. Email: paulemile@law.fordham.edu. ■

Nursing home bars black nurses, loses lawsuit

When considering whether to accommodate a patient's request regarding caregivers of a particular race, gender, or religion, the case that comes closest to setting a precedent for healthcare providers is *Chaney v. Plainfield Healthcare Center*, which involves a Plainfield, IN-based nursing home that forbade black nurses from treating certain patients.

In a 2010 decision, the Indiana Seventh Circuit Court of Appeals determined that Title VII of the Civil Rights Act bars nursing homes from acceding to their residents' racially discriminatory requests with respect to certified nursing assistants. *(See the case at http://tinyurl.com/pnpfzu9.)* Plainfield Healthcare Center is a nursing home that housed a resident who did not want assistance from black certified nursing assistants (CNAs). Plainfield complied with this racial preference by noting in each day's duty sheets that "no black" assistants should enter this resident's room or provide her with care. Brenda Chaney, a black CNA, filed a lawsuit claiming the nursing home created a hostile work environment.

Chaney reluctantly refrained from assisting the patient, even when she was in the best position to respond. Once, according to the lawsuit, Chaney found the woman on the ground, too weak to stand. Despite wanting badly to help, Chaney had to search the building for a white CNA. Plainfield housed at least two other residents with a similar distaste for black CNAs.

The district court ruled in favor of the nursing home and accepted its argument that failure to comply with her request might have violated the state's patients' right laws. The Seventh Circuit Court of Appeals in Indiana disagreed and concluded that the nursing home "told Chaney that it was excluding her from work areas and residents solely on account of her race, thereby creating a racially-charged workplace that poisoned the work environment."

By accommodating the race-based request, the employer encouraged racial abuse toward the black CNA, the court determined.

"The hostility that Chaney described came from daily reminders that Plainfield was employing her on materially different terms than her white co-workers. Fueling this pattern was the racial preference policy, both a source of humiliation for Chaney and fodder for her co-workers, who invoked it regularly," the court wrote. "It was, in short, a racially hostile environment."

Plainfield later settled the case for $150,000, according to court records. ■

New and increased liabilities emerging from Affordable Care Act

Risk managers should be aware that the Affordable Care Act (ACA) is creating new liabilities that were not apparent when the law first took effect, says **Rob Francis**, COO of The Doctors Company, based in Napa, CA, and the nation's largest physician-owned medical malpractice insurer.

Part of the ACA's overall goal is to move the health system from fee-for-service to a quality-based model, and some unintended consequences are beginning to appear, Francis says. Reimbursement is increasingly tied to meeting quality standards, which can skew how physicians and hospital leaders provide care, he says.

One troubling trend is the creation of default standards of care that prevent physicians from making clinical decisions based on their best judgment. As reimbursement guidelines become a new standard of care, malpractice lawsuit opportunities could increase up to eightfold, Francis says.

"Doctors are telling us that they

EXECUTIVE SUMMARY

The Affordable Care Act (ACA) is creating new liability risks for hospitals and exacerbating some existing risks. The potential dangers involve implied standards of care and cost constraints that affect medical care.

- Default standards of care are being created through reimbursement guidelines.
- There is a greater risk that patients will allege care decisions were made for financial reasons.
- Reimbursement guidelines cannot be cited in court as standards of care, but they still will be used in that manner.

are not being allowed to use their own judgment because if they deviate from the guidelines, they won't receive reimbursement," Francis says. "They're being told that they have to do it that way or not get paid, and that means they sometimes have to provide care in a way that is not what they think best. That greatly increases the chance of a malpractice allegation."

The Sustainable Growth Rate bill passed by Congress in April establishes a new two-track payment system for doctors that is intended to move more patients into risk-based payment models. Doctors that qualify for the alternative payment track will receive higher reimbursement rates starting in 2019. That bill also included a provision stating that the quality standards cannot be used as standards of care in liability actions.

"But what actually happens is that, in people's minds, they are becoming the standard," Francis says. "Even without being able to refer back to the federal quality standards, they come into play because the expert witnesses are adopting them as the standard of care and then testifying that those are the standards accepted in the medical community. They don't have to mention the reimbursement guidelines themselves."

Clinicians should be encouraged to follow their own judgment and carefully document any deviation from the reimbursement guidelines, so that there is evidence of the effort to provide the best care for the patient, Francis says.

Cost concerns

As fee-for-service medicine continues to be replaced by value-based, pay-for-performance compensation, Francis says there will be increased allegations that care is being withheld for financial gain of the providers. At the same time, with more aggressive Medicare payment denials leaving patients with high medical bills, more patients will sue for what they deem unnecessary care.

"Any allegation of care decisions based on financial motivation is something that blows up jury awards," Francis says. "If you look back at the managed care movement in the 1990s, there were huge awards that came out of accusations that HMOs and hospitals were choosing care because they made more money doing it this way instead of another way. Any time that allegation creeps into a lawsuit, it inflames the jury and substantially increases the awards."

> "ANY ALLEGATION OF CARE DECISIONS BASED ON FINANCIAL MOTIVATION IS SOMETHING THAT BLOWS UP JURY AWARDS."

Francis cites the example of a post-surgical patient who develops complications at home and needs to go an emergency department (ED). If that patient is directed to the hospital that is part of the physician's network, rather than the closest hospital, allegations could arise that the referral was made for financial reasons.

"Those facts did result in a multi-million dollar settlement back in the 1990s, and I'm afraid we're going to those cases again," Francis says. "It would be worthwhile to remind physicians and nurses that if they send someone to the emergency room, they should tell the patient to go to *an* emergency room and not *our* emergency room."

