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AHC Media

JULY 2016 Vol. 38, No. 7; p. 73-84

EMTALA Still a Risk, But Some Are Letting Down Their Guard

Violations still occur — Administrators surprised by faults in compliance

In May, the Kentucky Supreme Court affirmed an award of punitive damages against a hospital that was 386 times the hospital's share of compensatory damages for a violation of the Emergency Medical Treatment and Labor Act (EMTALA).

The court acknowledged that the hospital had rendered helpful assistance to the patient in its ED, but it still upheld the jury's award of $1.45 million. *(See the story in this issue for more on that case.)*

EMTALA has been in effect for 30 years. Despite the fact that all covered medical facilities have developed policies and procedures to ensure compliance, violations still occur, and hospitals still are paying significant penalties.

CMS conducted 6,035 investigations from 2002 to 2015, with 2,436 found to have merit as EMTALA violations (40.4%). A study of those cases revealed there were 192 settlements, with fines against hospitals and physicians totaling $6.35 million. The average hospital settlement was $33,435, and the average physician settlement was $25,625. The most common violations were failing to screen (75%) and failure to stabilize (42.7%). (*The study is available online at http://bit.ly/1r5HOWZ.)*

Why are hospitals still violating EMTALA? The answer may lie in a mix of complacency and several changes occurring in healthcare.

Special Report: EMTALA vigilance

This month's *Healthcare Risk Management* includes a special report on the Emergency Medical Treatment and Labor Act (EMTALA) and how hospitals still are at risk from this well-established law. The cover story addresses how some hospitals could be letting their guards down, and two other stories discuss cases that illustrate the ongoing challenges to EMTALA compliance. ■

Financial Disclosure: Author Greg Freeman, Executive Editor Joy Daughtery Dickinson, and Nurse Planner Maureen Archambault report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Arnold Mackles, MD, MBA, LHRM, physician reviewer, discloses that he is an author and advisory board member for The Sullivan Group and that he is owner, stockholder, presenter, author, and consultant for Innovative Healthcare Compliance Group.

HEALTHCARE RISK MANAGEMENT™

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

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

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

SUBSCRIBER INFORMATION: Customer Service: (800) 688-2421. Customer.Service@AHCMedia.com. AHCMedia.com

SUBSCRIPTION PRICES: USA, Print: 1 year (12 issues) with free CE nursing contact hours and free *AMA PRA Category 1 Credits*™, $519. Add $19.99 for shipping & handling. Online only, single user: 1 year with free CE nursing contact hours and free AMA PRA Category 1 Credits™, $469. Outside USA, add $30 per year, total prepaid in USA funds.

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Hospitals are facing some challenges that were not as pronounced in past years when risk managers formulated EMTALA policies and accepted them as sufficient, says **Ann Lambrecht**, RN, BSN, JD, FASHRM, senior risk specialist with Coverys, a Boston-based company that provides insurance, risk management, and claims service for caregivers in the Northeast. Lambrecht has more than 30 years of experience in the risk management field and has held positions of hospital risk manager, director of risk services at a large healthcare system, vice president of risk services at two organizations, and a risk consultant in the insurance industry.

She says that while there is evidence that some hospitals are becoming complacent about EMTALA compliance, she suspects recent violations are more attributable to other challenges happening in healthcare.

The first issue to consider is staffing, Lambrecht says. Turnover is typically higher in the ED, and hospitals may pull personnel from other areas or use temporary staff, who may not be as familiar with EMTALA, to supplement staffing, she says. Ensuring that new ED staff, temporary staff, and all hospital employees understand EMTALA is a significant challenge, Lambrecht says.

Confusing Decisions

Another problem is the different interpretations of EMTALA among court jurisdictions, Lambrecht says. There have been different interpretations of EMTALA by various courts that can cause confusion as to how to comply with EMTALA, she notes. *(See the story in this issue for an example of one such case.)*

"A good example is the 2009 EMTALA updates, which advised that EMTALA was not applicable to inpatients so long as the patient was admitted in good faith," Lambrecht says. "Some courts have ruled that if an inpatient was discharged with some of the same symptoms for which he or she was admitted, that patient was not stable for discharge and, therefore, the hospital violated EMTALA."

To avoid this confusion, know the court's decision in your jurisdiction, and consult legal counsel, she says.

There are also significant issues with transferring mental health patients after a medical screening exam revealed an emergency

EXECUTIVE SUMMARY

Despite every hospital's familiarity with the Emergency Medical Treatment and Labor Act (EMTALA), violations and penalties still occur. There is concern that some healthcare providers have become lax about EMTALA and falsely assume that current procedures are sufficient.

