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INSIDE

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Improve on-call ED coverage by making it easier on specialists

You come to work Monday morning and hear this tale from your emergency department (ED): A patient presented in the ED over the weekend with compartment syndrome and needed a fasciotomy, but no specialist was available. None of the available physicians had done one since medical school, so the physician who drew the short straw studied the procedure on YouTube before proceeding.

The mind reels with the potential liability, but that incident actually happened at a respected hospital, a physician tells *Healthcare Risk Management*. Ensuring that your ED has adequate specialists on call is one of the oldest and most frustrating challenges for risk managers, and it seems no one has yet found the perfect solution. Some strategies have emerged, however, that can lessen the risk of liability from failing to have physicians on call.

In her years as risk manager and chief nursing officer at several facilities, **Kim Adams,** RN, MSN, LHRM, tried several strategies for improving on-call coverage in the ED but never found the perfect solution. Adams is now a risk management consultant and president of Adams & Associates of North Florida in Lynn Haven.

"THE OTHER COMMON STRATEGY IS BEGGING AND PLEADING, TALKING THE SPECIALISTS UP ABOUT HOW IMPORTANT THEY ARE TO THE COMMUNITY ... "
— DAVID BIRDSALL, MD, CEP AMERICA

The first step in trying to ensure adequate ED call coverage is to make sure hospital bylaws specify that physicians on staff must take call coverage, she notes. That requirement can include physicians who maintain their own practices but still remain on active status with the hospital, which often is required by malpractice insurers.

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"Requiring a certain number of days on call will make some physicians say they won't be on staff, so it's a push and shove," Adams says.

In the Florida panhandle where she works, finding orthopedic specialists and ear, nose, and throat (ENT) specialists for ED coverage have been the biggest challenges, she notes. Many orthopedists would resist coming to the ED when called. They would insist that the patient didn't need emergency care from a specialist and could be seen in the physician's office later. Thus, ED physicians and staff members were in the habit of providing whatever treatment was immediately necessary, such as putting a boot on a fracture, and instructing the patient to make an appointment with the orthopedist.

Then patients complained that when they had a Medicaid referral, the physician wouldn't see them without payment upfront because many Florida physicians won't accept Medicaid. That situation led patients to come back to the ED and complain that the physicians wouldn't see them. After some negotiation involving Adams' sister-in-law, who worked at an orthopedic practice, a group of about 10 physicians agreed to take Medicaid patients. That change helped ED coverage with that specialty.

"But at another facility, we were launching a trauma center, and orthopedists didn't want to be on call without payment because of the type of patients they would get. We weren't willing because that's a slippery slope, and then your ENT won't be on call without pay. You become a hospital that subsidizes physician practices, and it's no longer the collaboration and becomes more an employee model."

Employee model

Rather than paying for on-call coverage, Adams' hospital went ahead and adopted the employee model. It hired its own specialists, gave them office space, and allowed them to run their practice from the hospital.

That situation didn't work out in the end because the specialists found that, between their regular practice and the hours spent on call for the ED, they were overloaded. In the trauma center, the specialists were required to go to the ED and see patients within 30 minutes when on call, rather than simply referring them for an office visit.

The orthopedists are negotiating with the hospital to go back to the original offer and provide on-call trauma coverage for a fee, Adams says. The hospital is considering that option, because it was never successful in putting together a large,

EXECUTIVE SUMMARY

Risk managers still struggle to ensure the emergency department has adequate on-call coverage. There is no perfect solution, but several strategies may help.

- Paying some specialists for on-call coverage is a slippery slope.
- Physicians are more likely to take call coverage if they are treated well at the hospital.
- Agreeing to round on patients the next morning can reduce nighttime calls.

profitable orthopedic group.

"This is a problem that hospitals and risk managers struggle with every day, and we're always looking for another idea that might work better," Adams says.

Strategies for addressing on-call coverage will differ depending on why you have a shortage, says **David Birdsall**, MD, a practicing emergency physician and vice president for leadership development with CEP America, a national physician staffing company in Emeryville, CA. Are you having trouble with call coverage because there is a lack of those specialists in the area, or is it because they just don't want to take call coverage because it is inconvenient and they can make more money in their offices? Also, do you need a wide range of specialists as you would for a trauma center, or are you in a small hospital that routinely refers patients to larger facilities, and so you can get by with specialists in a few key areas such as surgery and obstetrics?

Requiring call coverage for physicians on staff tends not to be popular and is especially ineffective when the physician can take his or her business down the street to another hospital, Birdsall notes. The advent of ambulatory surgery centers has given many surgeons the option of practicing without being on staff at a hospital, says **Peter D. Steckl**, MD, a practicing ED physician and the risk manager for EmergiNet, an emergency medical staffing and management company based in Atlanta.

"It used to just be assumed that you would have to do call coverage just to maintain your staff privileges and operate, but now you don't have to have staff privileges to operate," Steckl says. "That means the doctors that remain have more leverage to say you're going to have to pay them for taking call."

Steckl notes that having insufficient specialists on call can be a serious threat to patient safety. Transferring a patient to another hospital with specialist care carries its own patient safety risks, he notes, and ED physicians often are forced to do specialty procedures that they would rather not do.

"We're being called upon to deal with high-risk patients, high-risk procedures that are better handled by a specialist. We're all trained in those procedures, but I can tell you I've done a total of three cricothyrotomies in my 25 years," he says. "When we're doing them, it's stressful and we get them done, but likely not as well as a specialist. And then we have a patient with a cricothyrotomy, and we're going to put them in an ambulance and ship them 45 minutes down the road."

Pay structure options

Birdsall agrees with Adams that paying for on-call coverage is a slippery slope, but he notes that there are different ways to structure a pay agreement.

Specialists can be paid a stipend for simply agreeing to be on call a certain number of days, but you also can pay a response stipend that they receive if they come to the ED. You could add on a bonus rate for patients who are underinsured, he says. In that case, the hospital will pay the physician a certain percentage of Medicare rates, usually over the Medicare rate, to see that patient, he explains.

"That makes it financially viable, or at least not as burdensome, for the doctor to come in," Birdsall says. "The other common strategy is begging and pleading, talking the specialists up about how important they are to the community, and that's been known to work. I know a couple of hospitals where the medical staff lounge is probably the most opulent place I've ever seen. They get people to be on call and work at those sites because they get treated very well."