Deductibles worrisome

The influx of newly insured patients also is increasing liability risks, Francis says. Many of these patients typically received care in the past on an acute basis through EDs and clinics, but now their high deductibles are causing them to forego care until the condition worsens. As their health condition worsens, liability risk increases because the malpractice risk is always higher when the patient is sicker.

Physicians also are reporting concerns that requirements for electronic medical records (EMRs) pose a number of liability risks. They worry that despite all the benefits, EMRs can harm the physician-patient relationship. Physicians can be so busy entering information into the EMR or going through the great volumes of data available that they devote less time to interacting personally with the patient, Francis says.

"That disconnect always works against the doctor if there is an adverse event and you end up in litigation. The patient who feels like you ignored him or her and only had half your attention during the exam will be more likely to sue and less willing to settle," Francis says. "On top of that, we're also hearing concerns that EMRs can lead to an overload of frequent and disruptive alerts, causing alert fatigue. That's one more risk factor."

SOURCE

- **Rob Francis**, COO, The Doctors Company, Napa, CA. Email: rfrancis@thedoctors.com. ■

Hospital investigating after ESPN publishes football player's medical record

When a professional football player's medical record was published by the sports network ESPN, even those who are outside the healthcare community scratched their heads and wondered how that could happen. The hospital administration is determined to find out.

New York Giants pass rusher Jason Pierre-Paul sought treatment at Jackson Memorial Hospital in Miami after a fireworks accident over the Fourth of July weekend. On the following Wednesday, ESPN reporter Adam Schefter posted a photo of part of Pierre-Paul's medical record on Twitter, with the note "ESPN obtained medical charts that show Giants DE Jason Pierre-Paul had right index finger amputated today."

The news was significant in the sports world because of how the injury could affect Pierre-Paul's performance and also because some critics were questioning why a professional athlete would jeopardize his career by playing with fireworks.

That news was almost overshadowed, however, by immediate questions about how Schefter obtained the medical record and whether it was proper to publish it. Hospital administrators learned of the disclosure quickly. Within 90 minutes of Schefter's tweet, the Jackson Health System tweeted two statements:

- "Federal privacy laws prevent hospitals from disclosing information about patients or their medical records without the patient's consent."
- "Jackson Health System takes patient privacy seriously and aggressively investigates any alleged violation."

The next day, **Carlos A. Migoya**, Jackson Health System president and CEO, issued this statement:

"Late Wednesday, media reports surfaced purportedly showing a Jackson Memorial Hospital patient's protected health information, suggesting it was leaked by an employee. An aggressive internal investigation looking into these allegations is underway.

"If these allegations prove to be true, I know the entire Jackson family will share my anguish. Our nurses, doctors, and other healthcare professionals are passionate about our patients' health and well-being, and that includes the right to privacy. If we confirm Jackson employees or physicians violated a patient's legal right to privacy, they will be held accountable, up to and including possible termination. We do not tolerate violations of this kind.

"In order to protect our patients' rights and private information, we enforce strict rules for those who handle patient information and continually educate all employees on privacy regulations. Those rules are constantly evolving as technology changes, but always remain focused on putting our patients first."

A spokeswoman at the Health and Human Services Office of Civil Rights, which investigates violations of the Health Insurance Portability and Accountability Act (HIPAA), issued a statement saying the office was aware of the incident but could not comment on current or potential investigations.

Hospital at fault

Any responsibility for a HIPAA violation falls on the hospital and perhaps individual employees, says CEO **Nick Merkin** of Compliagent, a compliance consulting firm in Los Angeles.

"It's important to clarify that, by definition, neither ESPN nor Adam Schefter, the reporter involved in the case, violated HIPAA. HIPAA regulations can only be violated by a healthcare provider, healthcare clearinghouse, or a health plan — in this case, Jackson Memorial Hospital and its related healthcare professionals," Merkin says. "There may arguably be issues of journalistic ethics or integrity to debate, but as a legal matter, the press is not covered by HIPAA."

Additionally, Merkin says, there is no private right of action under HIPAA — only government-imposed fines and penalties. Thus, Jason Pierre-Paul cannot sue any party as

EXECUTIVE SUMMARY

A hospital is conducting an internal investigation after a patient's medical records were obtained by a television network and published. The patient was a professional football player who had injured his hand.

- The disclosure appears to be a clear violation of the Health Insurance Portability and Accountability Act (HIPAA).
- The reporter who obtained the record is not subject to HIPAA restrictions.
- The patient cannot sue the hospital under HIPAA but could seek civil damages.

part of a HIPAA claim, although there might be significant state law claims that he can bring, along with common law allegations such as invasion of privacy and negligence.

The statements released by the hospital suggest it is handling the allegations of improper disclosure properly by immediately conducting a risk assessment to determine whether an actual HIPAA breach occurred, Merkin says. The results of the internal investigation will dictate the hospital's next steps, including any breach notification requirements.

The most important question for Jackson Memorial Hospital and other healthcare providers is where the breakdown occurred organizationally, Merkin says.

"In other words, what compliance infrastructure was in place or was lacking that allowed for this improper disclosure to happen? Where was the faulty execution? Was it a result of deficient policies and procedures, inadequate training, ineffective monitoring and auditing, or poor compliance management and oversight?" he says. "And most important, what can be done to prevent these kind of breaches from reoccurring?"

SOURCE

- **Nick Merkin**, CEO, Compliagent, Los Angeles. Telephone: (310) 996-8950. Email: nmerkin@compliagent.com. ■

Greater New York Hospital Association says no more reality television access

After complaints by a family that New York Presbyterian Hospital/Weill Cornell Medical Center in New York City allowed a dying man to be videotaped for a reality television program without his permission, the Greater New York Hospital Association (GNYHA) announced recently that emergency departments (EDs) in the city will now ban television crews.