- Staffing challenges and turnover rates can increase the risk of EMTALA violations.
- Court jurisdictions can interpret EMTALA compliance differently from one another.
- A jury recently awarded a plaintiff $1.5 million for an EMTALA violation even though the hospital rendered care.

condition that required stabilization, Lambrecht says. Many hospitals don't have psychiatric units in which to place the patient or have psychiatrists on staff who understand psychiatric issues and can provide stabilizing care, so these patients often reside in the ED for days and even weeks before a transfer takes place.

"Hospitals that do have psychiatric units are often under the impression that they can refuse a transfer for various reasons when, in fact, they should accept the transfer," Lambrecht says.

Transfer Done Properly?

Lambrecht lists these other potential EMTALA pitfalls:

• It may not always be clear to a transferring hospital if the person accepting the patient has the authority to do so.

This lack of clarity can slow the transfer, prohibit it, or result in an improper transfer.

• A patient with an unstable condition who requires a higher level of care easily can deteriorate during transfer.

The hospital receiving that patient may receive a patient in far worse condition than was described and believe that they were not given an accurate description of the patient's condition. This situation could trigger an EMTALA violation.

• On-call issues continue to be an area of confusion, Lambrecht says.

Court decisions vary widely, and the rules governing on-call coverage overlap, as they cover several scenarios. For example, a surgeon may be on call and performing surgery on a patient, only to receive a request to evaluate a patient in the ED.

"A variation on this theme is that a surgeon can schedule surgeries while she or he is on call and is also permitted to take simultaneous calls from different hospitals," Lambrecht says. "These are very challenging situations to plan for, especially in small community hospitals."

None of those problems can be eliminated, but the EMTALA risk can be reduced by ensuring that all staff are educated on key points of EMTALA. This education is an area in which risk managers and hospitals can become complacent, Lambrecht says. EMTALA policies and procedures have become so thoroughly embedded in hospital administration, it is easy to assume all staff members are up to speed, she says. In many cases, they are not, Lambrecht says.

She advises risk managers to have someone in the hospital available at all times to answer questions about EMTALA compliance. Difficult situations and gray areas often crop up at the most inconvenient times, but ED physicians and staff should not be left on their own to assess complex legal issues, Lambrecht says.

"Additionally, transfer agreements must be in place with those organizations that will provide a higher level of care. Policies should clearly state which personnel have authority to accept transfers," she says. "On-call policies should determine the responsibilities of on-call physicians and who has final authority to call a physician in."

Deciding Capabilities

Inappropriate transfers are the root of many EMTALA violations, says **Douglas B. Swill**, JD, partner with the law firm of Drinker Biddle in Chicago. In many cases, members of the hospital staff misjudged their ability to provide adequate care, Swill says.

ED personnel must be careful about determining that the hospital cannot provide the necessary care, because CMS and courts will be looking for any suggestion that the hospital merely was using that position as an excuse to dump a patient, he says. Any decision to transfer a patient for that reason should be reviewed and confirmed by an administrator with a thorough understanding of EMTALA and the hospital's capabilities, he says.

Urgent care centers are another concern, Swill says. EMTALA can apply if the urgent care center is tied to the hospital's license and is on the hospital campus or nearby, he says.

"Most hospitals have a robust EMTALA compliance program, but you still cannot get complacent. You have to stay on top of it and constantly provide training," Swill says. "It only takes one physician who refuses to come in when called, or one manager who makes the wrong decision about a transfer, to result in serious trouble."

Swill also notes that hospitals are hiring more physicians than in the past, which creates a more strict line of liability when the physician violates EMTALA. Regarding the list of on-call physicians, court decisions indicate you must specify individual physician names and not just physician groups, Swill points out. He suspects three-fourths of hospitals list physician groups, which he says CMS will find insufficient if it conducts an investigation.

Designed for EMTALA?

The advent of the electronic medical record (EMR) also has opened up more possibilities for EMTALA violations, says **Kenneth**

N. Rashbaum, JD, partner with the Barton law firm in New York City. The ability to cut and paste, and use boilerplate language in the ED, was not factored into EMTALA policies and procedures crafted years ago, he says.

"There is a significant amount of trust put in the discharge templates, the history, and the physical templates in emergency departments," he says. "I don't think they were created with a good understanding of EMTALA, so you don't have appropriate documentation of the medical screening exam, the care given, or the basis of a transfer."