Having a hospitalist on staff can significantly reduce the need for on-call specialists, Birdsall notes. In many cases the ED physician does not need the specialist to come in, but only needs advice, and a hospitalist often can fulfill that need. A hospitalist also can admit the patient for the specialist, which can help reduce the burden on being on call, he says.

When the problem is a lack of specialists in the community, the hospital can recruit them for its own benefit. Recruiting also can be an effective strategy when you have enough available but they refuse to be on call. Birdsall worked with one hospital that recruited a specialist to the community specifically to take call coverage, and that caused the local specialists to worry so much about losing business that they agreed to start taking call coverage too.

Telemedicine also can ease the burden on specialists being on call, Birdsall notes. Anything that helps the specialist avoid coming in to the ED will encourage them to take call coverage, he says.

Morning rounds instead

Another strategy is to have physicians agree that, as necessary, they will round on patients the next morning who were admitted through the ED during their on-call period.

In many cases, such as a gastrointestinal bleed, the ED physician is reluctant to admit the patient without the specialist coming in because there is a chance that the patient could get worse and need the specialist in the morning. If the specialist didn't come in during

the on-call period, he or she is not obligated to see the patient in the morning, and so the hospital is left to look for a specialist who will come see the patient. By agreeing to see such patients the following morning, specialists can avoid getting calls from ED physicians in the middle of the night just to ensure they're not left stranded after the call period.

"That can be a good compromise that gets more specialists to say yes to being on call," Birdsall says. "They worry less about being awoken in the middle of the night and then have to do a full day at work the next day. That appeals especially as you get older."

Similarly, hospitals without adequate specialist coverage can make agreements with larger hospitals to accept transfers after patients are admitted. If that patient with a gastrointestinal bleed was not emergent during the night but does need a specialist in the morning, the larger hospital agrees to accept the transfer even though the Emergency Medical Treatment and Labor Act (EMTALA) no longer requires them to do so. That agreement can reduce the number of patients who are transferred before admission, while EMTALA still applies, just as a precaution.

"They agree that they will take the patient in the morning, if necessary, because they don't want you sending over every patient just in case," Birdsall explains. "The agreement also can specify that once the specialist care is provided at the larger hospital, the first hospital will take the patient back with no muss, no fuss."

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Risk management falls under criticism after a patient is forcibly removed

Risk management at a Florida hospital was cited as insufficient in the state investigation following a high publicized incident in which a patient was forcibly removed, and the state rejected the hospital's corrective action plan.

The state is seeking $45,000 in fines against Calhoun–Liberty Hospital in Blountstown, FL, following an incident in which 57-year-old Barbara Dawson refused to leave the hospital and was forcibly removed by a police officer. She collapsed outside and died from what the medical examiner's office determined was a blood clot in her lung caused by obesity. *(For more on the incident, see "Staff disciplined, investigations launched when patient ejected after discharge,"* Healthcare Risk Management*, March 2016, at bit.ly/21rdnpN.)*

Dawson's death received widespread publicity and prompted a probe by Florida's Agency for Health Care Administration (AHCA), the state agency in charge of licensing and administering policy and planning for healthcare facilities. AHCA Secretary **Elizabeth Dudek** announced that the investigation found 10 deficiencies at the hospital, including deficiencies regarding patient rights and care, emergency services, and the risk management program – patient grievance analysis. *(The full report is at http://tinyurl.com/h4c63gj.)*

"Our Agency found the deficiencies at Calhoun–Liberty Hospital so egregious that the facility will be fined and is required to submit a Plan of Correction by February 19, 2016," Dudek said. The hospital submitted a corrective action plan by that date, but AHCA rejected it. The Agency sent a four-page letter to the hospital's CEO and administrator Ruth Attaway and said the facility's submission included several unreadable pages and that the facility failed to specify numerous aspects of

EXECUTIVE SUMMARY

Investigators cited risk management failures in a state investigation of a Florida hospital. The investigation was prompted by the forcible removal of a patient.

- Investigators uncovered a second incident in which risk management failures also were cited.
- Criticism focused on risk management not being alerted to the incidents promptly.
- The hospital's corrective action plan was rejected by the state.

its plan.

The hospital was given a deadline of March 1 to correct the deficiencies, but AHCA did not announce any decision immediately after that date passed. If the agency determines the deficiencies were not corrected, the hospital will be suspended from the Medicaid program.

The hospital recently fired two nurses and a paramedic who were involved in the incident. They had been removed from patient care duties soon after the incident.

In addition, the former chief financial officer for Calhoun–Liberty Hospital filed a federal whistleblower lawsuit claiming the hospital's board members did not stop harassment from the hospital's former administrator. Haley Green filed the lawsuit in U.S. District Court for the Northern District of Florida, and Green alleged that she discovered fraudulent transactions for medical supplies by then director of emergency medical services Phillip Hill. Green claims Hill threatened her job and harassed her when she refused to overlook the alleged fraud.

The state's report addresses two incidents that occurred in the Calhoun-Liberty emergency department (ED). The first involves a patient identified as no. 10, who was Dawson, the woman who was forcibly removed and subsequently collapsed outside the hospital. The second involves a patient identified as no. 23, a woman who requested pain medication in the ED because the medicine prescribed by her doctor was not working.

Calhoun-Liberty violated the state rule requiring a hospital to have written policies and procedures specifying the scope and conduct of emergency services with both patients, the report says. With Dawson, the hospital failed to follow its policies on medical screening examinations, respiratory distress evaluations, assessment, and change of condition assessment, investigators concluded. The report also indicates that the risk manager was out of state during the incident and when an investigator called her on some unknown date (interview dates are redacted in the report), she said she had not had the opportunity to speak with any of the staff members involved and had only begun a review of the medical record.

THE STATE'S REPORT ADDRESSES TWO INCIDENTS THAT OCCURRED IN THE ... EMERGENCY DEPARTMENT.

With the second patient, no. 23, hospital staff explained to her that the ED was staffed with only an advanced registered nurse practitioner (ARNP), rather than a physician, and the ARNP could not prescribe the pain medication because of another medication she was taking. The woman became angry and left the ED without seeing the ARNP. Agency investigators found no documentation indicating that the staff ever triaged the patient, obtained vital signs, completed a pain assessment, or conducted a medical screening exam.