The ABC television show *NY Med*, a reality show featuring real-life trauma cases at the hospital, aired video of an 83-year-old man's last moments after being hit by a garbage truck on April 29, 2011. In addition to showing Mark Chanko as he died, the show depicted heart-wrenching conversations between his family and the treating physician.

Chanko's face and those of his family were blurred, but his family watched the show when it was broadcast and said they could identify him. The family contends that the man never gave permission to be recorded for broadcast, and the family filed complaints with the New York State Department of Health, ABC, The Joint Commission, and the Office of Civil Rights at the Department of Health and Human Services.

In addition, the family sued ABC, New York Presbyterian, and Chanko's physician in the emergency department. An appellate court dismissed the case, but the family is appealing that decision.

A report from the state health department concluded that the hospital violated Chanko's rights because he was "unaware and uninformed that he was being filmed and viewed by a camera while receiving medical treatment."

In court filings responding to the complaint, ABC defended its actions by saying the patient was not identifiable to the public and that because *NY Med* is produced by the network's news division, it is protected by the First Amendment. ABC did not claim that it had obtained permission from the patient.

The American Medical Association and other professional groups have expressed concern about patients being videotaped at a time when they might not be able to grant informed consent and the practice of recording patients first and asking permission later. Risk managers and medical ethicists have been critical of hospitals granting access to reality television crews since their inception more than 10 years ago.

Citing the Chanko case as proof

EXECUTIVE SUMMARY

New York City hospitals will no longer allow reality television crews in their emergency departments. The decision came after a man was shown dying.

- The man's family said he never gave permission to be recorded.
- Reality television crews usually record in emergency situations and ask permission afterward to use the material.
- The family filed complaints with regulators and sued the hospital, the television network, and the doctor.

that the concerns of critics were valid, the GNYHA issued a statement recently saying its member hospitals "will no longer allow patients to be filmed for entertainment without obtaining their prior written consent." Because the television crews are unable to obtain permission in an emergency, the standard procedure has been for hospitals to allow the videotaping of patients first and then the producers ask for permission to use the footage, the hospital group noted.

"This effectively puts an end to 'reality TV' in New York's emergency rooms," the GNYHA statement concluded. ■

Infant injured by an 'old school' trick that most hospitals and healthcare systems ban

A Houston, TX, hospital is facing a lawsuit after a newborn was seriously burned in an attempt to draw blood, and the incident could be a warning bell that techniques formally banned as too dangerous might still be performed in your hospital.

Newborn Isabel Lewandowski was burned when a nurse tried to increase blood flow to the baby's foot by applying a hot disposable diaper to the skin, says Houston attorney **Tim Culberson**, JD, who is representing the family in the lawsuit against St. Joseph Medical Center in Houston. After the baby was injured, staff members told the parents that the hot diaper was applied to the skin to facilitate the blood draw for the routine phenylketonuria (PKU) test, Culberson says.

Clinicians have explained to Culberson that it is sometimes difficult to draw enough blood from the baby's heel, where the stick is usually done, so the heat is applied in an attempt to increase blood flow to the area.

"From what I understand, back in the old days, nurses used to take cloth diapers and put them in warm or hot water and apply that to the heel for the PKU. It became known as a neat trick among the nurses, an effective way to get the blood drawn, and it was adopted by a lot of hospitals," Culberson explains. "Eventually a lot of babies started getting burned, and they stopped doing that. Risk managers at hospitals pretty much outlawed the practice and said 'we're not doing this anymore.'"

In the Lewandowski case, Culberson says a nurse in her mid-40s tried to use a modern disposable diaper in the same way. Two factors worked against her: First, disposable diapers contain a gel that expands when wet and can retain a great deal of heat. Second, she reportedly heated the wet diaper in a microwave. As anyone who has reheated food in a microwave knows, the substance can be extremely hot in some spots while only warm to the touch in other areas.

"So she had a diaper with an unknown amount of heat in it, in a gel that holds and transfers that heat very well, and she wrapped that around the baby's foot," Culberson says. "The practice has been banned for years, but somehow this nurse knew about it and got the idea that this was a good thing to do."

St. Joseph Medical Center issued a statement acknowledging the lawsuit. Hospital leaders say they are conducting a thorough investigation of the incident.

It is not yet clear whether the nurse had used the technique previously on other newborns or whether it was an openly accepted practice in the hospital, Culberson says. However, since the news broke of the Lewandowski baby's injury, parents from across the country have called Culberson to report the same injuries to their children.

Risk managers should see this case as a warning that techniques formally banned by the hospital still might be used surreptitiously, Culberson says. There also might be a need to caution clinicians about using "tips and tricks" that are passed along from other clinicians or ideas they come up with on their own, he says.

EXECUTIVE SUMMARY

A hospital is being sued by the parents of a newborn who was seriously burned during a routine testing procedure. The nurse used a method for improving blood draws that is forbidden at most hospitals, according to the plaintiff's attorney.

- The nurse was drawing blood for the routine PKU test on the newborn.
- Staff members explained that a hot diaper was applied to the baby's foot to improve blood flow, the attorney says.
- The baby suffered serious second-degree burns.

"My understanding is that the old school method with the diaper was eliminated many years ago, so I don't think a nurse of this age would have used it before and resurrected it," Culberson says. "So you have to wonder if it was something the nurses heard about from back in the old days and wanted to try, or if maybe they just knew that heat would help and came up with this way to apply it. Either way, it resulted in a terrible injury to this child."