Rashbaum also questions whether ED physicians and staff members are sufficiently trained on the nexus of EMTALA and the EMR: how the EMR changes the documentation of EMTALA-specific information and how to avoid the temptation of ticking off standardized choices instead of fully describing the patient's situation.

Also beware of the assumption that whoever designed the EMR knew what they were doing and considered all the EMTALA implications, Rashbaum says. The intricacies of EMTALA likely were not understood and documentation needs not fully anticipated, he says.

"Hospitals also switch EMR providers from time to time, and you have to wonder if the ED is trained on each new template and how to apply the requirements of EMTALA in this new format," Rashbaum says. "A lot of the electronic documentation in the ED is templates and macros, and there is some necessity for that, but they can get you in trouble. I see this all too often." ■

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$1.45 Million EMTALA Award Despite Rendering Aid

The Kentucky Supreme Court recently affirmed an award of punitive damages against a hospital for violating the Emergency Medical Treatment and Labor Act (EMTALA) that was 386 times the hospital's share of compensatory damages. The jury originally awarded $1.5 million in punitive damages against the hospital, which was later reduced to $1.45 million.

The hospital was held liable even though the court acknowledged that the hospital "[u]ndoubtedly ... rendered helpful assistance to [the patient] during the final agonizing hours of his life," according to the Supreme Court's decision. *(The decision from the court can be accessed at http://bit.ly/1UCJVvR.)* The court explained that a hospital can violate EMTALA even if "it did some things right," and it rejected each of the hospital's challenges to the punitive award.

The case involved a claim that the defendant hospital violated EMTALA when it failed to stabilize "an uninsured and indigent paraplegic" homeless man who came to the hospital's ED twice during an 18-hour period and complained of extreme pain. He was discharged after both visits. A few hours after a second discharge, the man died from a ruptured ulcer.

A trial court granted the hospital a directed verdict on the medical screening part of the plaintiff's EMTALA claim but allowed the claim that the hospital failed to stabilize the decedent to go to the jury. The jury awarded the plaintiff $25,000 in compensatory damages and apportioned 15%, which was $3,750, to the hospital. The jury's original $1.5 million in punitive damages against the hospital was later reduced to $1.45 million. The hospital appealed. It challenged the evidence and the amount of punitive damages.

The hospital cited an extensive list of the medical services provided to the man during the two emergency department visits preceding his death as evidence that it had provided the necessary care under EMTALA. The court was not impressed and said a party that allegedly committed a tort "is not absolved of liability simply because it did some things right." The court stated, "From the totality of evidence, the jury could have reasonably believed, as it apparently did, that the Hospital engaged in illegal 'patient dumping' in its actions toward [the decedent]."

The hospital claimed it did not endorse the way the ED personnel handled the patient. The court concluded that "[t]he proactive nature of the concerted effort to keep [the decedent] away from the Hospital supports a reasonable inference the Hospital's management personnel were aware of what was happening, and ... ratified it."

The hospital also argued that it could not be held liable for punitive damages based on the conduct of its independent contractor physicians. The court said that it could and explained that a "hospital remains liable for compliance with EMTALA, and does not escape responsibility by affiliating independent contractor physicians and other nonemployees to provide EMTALA compliance."

In an analysis posted recently, attorneys from the McGuireWoods law firm in Richmond, VA, explained that the court's ruling could have far-reaching implications. *(The analysis was written by Mitchell K. Morris, JD, and Nathan A. Kottkamp, JD, with Davis M. Walsh, JD. The analysis is available at http://bit.ly/25BUgxb.)*

"Although somewhat couched in terms of vicarious liability for contractor conduct, the true thrust of the court's holding appears to be that a hospital's duties under EMTALA are non-delegable. In other words, even if the day-to-day operations of an emergency room are being carried out by contractors, the hospital itself will be liable — including, potentially, for punitive damages — if a patient is discharged in violation of EMTALA," they wrote. "It should be expected, however, that plaintiffs will attempt to use [this decision] beyond the EMTALA context as a means to hold principals liable for punitive damages based on the conduct of independent contractors." ■

Case Shows How EMTALA Can Apply to Inpatients

The case of *Moses v. Providence Healthcare System* is a good illustration of how a court can interpret the Emergency Medical Treatment and Labor Act (EMTALA) in a surprising way, says **Ann Lambrecht**, RN, BSN, JD, FASHRM, senior risk specialist with Coverys, a Boston-based company that provides insurance, risk management, and claims service for caregivers who are located in the Northeast.