The risk manager apparently did not learn of the no. 23 incident for at least three days after it happened. In the narrative detailing the incident and the investigation, the AHCA report notes that an investigator interviewed the hospital's risk manager, who stated "that she had not been in at the time of the incident and had not known of the incident until yesterday, [date redacted], when she asked the administrator about it."

The director of nursing told investigators that the ED always has a physician on call who can prescribe medications. The director said that it was not normal procedure to tell patients that the ARNP cannot prescribe a medication and that she would expect that conversation to take place between the patient and the ARNP.

The report cites the state's requirements for an incident reporting system "based upon the affirmative duty of all health care providers and all agents and employees of the licensed health care facility to report adverse incidents to the risk manager, or to his or her designee, within 3 business days after the occurrence." That requirement was not met, the report says, because "[b]ased on patient interview, staff interview and record review, the hospital failed to implement their incident reporting system for two of 24 patients sampled to the emergency department (no. 10 and no. 23). The administrator failed to complete an incident report and initiate an investigation after receiving a complaint from patient no. 23 about being turned away from the emergency department, a violation of State Emergency Access Laws."

The report states that by the end of its investigation, the hospital had not filed an adverse incident report with the state agency for the Dawson incident, as required within 15 days by state law. The federal component of the survey is under review by the Centers for Medicare and Medicaid Services. ■

Sexual abuse and harassment are challenging liability areas to address

In light of recent high profile cases of sexual assault and harassment in healthcare facilities, risk managers should assess whether their policies and procedures are strong enough to produce an adequate response when staff members or patients report these incidents, one experienced risk manager suggests. The policies must lead to disciplinary action when appropriate, she says.

"It needs to be a policy that has teeth," says **Delphine O'Rourke**, JD, in-house general counsel and chief advocacy officer of Our Lady of Lourdes Memorial Hospital in Binghamton, NY, and managing partner of the Philadelphia, PA, office of the law firm Hall, Render, Killian, Heath & Lyman.

Two recent cases in the news drew attention to the problem of sexual abuse and harassment in healthcare. One involved a physician accused of sexually abusing a patient, and another involved a surgical tech accusing a nurse anesthetist and surgeon of sexually harassing her. Both incidents resulted in lawsuits against the hospitals and others. *(See the story enclosed in this issue for more information on those incidents.)*

"In both of these cases, there were allegations that hospital administrators didn't respond or didn't investigate," O'Rourke says. "The policy has to be strong enough to create a culture of compliance, to communicate to physicians and staff that we take this seriously and there are concrete identifiable consequences to this behavior. [Have] zero tolerance for this type of behavior."

Consider a hotline

There also should be a process to facilitate concerns about sexual abuse and harassment, O'Rourke says, such as a hotline dedicated to staff concerns or even to this particular concern.

Anonymous reporting is critical because staff members cite fear of retaliation as one of the main reasons they do not report sexual misconduct, as victims or witnesses. Particularly with the physician/staff dynamic in healthcare, employees can be very fearful that a physician will retaliate in the workplace, even if there are no negative consequences from administration in a formal way, she says.

"They won't get the high-paying shifts, they'll be cut off from surgeries with that physician, moved from their units, subject to greater harassment by the person they report," O'Rourke explains. "That fear of retaliation can be a powerful disincentive even when the person knows that what is happening is wrong and shouldn't be tolerated."

Reasons for reluctance

Victims also can be dissuaded from reporting because they think nothing will be done to stop the behavior.

There is some justification for that thought because even when physicians are accused of sexual misconduct, state boards rarely take any disciplinary action, according to the first study using information on physician sexual misconduct from the National Practitioner Data Bank (NPDB). *(See the story enclosed in this issue for more information on that report.)*

Though allowing anonymity, the process for reporting concerns must give administrators enough information to investigate and act. Achieving both requires a delicate balance, O'Rourke says. It is not unusual for hotlines to receive calls that indicate a serious problem but provide too little information for follow up, she says.

Any information promoting the hotline, and the recording the caller hears, should emphasize the need for enough detail to allow administration to respond. That information must be paired with assurances that any retaliation in the workplace will not be tolerated.

O'Rourke notes that encouraging people to report concerns directly to risk management may not be the best choice. Like it or not, many

EXECUTIVE SUMMARY

Two high-profile cases of sexual misconduct in healthcare illustrate the need for good risk management in this area. Both cases led to the hospitals being sued.

- Policies and procedures regarding sexual abuse and harassment must be rigidly enforced.
- Employees and patients need an anonymous method for reporting their concerns.
- The hospital cannot allow retaliation against anyone reporting claims of sexual misconduct.

employees and patients perceive risk management as working to protect the hospital rather than them, so they may be discouraged from reporting, she says. Even if the reports go directly to risk management, it probably is not a good idea to promote that point, she says.

It also is not enough to sit back and wait for the calls to come in. Risk managers should proactively monitor some hospital areas and types of care where sexual misconduct is more likely because patients are more vulnerable, she says. Those areas include geriatrics, pediatrics, surgery, home visits, and anywhere patients are anesthetized. O'Rourke recommends talking with staff in these areas frequently to get a feel for the culture, what is tolerated and what is not, and how comfortable people might feel reporting a problem.

Another strategy is to randomly audit charts of vulnerable patient populations, such as those receiving home care, by contacting those patients and asking about their experiences, O'Rourke suggests. Particularly when you are sending employees to the homes of vulnerable patients, give them the opportunity to voice concerns about sexual misconduct, theft, or any other problem. Those issues may not be detected by in-house efforts, so outreach is necessary.

Areas of liability

Failing to have a meaningful, effective process for reporting and investigating sexual misconduct claims opens up the hospital to liability on several levels, O'Rourke notes.

The hospital can be sued for retaliation even if the administrators did not formally discipline the employee for reporting. The employee can show that he or she was denied higher paying shifts, promotions, or otherwise suffered as a result of reporting, O'Rourke explains. The hospital also can be sued for failing to act after receiving a report and for failing to follow its own policies and procedures.