SOURCE

- **Tim Culberson**, JD, The Culberson Law Office, Houston, TX. Email: tim@culbersonlaw.com. ■

Sleep apnea can pose malpractice risk in surgery

Surgical malpractice cases are increasingly citing obstructive sleep apnea (OSA) as a factor in the patient injury, according to a new study.

In the journal *Anesthesia & Analgesia*, Dennis Auckley, MD, of the MetroHealth Medical Center in Cleveland, OH, and colleagues reviewed three primary databases of legal literature to find cases in which patients with known or suspected OSA had adverse perioperative outcomes between 1991 and 2010. The article was published online ahead of print (doi: 10.1213/ANE.0000000000000841). OSA had to be directly implicated in the outcome, and surgical mishaps such as uncontrolled bleeding were excluded.

The adverse perioperative outcome had to result in a lawsuit that then was adjudicated in a court of law with a final decision rendered. Data were abstracted from each case regarding patient demographics, type of surgery, type and location of adverse event, associated anesthetic and opioid use, and legal outcome. They found 24 cases, most occurring in or after 2007. Most of the operations (92%) were elective, and 71% of the overall group died. The researchers suspect that use of general anesthesia and opioids might have led to complications in 58% and 38% of cases, respectively.

They also found that verdicts favored plaintiffs 58% of the time, with an average award of $2.5 million, ranging from $650,000 to $7.7 million.

Standardized screening tools for OSA should be used more extensively in surgery, the researchers suggest. OSA patients also might need special precautions postoperatively, they say. Some precautions include:

- minimizing opioid use postoperatively;
- trying to keep patients off their backs;
- additional monitoring for patients with known or suspected OSA.

Patients also should be required to bring their at-home therapy, such as a sleep apnea mask, and use it at the hospital postoperatively, they say.

OSA affects about 5% of the population, but most cases are undiagnosed, the researchers note.

"Perioperative complications related to OSA are increasingly being reported as the central contention of malpractice suits. These cases can be associated with severe financial penalties," the researchers concluded. "These data likely underestimate the actual medicolegal burden, given that most such cases are settled out of court and are not accounted for in the legal literature." An abstract of the study is available online at http://tinyurl.com/q5rxhqc. ■

Work hour restrictions not improving safety

Work hour restrictions for resident physicians, revised nationally four years ago largely to protect patients against physician trainees' fatigue-related errors, have not had the desired effect of lowering postoperative complication rates in several common surgical specialties, according to new study results.

A summary of the study was provided to the media by the *Journal of the American College of Surgeons*, which will publish it later this year.

There was no significant difference in measured surgical patient outcomes between one year before and two years after the 2011 resident duty hour reform was implemented by the Accreditation Council for Graduate Medical Education (ACGME), according to the study authors. The ACGME is the accrediting and standards-setting body for about 9,500 U.S. medical residency programs.

The investigators evaluated outcomes, a combined measure of patients' deaths and serious complications, within 30 days of an operation in five surgical specialties: neurosurgery, obstetrics/gynecology, orthopedic surgery, urology, and vascular surgery. The number of patients included in this retrospective study ranged from 22,158 in urology to 61,640 in vascular surgery during

the three-year period examined.

The study adds to the body of medical literature showing no strong association between resident duty hour reform and change in postoperative outcomes, says lead investigator **Ravi Rajaram**, MD, MSc, a resident clinical scholar at the American College of Surgeons (ACS) and a fellow with the Surgical Outcomes and Quality Improvement Center at Northwestern University Feinberg School of Medicine in Chicago. "Our finding suggests the ACGME reform is not meeting its goal of improved patient safety in surgery," Rajaram said.

Prior studies found that the 2011 ACGME duty hour reform didn't affect patient outcomes among general surgical patients. However, Rajaram says the workload changes might have affected surgical specialties differently than general surgery. "Our study is the first to examine the association of the 2011 resident duty hour reform and patient outcomes among specific surgical specialties for two years after the policy changes took effect," he explains.

On July 1, 2011, the ACGME made the first changes to resident duty hours since the 2003 major reform that came amid controversy over patient safety and resident abuse. The 2011 policy limits first-year residents to working at most 16 hours continuously and requires they be directly supervised by senior physicians at all times when in-house. These new standards also mandate at least 14 hours off work after a 24-hour shift. Additionally, residents working 24-hour shifts may spend no more than four hours (instead of the former six hours) in transferring patients to another care provider.

"These restrictions impose obstacles for residents and their residency programs," Rajaram says. "Under the new policies, residents are handing off patients more often, and patient handoffs are one of the most common preventable causes of serious patient harm events."

According to The Joint Commission, at least half of communication breakdowns occur during handoffs, and communication problems are responsible for nearly 70% of sentinel events.

For this new study, patient outcomes data were obtained from the American College of Surgeons National Surgical Quality Improvement Program (ACS-NSQIP). ACS-NSQIP is a risk-adjusted, outcomes-based program to measure and improve the quality of surgical care in hospitals.

In each of the five surgical specialties, the investigators evaluated patient outcomes in the year before the 2011 reform, the first year after reform, the second year after reform, and both post-reform years combined. First, the researchers compared outcomes between teaching hospitals and nonteaching hospitals. Because changes in resident duty hours should not affect nonteaching hospitals, this group allowed the investigators to adjust for other factors that might affect surgical care universally over time, such as different medications or new medical technologies. Using this statistical approach, known as a difference-in-differences model, they were able to more accurately estimate the association between duty hour policies and patient outcomes at teaching hospitals, according to Rajaram.

Additionally, the researchers controlled for other factors that could influence surgical outcomes, such as patient demographics and pre-existing medical conditions.