In this case, a psychiatric patient made threatening statements and was taken to the ED of a hospital. He was admitted for treatment and observation to a general medical floor, Lambrecht notes. *(The decision from the appeals court is available to readers online at http://1.usa.gov/1U2Rhdd.)*

"After about five days of inpatient care, the psychiatric resident believed the patient made some progress and crafted a progress note about the patient's insurance company needing to authorize care in a psychiatric unit," Lambrecht says. "The patient was not transferred to the psych unit reportedly because he refused, was discharged, and 10 days later, killed his wife."

The patient later testified he was not given the option for inpatient psychiatric care. The wife's family alleged an EMTALA violation, and the hospital responded that EMTALA did not apply to inpatients.

The district court granted summary judgment to the hospital and said EMTALA did not apply because the patient had been admitted. The lower court said, "The patient was undisputedly completely screened, as the statute requires, even if on the basis of a wrong diagnosis; and he was thereafter admitted to the Defendant hospital, and no emergency medical condition was recognized on the screening."

When the plaintiffs appealed, the hospital argued that even if the man had an emergency medical condition at the time of his admission, the hospital physicians no longer believed that he had such a condition when they released him. He was stable upon discharge, the hospital said. The appeals court disagreed, saying, "Because issues of fact exist relating to [the patient's] medical condition — upon his initial screening as well as prior to his release — the district court erred in granting summary judgment on this ground."

The appeals court concluded that it was at least arguable that the patient was still in an emergency condition and not stable when discharged, and that the defendant hospital had been required to ensure that the patient, even as an inpatient, was stabilized under EMTALA before discharge. The appeals court sent the case back to the district court. ■

HIPAA Can Be Challenging with Dementia Patients

(This is the last part of a two-part series on the implications of treating patients with dementia. The June 2016 Healthcare Risk Management *addressed patient safety risks, and this month's article addresses potential problems with privacy rules.)*

Patients with dementia may require special attention with regard to the Health Insurance Portability and Accountability Act (HIPAA), as they aren't always able to communicate effectively or give permission for clinicians to talk to

EXECUTIVE SUMMARY

Complying with the Health Insurance Portability and Accountability Act (HIPAA) can be difficult when a patient has dementia. Special policies and procedures may be necessary.

- Do not assume all dementia patients are incompetent for consent.
- Patients with dementia may have periods in which they are competent for consent and other times when they are not.
- A family caregiver should be consulted when the patient is unable to provide HIPAA-required permission for communication.

others about their healthcare. The issue of HIPAA compliance also is tied closely to the patient's ability to consent.

Identifying the patient's personal representative should be a primary task from the outset of care when dementia is involved, says **Ronald D. Adelman**, MD, medical director of the Irving Wright Center of Aging and co-chief of the Division of Geriatrics Medicine and Gerontology at NewYork–Presbyterian Hospital in New York City. Even when the patient is able to make decisions and provide consent, the clinical care team should anticipate that the situation may change and be prepared to consult the patient's representative, usually a family member who has been closely involved with the person's care.

That person already may have the patient's power of attorney and may be specified in an advance directive. But if not, the clinicians should inquire upfront about whom to turn to when the patient's dementia hinders care, Adelman says. Don't assume that the person accompanying the patient will be the healthcare proxy, he says, even if it is a close relative such as a son or daughter. The patient may direct clinicians to a different family member who is not present or even an attorney.

"If the patient comes with a hired caregiver rather than a family member, that person is probably not the personal representative or someone who can receive personal information," Adelman says. "It's really critical from the beginning, with the patient's participation, to determine who to turn to if the patient becomes profoundly demented. At that point, we know who needs to be engaged and can do so without interrupting care."

At the same time, clinicians should be careful not to engage in what Adelman calls "ageism" or "dementiaism" by assuming that all elderly people with cognitive disabilities are incapable of understanding and directing their own healthcare. A diagnosis of dementia does not automatically mean the patient cannot make decisions, he says, so clinicians must be careful in assessing the patient's clarity.

Patient Offended

Adelman recalls a patient who entered the hospital with pneumonia. When the residents saw that she had a diagnosis of mild dementia, they stopped interacting with her and directed all conversation to her husband. The woman was greatly affected by the slight, even after it was brought to the residents' attention. She said she felt as if she wasn't being treated as a person anymore and feared that there would be more instances of that in her future healthcare, especially with regard to critical decisions about end-of-life care.

"Some people have just very mild cognitive deficits and are able to understand what's going on. If they don't understand some of the intellectual information, they might understand the emotional components," Adelman says. "The key is to learn how to communicate with the right people and do it inclusively. If you do it properly, it can be supportive and soothing to the person with cognitive impairment."