"Regardless of who the alleged harasser is, the hospital should follow the same policies and procedures," O'Rourke says. "Employees are very attuned to that because this is an environment in which there is a hierarchy, and it's very clear and acknowledged by everyone. If employees don't think the system will treat them equally when they report these things, problems will go unreported, and you're creating a hostile work environment where sexual harassment is tolerated, if not encouraged."

O'Rourke notes that in a California case in which a surgical tech claims a nurse anesthetist was exposing himself to her during procedures, the hospital administration allegedly refused to review the OR surveillance video after she reported the incidents or turn over the video without a court order. If that accusation is true, O'Rourke says, the hospital sent a bad message to employees by implying that it was not willing to investigate serious claims of misconduct.

"I've heard countless times, 'What happens in the OR stays in the OR,'" O'Rourke says. "That culture has to change. Whether it has to do with sexual harassment or infection control, the OR cannot be an environment where rules are broken or rules are bended because of a historic culture."

SOURCE

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Hospitals sued — claims of sexual abuse, harassment

Two hospitals are facing lawsuits, as are several physicians and staff, in two cases in which healthcare professionals are accused of sexual abuse and sexual harassment.

In the first case, a woman accused David Newman, MD, then-director of clinical research in emergency medicine at Mount Sinai Hospital in New York City, of drugging her, groping her, and masturbating and ejaculating on her in January 2016, according to her criminal complaint. Newman was arrested, and his attorney released a statement saying Newman pleaded not guilty.

The complaint alleges that the woman went to the Mount Sinai emergency department (ED) with shoulder pain on Jan. 11. The physician administered morphine to her, even though she already had pain medication, the complaint said. While sedated, she heard and saw the doctor masturbating and ejaculating on her face and breasts, according to her complaint. She called police after leaving the ED, and DNA evidence was collected. That DNA evidence matched the doctor's DNA, according to the lawsuit.

The woman's lawsuit names other ED staff members, claims that the hospital "failed to enforce internal policies," and alleges the hospital "negligently" hired, trained,

retained, and supervised the doctor. She is seeking unspecified monetary damages. The doctor has been charged with first- and third-degree sexual abuse and forcible touching, according to statements released by police. Mount Sinai Hospital issued a statement saying the physician is no longer employed at the hospital but did not respond to a request for comment on the lawsuit.

Tech records OR incident

In the other case, a surgical technician at Adventist Medical Center – Hanford in California took a cellphone video of a nurse anesthetist that shows him exposing himself and masturbating during a surgical procedure.

The woman's attorney, John Little, JD, of Fresno, CA, released the video publicly after she filed a lawsuit accusing the hospital of ignoring her reports of sexual harassment by the anesthetist and a surgeon. She alleges that urologist Seetharaman Ashok, MD, touched and kissed her without her consent and made inappropriate sexual comments about her. Some of the physical contact was recorded by hospital surveillance cameras, the lawsuit says.

The lawsuit also claims that the doctor made a false allegation of misconduct and incompetence against a friend and co-worker of the woman who had witnessed the harassment. The woman's attorney stated in a news conference that she had reported the harassment to hospital leaders, but the attorney said nothing was done. When the hospital also didn't respond to her reports that nurse anesthetist Richard McGrory was exposing himself to her during surgeries, she decided to record him, the lawsuit says.

The woman and her co-worker friend are seeking unspecified damages for sexual harassment, unlawful sexual battery in the workplace, and retaliation. According to their attorney, the urologist still has privileges at the hospital and the anesthetist was allowed to resign. The hospital provided favorable recommendations to the anesthetist for use in obtaining another job, according to the complaint.

The complaint against Adventist Medical Center – Hanford is available online at http://tinyurl.com/hdbpa7q. Adventist Health spokeswoman **Christine Pickering** issued a statement saying the allegations of cover-up were "false and misleading" but that the organization does not discuss pending litigation. ■

State boards don't discipline many physicians for sexual misconduct, consumer rights group says

State medical boards are failing to protect the public from many doctors already known to have committed sexual misconduct, according to a recent report from Public Citizen, a non-profit, consumer rights advocacy group and think tank based in Washington, DC.

Seventy percent of U.S. physicians — 177 out of 253 — who had engaged in sexual misconduct that led to sanctions by hospitals or other healthcare organizations or malpractice payments were not disciplined by state medical boards for their unethical behavior, according to the research. The study is the first published one that used information on physician sexual misconduct from the National Practitioner Data Bank (NPDB).

"It's clear that medical boards are allowing some doctors with evidence of sexual misconduct to continue endangering patients and staff," said **Azza AbuDagga**, MD, health services researcher for Public Citizen's Health Research Group and lead author of the study.

Public Citizen for years has pushed state medical boards to do a better job of disciplining problem doctors. "These boards must pay more attention to sexual misconduct that leads to health care organizations cracking down or to lawsuits," AbuDagga said.

AbuDagga co-authored the study with **Sidney Wolfe**, MD, founder and senior adviser of Public Citizen's Health Research Group; Michael Carome, MD, director of Public Citizen's Health Research Group; and Robert Oshel, MD, retired NPDB associate director for research and disputes.

When state medical boards do act on sexual misconduct, though, they take severe measures in the vast majority of cases. For the 974 NPDB reports of medical boards disciplining physicians in response to physician sexual misconduct, the boards took serious licensure actions — such as revoking, suspending, or restricting the medical license — in 89% of cases. In contrast, state medical boards took such severe actions in only approximately two-thirds of cases involving other types of misconduct.

"These numbers show that when state medical boards take action, the

action rightly tends to be much more severe for physicians who engaged in sexual misconduct than other offenses," Wolfe said. "Now, the medical boards need to pay increased attention to sexual misconduct that led to health care organizations cracking down or to lawsuits. State medical boards have full access to the NPDB data. The boards must protect the public."

Public Citizen examined physician reports in the NPDB from Jan. 1, 2003, through Sept. 30, 2013. The study focused on sexual misconduct-related licensure, clinical privileges, and malpractice payment reports for physicians, including medical doctors, osteopathic doctors, and intern/resident physicians. A "licensure" sanction refers to an action, such as revocation or restriction of a doctor's medical license, taken by a medical board. A "clinical privileges" sanction refers to actions such as revocation or denial of clinical privileges, voluntary surrender of privileges, and restrictions on a doctor's ability to practice. These actions are taken by hospitals, nursing homes, or managed care organizations.