In these adjusted analyses, the researchers found no significant association between the duty hour reform and the number of 30-day patient deaths and serious postoperative complications in the two years after reform, or either year separately, for any surgical specialty studied. ■

UCLA Health targeted in cyber attack

The UCLA Health system in Los Angeles was the victim of a cyberattack involving the personal data of 4.5 million people recently, and it is facing two class-action lawsuits from those affected.

Michael Allen, a UCLA Health patient, filed the lawsuit in U.S. District Court for the Central District of California after public reports said that UCLA Health System Auxiliary failed to have proper security measures in place to prevent the data breach. Most notably, it did not encrypt the data, according to reports. Another patient, Miguel Ortiz, filed a similar lawsuit. Both lawsuits make

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claims of breach of contract and negligence.

The health system reported that it first saw unusual activity in a computer server in October 2014 but only confirmed the attack on May 5. An initial investigation suggested the attacker had access to the UCLA Health's network since September 2014.

The attack hit parts of UCLA's network containing protected health information including names, addresses, birth dates, Social Security numbers, medical record numbers, health plan numbers, Medicare numbers, and some medical information.

Security experts were critical that such a large health system would lack sophisticated defenses for its network. The lack of encryption was particularly surprising, says **Adam Kujawa**, head of Malware Intelligence at Malwarebytes Labs, the research arm of the anti-malware company in San Jose, CA. "A big problem with this attack, like the breach of Anthem, was a lack of encryption, and therefore security standards that need to be met," he says. "While there are currently talks going on to create a nationwide security standard for all organizations that hold onto customer data, it might be a better solution to create a central authority for medical documents."

That authority could be queried and populated by individual hospitals, insurance companies, and other groups that require customer information, he explains. This information could be sent encrypted and held under a secure lock and key, which would make the breach of an individual organization less severe to the customers.

"Either way, this is a clear sign of the importance of changing our current security standards across the board," Kujawa says.

SOURCE

- Adam Kujawa, Head of Malware Intelligence, Malwarebytes Labs, San Jose, CA. Telephone: (800) 520-2796. ■

Research confirms 'weekend effect' on patient safety

Researchers from the University of Warwick in Coventry, England, say more research is needed to understand why patients are more likely to die in the hospital on the weekend.

Richard Lilford, PhD, and Yen-Fu Chen, MD, of the University's Warwick Medical School, raised the issue following a study published by *BMJ Quality & Safety* that says hospital weekend death risk is common in several developed countries including the United States. "Understanding this is an extremely important task since it is large, at about 10% in relative risk terms and 0.4% in percentage point terms," Lilford says. "This amounts to about 160 additional deaths in a hospital with 40,000 discharges per year."

Lilford and Chen wrote an editorial linked to the paper confirming the existence of the "weekend effect" in many countries. *(See the editorial at http://tinyurl.com/omzl5e9.)*

The research found that the heightened risk of death after admission to a hospital on the weekend is a feature of several developed countries' healthcare systems. The researchers looked at data on almost 3 million admissions between 2009 and 2012 from 28 metropolitan teaching hospitals in England, Australia, the United States, and the Netherlands.

They focused on deaths occurring in hospital within 30 days of an emergency admission or elective surgery. They found that, after taking account of influential factors, the risk of dying within 30 days was higher for emergency admissions at weekends for 22 of the 28 hospitals.

This risk was 13% higher in the five U.S. hospitals, 8% higher in 11 English hospitals, and 20% higher in six Dutch hospitals. There was no daily variation in the heightened risk of death after 30 days for emergency admissions at weekends in the Australian hospitals, and these hospitals had the largest proportion of emergency admissions. But those admitted on a Saturday were 12% more likely to die within seven days. All patients admitted on the weekend for elective surgery were more likely to die within 30 days across the board than those admitted on other days of the week, the findings showed. ■

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:

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2. Scan the QR code to the right or log on to the AHCMedia.com site to take a post-test. Go to "My Account" to view your available CE activities. First-time users will have to register on the site using the subscriber number printed on their mailing label, invoice, or renewal notice.
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CNE QUESTIONS

1. **What did researchers at the University of Michigan Health System, the University of Pennsylvania, and the University of Rochester determine in their 2010 study on patient demands to exclude some employees from their care?**

   A. Their demands are frequently met.
   B. Their demands are frequently denied.
   C. Their demands are usually met only for older patients.
   D. Their demands are usually met only regarding race.

2. **When is the bona fide occupational qualification defense helpful in defending against allegations of discrimination, after agreeing to a patient's request regarding caregivers?**

   A. Almost always
   B. Only when the claim is discrimination based on race
   C. Only in limited circumstances in which privacy is a concern

3. **In the incident involving a newborn accidentally burned at St. Joseph Medical Center in Houston, how does the family allege the burn happened?**

   A. A heating pad was faulty.
   B. The baby was placed too close to an ultraviolet lamp.
   C. A hot disposable diaper was placed on the baby's skin.
   D. The bassinet was placed too close to a heating vent.

4. **According to recent research, what was the impact on measured surgical patient outcomes between one year before and two years after the 2011 resident duty hour reform was implemented by the Accreditation Council for Graduate Medical Education?**

   A. There was no significant difference.
   B. There was a slight improvement, but only in some specialties.
   C. There was a statistically significant improvement only in general surgery.
   D. There was a statistically significant improvement across the board.