The analysis found that 1,039 physicians had one or more sexual misconduct-related reports, and of these, 786 (76%) had been disciplined only by a medical board. The study also revealed that the remaining 253 physicians had one or more clinical privilege reports or malpractice payment reports related to sexual misconduct, but 177 did not have a report of state medical board licensure action for such misconduct.

While the study provides important new information, it likely highlights a possible overall underreporting or inaction related to physician sexual misconduct. The authors caution that because sexual misconduct-related reports accounted for only 1% of the total reports in the NPDB, their study "represents only the tip of the iceberg of physician sexual misconduct in the U.S."

The full report is available online at http://tinyurl.com/z4ft236. ■

Minimize overrides of technology to improve patient safety

Patient safety could be improved by developing criteria for alerts that focus on opportunities for patient harm, while preventing alert fatigue and minimizing the need for overrides, according to recent research from the Pennsylvania Safety Authority in Harrisburg.

The research was conducted by **Matthew Grissinger**, RPh, FISMP, FASCP, manager of medication safety analysis, and was intended to determine how often healthcare workers override the safety features incorporated in medication-use technologies that provide warnings about possible unsafe conditions or errors. Grissinger also is director of error reporting programs with the Institute for Safe Medication Practices in Horsham, PA.

Grissinger found overrides were most common with automated dispensing cabinets, and the most common type of event involving overrides with the cabinets was unauthorized medication, such as obtaining a medication for a patient without a prescribed order. *(The full report is available online at http://tinyurl.com/hlk3z42.)*

"This technology has really exploded in healthcare over the past 10 years," Grissinger says. "You're always going to have alerts and overrides, but with some technology like computerized order entry, a lot of the alerts aren't meaningful. When people see so many alerts that aren't meaningful, they get in the habit of overriding them almost automatically, and that's when something terrible can happen because they override the alert that was significant and meaningful."

Grissinger studied the use of overrides submitted from January 2013 through December 2014 to the Pennsylvania Patient Safety Reporting System. Of the 583 event reports related to the use of overrides, automated dispensing cabinets accounted for 70%, followed by computerized prescriber order entry at 8.2%, and bar-code

EXECUTIVE SUMMARY

Automated dispensing cabinets account for most overrides on medication alerts, according to a recent study. The most common override is for unauthorized medication.

- Overrides occurred most often in medical-surgical units.
- More than half of overrides occurred with elderly patients.
- More than a quarter of overrides involved a high-alert medication.

medication administration devices at 7.5%. Antibiotics accounted for 12%, opioids accounted for 12%, and anticoagulants accounted for 7.4%. More than a quarter of the reports (26.4%) involved a high-alert medication.

Overrides occurred most commonly in medical-surgical units. Surprisingly, less than a quarter of the reports came from intensive care units and emergency departments, even though one would expect those areas to more frequently need to override an alert to obtain medications quickly. More than half of the reports involved patients 65 years or older; only 5.5% involved a pediatric patient.

Antibiotics and opioids accounted for more than a quarter of the events involving at least one high-alert medication. When a high-alert medication was involved, the three classes most commonly cited were opioids such as morphine, anticoagulants such as warfarin, and insulin.

Seventy-five percent of override events involved automated dispensing cabinets. After unauthorized medications, the most common types of overrides were wrong-drug events and wrong-dosage-form events.

Systems can cry wolf

Overrides appear in standard error reports, so Grissinger suggests that risk managers can monitor alerts and overrides on a monthly basis. The ratio can be used to assess whether systems are "crying wolf" so often that the truly significant alerts may be ignored.

"Be aware of those numbers over time. What has been the trend in the last three or six months?" he says. "You can determine a target that is safe for overrides, like 90% compliance with alerts on smart pumps. You'll never have zero overrides, and that's OK. There will be times when, even if the alert is clinically significant, they still have to override to get something done."

Risk managers also should dig deeper to obtain a more complete idea of how and why overrides occur, he suggests. The override ratio is a good starting point, but the numbers alone don't indicate why an alert was overridden, he says. The answer to that question could reveal potential patient safety improvements, Grissinger says.

The most common type of override in his study — obtaining a medication from an automated dispensing cabinet for a patient without a prescribed order — is particularly important to investigate because the reason for overriding could range from benign to extremely dangerous. A nurse may need to obtain a medication urgently and doesn't have the time to enter a pharmacy order, or the nurse may be trying to obtain a prescribed medication but for the wrong patient.

"Any time you override an alert from an automated dispensing cabinet, you're obtaining medications that have not been reviewed by a pharmacist," he says. "There are situations where that is unavoidable, but you have to structure your system so that is necessary in only the minimum circumstances."

Another issue to investigate is who is overriding the alerts. Are the overrides consistent across all departments, or are they more prevalent on one unit? Is one nurse responsible for a disproportionate number of overrides?

"Productivity can be a tremendous pressure on nurses and doctors, even if the situation is not an emergency," Grissinger says. "We put a lot of pressure on people to move people through the system quickly, not keep patients waiting, to relieve pain as quickly as possible, and sometimes that can lead to people just overriding the alert because they don't want to take the time to investigate why they got the alert or double check an order or a patient's identification."

Don't overuse hard stops

Hard stop alerts are one solution, but they cannot be overused, Grissinger says.

A hard stop does not allow the user to override it and, therefore, should be used only in extreme circumstances in which there could be no legitimate reason to override the alert, he explains.

"Balancing productivity and safety is a challenge," Grissinger says. "You have to find that middle ground where you're protecting patients but not making it impossible for people to enter orders and do their jobs."

SOURCE

- **Matthew Grissinger**, RPh, FISMP, FASCP, Manager of Medication Safety Analysis, Pennsylvania Safety Authority, Harrisburg. Email: mgrissinger@ismp.org. ■

COMING IN FUTURE MONTHS

- Hospital makes alarms more meaningful
- Nurse fired for lengthy preoperative calls?
- Liability from scope recalls
- Medical imposters: How can you stop them?

More nurses, hospitalists being sued for malpractice, studies say

Separate reports indicate that nurses and hospitalists are being sued for malpractice more than in the past.

Malpractice claims against nurses are increasing, with more than $90 million paid in nurses' malpractice claims over a five-year period, according to a report from the Hatboro, PA-based Nurses Service Organization (NSO), which provides malpractice insurance to nurses.

Of the 549 nurse closed claims:

- 88.5% involved RNs;
- 11.5% involved licensed practical nurses (LPNs) or licensed vocational nurses (LVNs).

These percentages were in proportion with the types of nurses insured by NSO.

Claims asserted against LPNs/LVNs resulted in a 58% increase in the average total incurred, compared with the NSO 2011 closed claim report. The higher severity was driven by several closed claims that settled for $250,000 or more and involved infant and pediatric patients with tracheostomies.

Nurses trained outside of the United States were more likely to be involved in a claim, but the average paid indemnity for foreign-trained nurses is almost half of that paid for those trained domestically. Nurses with additional certifications who worked in high-risk areas also were more likely to be sued:

- adult medical/surgical field, 36.1%;
- aging services, 16.4%;
- home health/hospice, 12.4%.

The highest average paid indemnity, $175,500, was for nurses working in the aesthetics/cosmetics fields. Next was obstetrics nurses' indemnities, which averaged $141,661.

Most of the malpractice claims involved the death of a patient. Almost 85% of the nurses who experienced a claim had been in practice for at least 16 years, but those with the largest indemnity payments had been practicing for only three to five years.

The NSO report is available online at http://tinyurl.com/hcqwfgn.

Challenge of high acuity

A study of 464 claims against hospitalists insured by The Doctors Company, a malpractice insurer based in Napa, CA, underscores the particular risks that hospitalists face because they treat patients with high acuity levels.

The research is based on the claims experience of more than 2,100 hospitalists from 2007 to 2014.

Researchers looked at all claims regardless of outcome, an approach that helps physicians and risk managers to better understand what motivates patients to sue hospitalists and to gain a broader overview of the system failures and processes that result in patient harm. The analysis found that 78% of all claims against hospitalists included the three most common patient allegations: failed, delayed, or wrong diagnosis; improper management of treatment; and medication-related error.

The study brings to light the particular challenges faced by hospitalists who manage high-acuity patients, have limited access to patients' past medical histories, and often receive patients with serious conditions, said **David B. Troxel**, MD, medical director of The Doctors Company in a statement accompanying the report. Troxel said the research is unique because it includes insights from expert physicians into the specific factors that led to patient injury.

Most significant factor

The top factor, the physician reviewers determined, was inadequate patient assessments, which occurred in 35% of cases. The inadequate assessments included failure to establish a differential diagnosis, failure or delay in ordering diagnostic tests, and failure to consider available clinical information. Also included in the study are examples of actual malpractice cases and suggested risk mitigation strategies.

Hospitalists should be on the lookout for rare diseases and conditions that can be missed, such as spinal epidural abscesses, which are historically uncommon but now are being seen more often in claims against hospitalists, the report says.

The study is available at http://tinyurl.com/hcgn9xw. ■

CE/CME 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™

CE/CME 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 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.

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 successfully completing the test, a credit letter will be emailed to you instantly.

5. Twice yearly after the test, your browser will be automatically directed to the activity evaluation form, which must be completed to receive your credit letter.

CE/CME QUESTIONS

1. **Which specialties does Kim Adams, RN, MSN, LHRM, president of Adams & Associates of North Florida in Lynn Haven, say are most difficult to obtain for on-call emergency department coverage?**

   A. Neurology and hematology
   B. Orthopedics and ear, nose, and throat
   C. Pediatrics and ophthalmology
   D. Surgery and urology

2. **According to David Birdsall, MD, a practicing emergency physician and vice president for leadership development with CEP America, why does having specialists agree to round on patients in the morning prompt more to take on-call coverage?**

   A. The specialists will receive fewer calls during the night just to ensure the patient will be seen in the morning.
   B. The specialists will increase patient volume for their practices.
   C. The specialists are already going to round on patients in that facility.
   D. Patients are more stable the next morning.

3. **In the state investigation of Calhoun-Liberty Hospital, what aspect of risk management did the investigators cite as insufficient?**

   A. Adequate malpractice insurance
   B. Building and campus safety
   C. Privacy of patient information
   D. Patient grievance analysis

4. **In the research conducted by Matthew Grissinger, RPh, FISMP, FASCP, on what technology were alerts most often overridden by healthcare workers?**

   A. Automated dispensing cabinets
   B. Infusion pumps
   C. Cardiac monitors
   D. Bedside alarms

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

Failure to timely diagnose complication leads to $1.57 million verdict for hospital

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News: In 2011, a woman underwent laparoscopic surgery to increase her likelihood of becoming pregnant. During the procedure, and unbeknownst to the woman and her obstetrician, the woman's small bowel was perforated. The woman went to the emergency department (ED) the day after the surgery complaining of pain in her lower abdomen and with a high fever and pulse. She was sent home without a CT scan or other test revealing her perforated bowel. On the third day after her surgery, she returned to the ED with a swollen abdomen and vomiting, and she was admitted to the hospital. After being in the hospital for two days, and a total of six days after her initial surgery, a CT scan was ordered and revealed the perforated bowel. As a result of her perforated bowel going untreated for six days, the woman underwent two subsequent surgeries to treat her condition. The woman filed a medical malpractice lawsuit against the obstetrician and hospital for which he worked, and she alleged that the obstetrician failed to timely diagnose her perforated bowel. There was no medical malpractice claim regarding the perforated bowel, as this risk was considered an acceptable one of the procedure. The hospital, which was held liable for the conduct of its staff, denied it was negligent for not diagnosing the perforated bowel earlier. The jury found that the obstetrician was negligent for the delayed diagnosis and the hospital was liable for $1.57 million, which consisted of $474,477 for past medical expenses and $1.1 million for pain and suffering.