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

Failure to transfer patient to a qualified facility results in $23 million jury verdict

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News: In 2010, an infant was born prematurely and with a severe white matter brain injury known as severe cystic periventricular leukomalacia, which is a brain issue that will lead to a lifetime of complications. Earlier that same year, the mother of the child went to her obstetrician for routine tests, which revealed she had high blood pressure and protein in her urine. These results are indicative of preeclampsia, a common but risky situation requiring the preterm birth of the baby. Given that the baby was to be delivered at about 26 weeks of gestation, her obstetrician, upon learning this information, should have referred her to a hospital equipped to deliver a baby at that stage of the pregnancy. However, the obstetrician referred her to a hospital qualified to deliver only infants that are more than 33 weeks gestation. This hospital lacked certain and necessary equipment and expertise for delivering infants that have yet to reach that level of maturity. Nevertheless, the mother had the baby delivered in the unqualified hospital, where there were complications that led to the infant's injuries.

The mother and child sued the physician and unqualified facility for failing to transfer her to a qualified medical facility and for negligent care. The infant's condition, white matter brain injury, could have been prevented or better treated by a qualified facility, the plaintiff said.

The jury awarded the mother and child $23 million in damages. The physician who failed to refer the mother to a qualified hospital was held 70% liable, and the unqualified hospital where the child was delivered was found 30% liable.

Background: After receiving a routine checkup at her obstetrician's office, tests revealed that a pregnant woman carrying a 24-week-old fetus had protein in her urine and high blood pressure. These symptoms presenting themselves in the pregnant woman are clear signs of pre-eclampsia, a condition that typically presents itself after the first 20 weeks of pregnancy. Physicians suggest that even a slight elevation of blood pressure is a sign of preeclampsia.

The best cure is to deliver the baby prematurely, as this condition leads to serious complications for the fetus. Blood pressure is considered "high" when it is higher than 140 mmHg systolic or 90 mmHg diastolic two times after the 20th week of pregnancy. Given the severity of the situation, the obstetrician referred the female patient to a hospital for 24-hour monitoring of her urine and blood pressure.

The hospital to which the pregnant woman was referred is a Level 1 community hospital that does not deliver babies less than 33 weeks of maturity and is not a "high level care hospital." Without ever having been transferred to a high level care hospital, the mother gave birth to the infant at 26 weeks gestation in the unqualified hospital. The infant was born with a white matter brain injury that

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led to severe cerebral palsy and the need for a lifetime of around-the-clock nursing care.

The mother contends that she never should have been transferred to anything but a high level care hospital that would have administered antenatal corticosteroids. That medication is required for women in a high-risk birthing condition between weeks 24 to 34 of pregnancy, and would have mitigated the damages to the infant's brain. As such, the mother and child sued the obstetrician for failing to refer her to a qualified medical center, as well as the hospital where the baby was delivered for failing to administer the proper medication and for negligently attending to her pregnancy in an unqualified facility.

Alleging that the child would need around-the-clock medical care for her entire lifetime and the clear fault of the obstetrician and attending hospital, the mother and child requested $54 million in damages. After a three-week trial, the jury awarded them $23 million in damages. The obstetrician who failed to refer the mother was held 70% liable for the damages, and the unqualified hospital where the child was delivered was found 30% liable.

What this means to you: This case highlights the need to be cognizant of and adhere to guidelines set forth in existing systems, such as the different levels of care hospitals can provide.

The "levels" refer to the standard of care and resources available at a given hospital. They are applied throughout the United States and put forth by American College of Surgeons. The American Congress of Obstetricians and Gynecologists also sets guidelines for the treatment of preeclampsia including requirements for providing safe pre-term deliveries. When faced with a condition requiring a certain level of care, as in this case with the pregnant woman suffering from severe preeclampsia, the physician must adhere to these guidelines and refer the patient to a qualified facility.

The presence of pre-eclampsia signals a high-risk pregnancy. A competent obstetrician has systems in place to manage these pregnancies and/or qualified colleagues who are called in to assist.

A fetus at 26 weeks is extremely premature. The receiving facility would need not only trained labor and delivery staff, but at least a Level 2 Neonatal Intensive Care Unit that could manage the newborn or provide immediate transfer to a tertiary-care children's hospital. From a legal standpoint, it becomes very easy to establish negligence when there is a well-known standard that the physician failed to observe. This situation can be seen in the current case, as the obstetrician failed to admit the patient to a qualified facility and the receiving facility failed to transfer the patient to a higher level of care, thus causing the infant to suffer an injury. That the mother could have received more sophisticated care, especially when there is a system in place to ensure that care, was enough to find liability against the physician who failed to adhere to the applicable standards. Familiarity and compliance with such systems are necessary to avoid liability.

Another lesson illustrated in this case is that, from a legal standpoint, due diligence always should be given to infant or minor patients. When calculating the damages for which a physician or hospital will be liable, the future medical expenses and pain and suffering are based in significant part on life expectancy and amount of time the patient will suffer the condition. Furthermore, infant and pregnancy-related cases hold a unique place in the heart of juries who will often instinctually be sympathetic toward an infant.

These two factors undoubtedly influenced the decision to award $23 million to the mother and child. As such, and with respect to the financial liability a physician or hospital might incur, the need to maintain the appropriate standard of care is enhanced when dealing with infants.

Lastly, this case shines a light on the need to adequately inform patients regarding the planned course of action. Had the mother in this case been informed of all the risks involved with her given treatment, and if the mother decided to move forward fully informed, the physician would have been better sheltered from liability.

However, when physicians fail to inform patients of all the risks, possible alternatives, and possible effects of those risks and alternatives regarding medical decisions, the physician takes away the patients' right to choose the care they wish to receive from an informed standpoint. When an injury occurs, even one the physicians expected, failing to inform the patients of relevant information that facilitates them making an informed decision can quickly lead to avoidable and costly medical malpractice claims. As such, physicians can help shelter themselves from this type of liability by providing patients with all the information necessary to make an informed decision.

REFERENCE

Florida Circuit Court, Charlotte County. Case Number 13-1984 CA (April 24, 2015). ■

Physician not following through on proposed plan costs hospital $4.8 million

News: An adult female went into the hospital for a consultation regarding surgery on her bowel. Upon examination and confirmation the woman was suffering from a leaky bowel, the surgeon recommended a laparoscopic ileocecectomy, which is a less invasive form of surgery using small incisions, special instruments, and cameras. One month later, the surgeon performed the procedure with what appeared to be no complications. However, the woman began suffering extreme abdominal pain and high fever the day after the procedure. A physician at the hospital where the procedure took place suggested a CT scan if the condition continued and informed the surgeon of this suggestion. The woman's symptoms continued, and blood tests were ordered. The initial lab results indicated an infection. The CT scan results the subsequent day affirmed that the woman was suffering from an abdominal infection with sepsis. The surgeon performed an additional corrective procedure, but the woman already was in septic shock. This incident, according to court documents, led the woman to have serious injuries, great pain, suffering, disability and disfigurement, and future medical costs. The woman sued the hospital where the surgeries occurred for the conduct of its staff, specifically the failure to diagnose the infection earlier and failure to inform her that the surgeon was inexperienced with these types of procedures. The hospital was ordered to pay the woman more than $4.8 million for the staff's negligence.

Background: In 2010, a female patient with a history of bowel problems sought treatment from a surgeon. The surgeon recommended laparoscopic ileocecectomy, a procedure designed to lead to speedy recoveries due to small incisions and special instruments. The surgery was set and performed one month later. The woman was monitored that day and had no fever, and her pain was being managed by pain medication. The next day the woman reported a score of 10 out of a possible 10 for pain in her abdomen and a fever of 100.8 F. The attending physician at the time suggested close monitoring and CT scan if the symptoms continued. The physician instructed the surgeon of the situation. The next day the woman's temperature increased to 102.56 F, and her pain had not subsided. Another physician in the hospital evaluated her and also recommended a CT scan but did not order it. The following two days yielded the same results, physicians noting the pain in the abdomen and a fever and recommending, but not ordering, a CT scan. During this time, the woman was not given any antibiotics to fight a possible infection.

Three days after a CT scan initially was requested and the woman had extreme pain and high temperature, blood work was ordered and revealed the infectious process had begun. It wasn't until the next day, four days after the initial CT scan was requested, that the woman was given a CT scan and antibiotics to fight the infection. Court documents allege that the woman was "considered" for a CT scan six times and had a temperature 103.46 F before being given the CT scan. The CT scan revealed fluid in the pelvis area and abscess, both of which are signs of bowel perforation.

Following the CT scan results, the surgeon performed surgery on her to correct the situation. During the surgery, a diverting proximal ileostomy, the surgeon found a large amount of bile in the abdominal area, a pelvic abscess, and a leaking anastomosis at the staple line from the previous surgery. The woman's condition led to abdominal infection and septic shock, which required numerous hospital visits and caused a regular bowel leak that caused pain for nearly a year. One year later, the woman had the situation surgically corrected and sued the hospital for her injuries.

The woman named the hospital as the defendant in the lawsuit. She sued the hospital under the legal theory of *respondeat superior,* which holds employers liable for the conduct of their employees in states where physicians are routinely hospital employees. The staff's negligence was primarily the surgeon not recognizing the early signs of infection, not ordering the CT scan called for in his plan, failing to administer antibiotics, botching the first surgery, and failing to inform the patient that the surgeon was inexperienced at performing these types of surgeries.

The hospital maintained its staff was not negligent in any regard, did not fail to adequately inform the woman, and obtained informed consent from her regarding the surgery.

The jury agreed with the woman and awarded her more than $4 million against the hospital. The breakdown of the verdict was $2.75 million for past and future pain

and suffering, more than $909,000 for past medical care, $895,000 for lost income, and $250,000 for disfigurement.

What this means to you:
The primary lesson to be learned from this case is physicians should always follow through on their own recommendations. A physician or hospital does not face liability simply for an injury or adverse development. Rather, the injury typically has to be connected to an act of negligence that is the cause of the injury or adverse development. As such, when physicians put their recommendations in writing, fail to follow through on their own recommendation, and that failure causes damages to patients, the attorneys representing the patients easily can establish that the standard of care was negligent because the physicians "neglected" to follow up on their own recommended standard. Such was the case here, as the surgeon failed to order the CT scan when the woman's condition persisted, even though his recommendation called for a CT scan if the condition persisted. Establishing he was negligent was an easy task because the woman's attorney was able to point to the documented plan the surgeon failed to follow. Moving forward, it is prudent for a physician to follow up on their recommendations or physically make a notation in the patient's file as to why the follow-up treatment was not the chosen course of action.

This situation is unfortunately recurring in hospitals today. The primary physician is usually managing the case with consultants, such as surgeons, being called upon by the primary physician to handle situations for which they are qualified to treat and the primary physician is not. What often happens is that the consultant, the surgeon in this case, writes his or her recommendations in the patient's progress notes, and these are overlooked by the attending physician. Leaks at the anastomoses sites are not uncommon, and patients must be monitored closely for this problem during the first 24-72 hours postoperatively. Nurses also are aware of this risk and, as hospital staff, have a duty to inform the attending and the surgeon of the patient's fever elevation and intractable pain.