Background: On Nov. 16, 2011, a 36-year-old woman underwent laparoscopic surgery to increase her likelihood of becoming pregnant. A known risk of this procedure is a perforated bowel, and during the surgery, the woman's small bowel was perforated by her obstetrician. Neither the patient nor the obstetrician were aware of the perforated bowel at that time. The following day, the woman went to the ED complaining of pain in her lower abdomen and a high fever and pulse. There was no CT scan ordered or other test administered that discovered the woman's perforated bowel. On Nov. 19, the woman returned to the ED with a distended abdomen and vomiting, which caused her obstetrician to admit her into the hospital on Nov. 20. It was still unknown to the obstetrician that the woman's bowel was perforated. On Nov. 22, which was six days after the initial laparoscopic surgery and two days after being admitted to the hospital, a CT scan was ordered, which revealed the perforated bowel.

The six-day delay to diagnose the woman's perforated bowel was alleged to be the cause of the woman having to undergo two additional surgeries to correct the perforated bowel and damage that resulted from the six days it went undiagnosed. Subsequently, the woman filed a medical malpractice lawsuit against the obstetrician and hospital for which he worked. The lawsuit alleged the obstetrician was negligent for failure to diagnosis her perforated bowel

inancial Disclosure: Co-authors Jamie Terrence & David Vassalli, author Greg Freeman, Exec. Editor Joy Daughtery Dickinson, & Nurse Planner Maureen Archambault have no financial relationships with companies having ties to this field. Co-author Damian Capozzola represents Currie Medical Specialties in an action against Tenet Healthcare and is in an administrative action against Westside Regional Center. Arnold Mackles, physician reviewer, writes CME/CE courses, is on The Sullivan Group advisory group, & is a stockholder, speaker, author & consultant for Innovative Healthcare Compliance Group.

in a timely manner. The obstetrician was deemed an agent of the hospital, and in defense of the allegation that it negligently failed to timely diagnose the woman's perforated bowel, the hospital denied all negligence. Because a perforated bowel is a known risk associated with the procedure, and the patient was aware of the risk, there was no medical malpractice claim for the performance of the surgery.

The jury found the obstetrician was negligent in not diagnosing the perforated bowel earlier and that the delayed diagnosis caused the woman's injury. As such, the jury awarded the woman $1.57 million against the hospital. The award consisted of $474,477 for the woman's past medical expenses and $1.1 million for her pain and suffering.

What this means to you: This case is an example of a missed opportunity for a hospital to correct its own mistake. The hospital in this case was not liable for the woman's bowel mistakenly being perforated during the procedure. Rather, it was the actions that took place in the days following the surgery — mainly, the failure to recognize or administer proper tests to discover that an error was committed during surgery — that led to liability. The woman returned to the very hospital where she received the surgery and where she complained of abdominal pain, fever, vomiting, and tachycardia, all classic indications of a bowel perforation. These symptoms, plus the immediate history of laparoscopic abdominal surgery, should have elicited, at a minimum, an order for a CT scan of her abdomen on the first visit. That scan was the standard of care, and that standard of care was breached. The delay that followed elevated that breach to negligence because at a similar facility under similar circumstances, a CT scan would have been ordered on the first visit. The hospital and its staff had numerous opportunities during the patient's two ED visits and subsequent admission to order a CT scan and other diagnostic tests to discover that the procedure performed by the obstetrician perforated the women's bowel. Had the hospital ordered a CT scan immediately or at any time before the six days it waited, it could have mitigated the harm to the patient as well as its own liability. In light of the woman's relatively minor injuries and the only fault assigned to the hospital being the damage that occurred in the time between the perforation and the discovery of it, the large jury award indicates that the jury found it particularly blameworthy for the hospital to fail to diagnose its own mistake. As such, hospitals and physicians should treat a patient returning with possible complications as not only a patient in need of care but also an opportunity to avoid or mitigate costly liability stemming from prior care.

This case also illustrates how informing patients of risks associated with a proposed medical treatment can shelter hospitals and physicians from liability caused by medical errors. It is known by physicians, patients, and jurors alike that medical treatments involve risks and complications. With this situation in mind, hospitals and physicians can shelter themselves from liability for known complications when the patient gives his or her informed consent regarding the risks of the procedure. Informed consent consists of the patient being reasonably informed of the nature of the procedure, the risks associated with that procedure, alternatives to the procedure, and the risks associated with the alternatives of a procedure. A patient need not be told every detail of every risk, but the patient is entitled to the relevant information a reasonable person should know to make a prudent decision regarding his or her own healthcare. In this case, the laparoscopic surgery did not go as planned and led to the patient's bowel being perforated. However, because this was a known risk of the procedure and the patient gave her informed consent regarding that risk, neither the hospital nor obstetrician was held liable for the mistake. As this case illustrates, obtaining informed consent regarding the risks associated with a medical procedure can shelter hospitals and physicians from liability when complications arise from their care.

In obtaining informed consent, it is also advisable to be certain that you are dealing with someone who can provide that consent. If your patient is a minor or potentially mentally ill, there could be significant problems down the road as to whether informed consent was obtained at all. Be sure to understand and document the patient's age, with special attention to patients who arrive through the ED. By definition, patients who arrive through the ED instead of a more standard referral from a general practitioner might not be able to provide consent for themselves. That said, there is generally a privilege to render emergency medical care without the patient's consent if the patient is unable to speak for himself or herself. Be sure to understand the definition of an emergency situation in the state where you practice, as this might vary from state to state. Also, if consent is expressly rejected, the doctrine of implied consent cannot apply.

Finally, when obtaining informed

consent, it is important to document not only the end result of the informed consent, but also the process that was undertaken with the patient. Talking a patient through a form and requesting the patient initial to express his or her understanding of each major point can be a useful way to accomplish this process. The informed consent form also might be structured in an ascending scale format adjusting for the intrusiveness of each of the procedures. One option in every medical case is to simply do nothing. This might be an option that offers little hope for success, but the patient should be informed of his or her right not to pursue medical care and the various risks of each option.