This case also raises the issue of informed consent. With the emergence of new medical technology rapidly growing, surgeons and physicians might be performing a procedure they have yet to perform on a patient. There is always a first time. Physicians in this situation should disclose their level of expertise, or lack thereof, to their patients. Moreover, before the surgeon ever goes to the operating room, the organized medical staff members of the hospital have a duty, through peer review, to evaluate the surgeon's qualifications. If the physician has not been proctored appropriately and to the pre-determined level of quality, the hospital's medical staff should require additional training before the surgery takes place. If an injury or adverse event occurs as a result of a surgery and the patients were unaware the physicians lacked experience with the performed procedure, patients can claim they lacked the requisite level of information to make informed decisions. Specifically, the patients can allege that knowledge regarding the surgeons' lack of experience would have led to the patients not undergoing surgery. In this case, the lack of disclosure with respect to the surgeon's inexperience regarding the performed procedure provided the basis for the woman's successful claim that she was not adequately informed of information that would have altered her decision to have the surgery that caused her injuries. Reasonable patients certainly regard the level of expertise of their physicians as a relevant factor that influences their decision to move forward with a proposed course of action, so prudent physicians should disclose their level of expertise regarding that procedure as well as associated risks and alternatives.

REFERENCE

Illinois Circuit Court, Cook County, Case Number 2011-L005165 (Dec. 17, 2014). ■

Clarification

In the August issue of *Legal Review & Commentary,* in the story "Failure to update a patient's EHRs leads to $35.4 million verdict against hospital," we should have said that the plaintiff's brain abnormalities required her treating physician to record her condition on a paper Problem List. When electronic health records (EHRs) were introduced, information on the Problem List was entered into an EHR, which physicians subsequently treating the woman were able to review as part of a review of all of her EHRs. Unfortunately, her primary physician failed to note the brain abnormality on the Problem List, which also led to the information not being fed into the EHR, and, in turn, to her future obstetrician being unaware of it. ■

Healthcare Risk Management

Confidential Salary Survey

This confidential salary survey is being conducted to gather information for a special report. Watch in coming months for your issue detailing the results of this survey and the overall state of employment in your field.

Instructions: Select your answers by filling in the appropriate bubbles completely. Please answer each question as accurately as possible. If you are unsure of how to answer any question, use your best judgment. Your responses will be strictly confidential. Please do not put your name or any other identifying information on this survey form.

1. What is your current title?

- ◯ A. Risk manager
- ◯ B. Lawyer
- ◯ C. Clinical manager
- ◯ D. Clinician
- ◯ E. Other _____

2. What is your annual gross income from your primary healthcare position?

- ◯ A.< $30,000
- ◯ B. $30,000 - $39,999
- ◯ C. $40,000 - $49,999
- ◯ D. $50,000 - $59,999
- ◯ E. $60,000 - $69,999
- ◯ F. $70,000 - $79,999
- ◯ G. $80,000 - $89,999
- ◯ H. $90,000 - $99,999
- ◯ I. $100,000 - $129,999
- ◯ J. $130,000 or more

3. Where is your facility located?

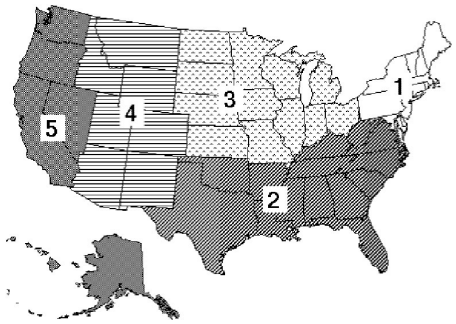
- ◯ A. Urban area
- ◯ B. Suburban area
- ◯ C. Medium-sized city
- ◯ D. Rural area

4. In the last year, how has your salary changed?

- ◯ A. Salary decreased
- ◯ B. No change
- ◯ C. 1% - 3% increase
- ◯ D. 4% - 6% increase
- ◯ E. 7% - 10% increase
- ◯ F. 11% - 15% increase
- ◯ G. 16% - 20% increase
- ◯ H. 21% increase or more

5. Please indicate where your employer is located.

- ◯ A. Region 1
- ◯ B. Region 2
- ◯ C. Region 3
- ◯ D. Region 4
- ◯ E. Region 5
- ◯ F. Canada
- ◯ G. Other



6. Which best describes the ownership or control of your employer?

- ◯ A. College or university
- ◯ B. Federal government
- ◯ C. State, county, or city government
- ◯ D. Nonprofit
- ◯ E. For profit

7. How long have you worked in healthcare?

- ◯ A. Less than 1 year
- ◯ B. 1-3 years
- ◯ C. 4-6 years
- ◯ D. 7-9 years
- ◯ E. 10-12 years
- ◯ F. 13-15 years
- ◯ G.16-18 years
- ◯ H. 19-21 years
- ◯ I. 22-24 years
- ◯ J. 25+ years

8. Which certification best represents your position?

- ◯ A. CPHRM
- ◯ B. ARM
- ◯ C. FASHRM
- ◯ D. MSM
- ◯ E. CPHQ
- ◯ F. Other _____

9. If you work in a hospital, what is its size?

- ◯ A. < 100 beds
- ◯ B. 100 - 200 beds
- ◯ C. 201 - 300 beds
- ◯ D. 301 - 400 beds
- ◯ E. 401 - 500 beds
- ◯ F. 501 - 600 beds
- ◯ G. 601 - 800 beds
- ◯ H. 801 - 1,000 beds
- ◯ I. > 1,000 beds
- ◯ J. I don't work in a hospital

Deadline for Responses: Nov. 1, 2015

Thank you very much for your time. The results of the survey will be reported in an upcoming issue of the newsletter, along with an analysis of the economic state of your field. Please return this form in the enclosed, postage-paid envelope as soon as possible.

If the envelope is not available, mail the form to: AHC Media LLC, P.O. Box 550669, Atlanta, GA 30355.