REFERENCE

Richmond County Superior Court, Georgia, Case No. 2013RCCV00615 (June 12, 2015). ■

Jury awards man's estate $950,000 after physician failed to adequately test for his heart condition

News: In 2008, a man went to a hospital complaining of chest pains. The man's treating physician at the hospital administered tests and diagnosed him with a peptic ulcer. The treating physician then instructed the man to follow up with his primary care physician. The man followed up with his primary care physician the next morning and again two days later for the ulcer. The man still was experiencing chest pains and was admitted to the hospital the same day. He was monitored in the hospital for two days, during which time his heart rate and pulse were fluctuating. He was discharged and told to follow up with his primary care physician in one week. However, the man's chest pains continued, and he returned to the hospital the next day. He was seen by the treating physician he saw on his initial visit, who performed an evaluation and again diagnosed him with a peptic ulcer. He was admitted back to the hospital, where he died from heart failure that day. An autopsy revealed that he had no ulcer and that the cause of his death was hemopericardium and a rupture of his left ventricle. A malpractice lawsuit was filed on behalf of the man against the hospital, the treating physician at the hospital, the man's primary care physician, and the medical center where the man's primary care physician was employed. The lawsuit alleged that all the providers failed to adequately test for the man's heart condition, which went untreated as a result and ultimately led to his death. The providers denied liability. The jury agreed with the man's estate and found it negligent not to administer more diagnostic tests or to refer the man to a specialist regarding his chest pains and heart condition. The jury further found that the primary care physician was the only party that fell below the standard of care and that the treating physician and hospital were not negligent. As such, the medical center where the primary care physician was employed was held liable for the $950,000 jury award, which consisted of $400,000 for financial loss, $450,000 for pain and suffering, and $100,000 for disability.

Background: On Oct. 6, 2008, a 73-year-old man went to the hospital with chest pains. The treating physician at the hospital administered tests, one of which was a cardiac enzyme test to determine if the man had suffered a heart attack. The physician concluded that the man was suffering from a peptic ulcer and instructed him to follow up with his primary care physician. The next morning, the man followed up with his primary care physician for the peptic ulcer. On Oct. 9, 2008, the man still was experiencing chest pain and returned to his primary care physician before being admitted to the hospital that day. He was monitored in the hospital for the following two days, during which time his heart rate and pulse were reportedly fluctuating. He was discharged on Oct. 11, 2008, and informed to follow up with his primary care physician in one week and a second doctor the following week.

The man's chest pains continued, and he decided to return to the hospital the following morning on Oct. 12, 2008. The man again was seen by the physician who had diagnosed him with an ulcer, took the cardiac enzyme test, and referred him to his primary care physician. The treating physician evaluated the man and again diagnosed him with a peptic ulcer. The man was admitted to the hospital. That same day, while at the hospital, the man's heart stopped, and he was pronounced dead. An autopsy revealed that he was not suffering from an ulcer but that the cause of the man's death was hemopericardium, which is an accumulation of blood in the heart, and a ruptured left ventricle.

The man's estate filed a wrongful death action alleging medical

malpractice on behalf of the hospital, the treating physician at the hospital, the man's primary care physician, and the medical center where the man's primary care physician was employed. The lawsuit particularly alleged the healthcare providers committed negligence by failing to adequately test for or diagnose the man's heart condition, which would have included a diagnostic test for atherosclerosis, additional cardiac enzyme tests, and tests to determine if the man suffered cardiac ischemia in light of his fluctuating heart rate and other symptoms. The lawsuit alleged these tests would have detected the man's heart condition and prevented his death. All of the healthcare providers in this case denied liability.

In a jury deliberation lasting only four hours, the jury found that the man's death was caused by his heart condition and that it was negligent not to adequately test for it or refer the man to specialists. However, the jury found that it was only the man's primary care physician who fell below the standard of care in this regard, and the jury did not find that the hospital or the treating physician provided inadequate care. The jury particularly found that the man's primary care physician failed to administer proper cardiac testing or refer the man to a specialist when he saw the man and learned of his condition, and that because the physician was an employee of a medical clinic, the medical clinic where he worked was liable for the $950,000 jury award. The award went to the man's estate and consisted of $400,000 for financial loss, $450,000 for pain and suffering, and $100,000 for disability.

What this means to you: This case demonstrates how administering relevant tests and referring a patient for follow-up care can shelter a physician and the physician's employer from legal liability. In this case, the treating physician who saw the man twice at the hospital, and twice misdiagnosed him with a peptic ulcer, was not found to have acted negligently for failing to diagnose the man's heart condition, but the man's primary care physician at a separate healthcare facility was found negligent for it. The liability-sheltering acts on behalf of the treating physician were the initial cardiac enzyme test and informing the man to follow up with his primary care physician. However, the primary care physician was found to be negligent for failing to administer diagnostic testing for cardiac issues or to refer the man to a specialist in light of his continued chest pains and other symptoms.

As illustrated by the jury's decision and the acts by the treating physician at the hospital, the administration of diagnostic tests and referring the patient to the next step of care can shelter physicians and hospitals from legal liability. As such, prudent physicians and hospitals should be encouraged not only to consider the benefit to the patient when ordering diagnostic tests, but also to consider the positive, liability-sheltering effects of administering diagnostic tests and making physician referrals.

The jury decision in this case also demonstrates that each physician has a separate responsibility to each patient and can be held independently liable when a patient suffers harm while seeing multiple physicians. The patient in this case was sent to the primary care physician with an incorrect diagnosis of a peptic ulcer and complaining of chest pains, yet the primary care physician was held to be negligent by the jury for being the physician who failed to adequately test for or diagnose his heart condition. While the primary care physician was made aware of his chest pains, saw the man twice, and failed to administer diagnostic tests for his heart condition, he did not actively misdiagnose the man or otherwise commit a direct harmful act.

Each physician has a separate obligation to diagnose and treat a patient, and independent liability can result from failure to do so. This liability is demonstrated by the fact that the primary care provider was considered negligent, with his employer being liable for all the damages in this case, despite the man being misdiagnosed by another physician. Bearing this fact in mind, physicians treating patients who have been sent to them by other physicians should not rely solely on the findings of the fellow physicians and should administer tests and otherwise treat the patients as if they themselves are independently liable for harm that might befall the patients.

Finally, as in the preceding case studied in this article, this case likewise provides a platform for a short discussion on the importance of good documentation. It is important for a physician in a chain of treatment to have documentation from start to finish: what information and instructions are being handed off to the physician, what is done with and said to the patient, and what information and instructions then are handed downstream to the subsequent provider. A lack of strong documentation makes it more difficult to defend oneself against efforts by other physicians to shift blame in a case involving a chain of treatment.

REFERENCE

Ford County Courthouse, Illinois Case No. 2011L16 (Dec. 11, 2015). ■