Dementia patients who still are capable of anticipating future needs and communicating their preferences should be provided counseling, which may involve family members and the future healthcare proxy, to make important decisions and document them for the record, Adelman says. This step isn't always possible by the time a patient with dementia enters the healthcare facility, but the information can ease future clinical care and help ensure the patient's wishes are respected.

Family Exchange Allowed

Communicating about a patient's care with someone not authorized to receive that information can be a HIPAA violation. **Mary Anne Theiss**, RN, MS, JD, PhD, CNE, a faculty member with the Kaplan University School of Nursing in Fort Lauderdale, FL, says that the good news is that HIPAA anticipates situations involving dementia or other cognitive impairments, and it allows clinicians to share information "directly relevant to the involvement of a spouse, family

member, friend, or other person identified by that patient." The key is that the person must be identified by the patient, and the patient also has the power to denote that certain people are not to receive information or make decisions, she says.

"HIPAA was not intended to hinder appropriate disclosure and communication with people who can help the patient. Don't allow care to be compromised because you think HIPAA means you can't talk to anyone about the patient," she says. "It has to be the appropriate person, identified by the patient, unless it is an emergency situation, and you have to assume close relatives would be authorized."

Theiss notes that clinicians may be challenged by the way some dementia patients vary in their cognitive abilities from one moment to the next. She recalls such incidents with her own mother, who had Alzheimer's. "There are times when a person who has dementia will be lucid and capable of making decisions about their care. It is important not to look at the dementia diagnosis, or your decision that the patient cannot make decisions, as a final assessment that will be the same tomorrow," Theiss says. "Anyone caring for the patient needs to anticipate these changes and respond accordingly, rather than assuming that the patient is the same as he or she was yesterday."

In lucid periods, patients have the right to reject or alter healthcare proxy agreements that they made previously, she notes. Hospitals should have policies and procedures that direct clinicians to reassess a dementia patient's abilities frequently and respect the individual's rights whenever possible, Theiss suggests.

Erring on the side of caution is necessary in this regard, says **Scott Johnson**, JD, professor of law at Kaplan University's Concord Law School in Los Angeles. He recommends a policy that encourages frequent reassessments of the patient's cognitive ability, especially when there is no advance directive. "This issue can be most difficult when a patient is refusing care," he says.

"There are circumstances in which healthcare providers are allowed to provide care even when the patient refuses, but those are very limited. For the most part, the law sides with a patient who says 'no' to care, and a diagnosis of dementia does not automatically change that," Johnson says. "When a patient with dementia refuses care, you have to rely on your assessments, advance directives, and, if necessary, the decision of the person designated to make these decisions."

Clinicians should be reminded, however, that they are not mere pawns in this process. In difficult situations involving dementia patients, HIPAA allows for "professional judgment" by clinicians, notes **Nicole DiMaria**, JD, a healthcare attorney with the law firm of Chiesa Shahinian and Giantomasi in West Orange, NJ. "If the patient is incapacitated or not present, that's an area where HIPAA says the health professional can use his or her professional judgment, and if it is in the patient's best interest, the disclosure can be made," she says.

Even when the patient has designated a personal representative, clinicians still have the ability to intervene in the patient's best interest, DiMaria says.

"Under HIPAA, a personal representative must be treated as the individual, unless the healthcare professional feels that there is a situation of abuse or neglect and it would not be in the best interest of the patient to treat that person as a representative," she says. "In that circumstance, they can decline to do so." ■

SOURCES

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Vicarious Liability Becoming More of a Threat

With all the legal risks that hospitals face, it used to be that risk managers could be confident, at least, that vicarious liability was a pretty weak threat. In most cases, hospitals were not held liable if the physician was independent and no hospital employees were involved. The hospital was off the hook.

That's not necessarily the case anymore, says **Angela M. Jones**, JD, an attorney with the law firm of O'Neill McFadden & Willett in Schererville, IN. Case law in Indiana is similar to that in many other

EXECUTIVE SUMMARY

Vicarious liability is becoming more of a threat to healthcare providers. Past assumptions about a hospital's independence from physicians and other contractors are being tested.

- Standard forms about independent contractors may be insufficient.
- Courts are now expecting more "meaningful notice" about the distinction.
- Risk managers should review notification forms and processes.

states, which indicates a distinct shift toward more vicarious liability for hospitals, she says. In Indiana, a 1999 Supreme Court decision in *Sword v. NKC Hospitals* adopted the theory of "apparent and ostensible agency" to find that a hospital may be vicariously liable for the acts of its independent contractors, Jones explains. The court argued that it was reasonable for the patient to assume that the physician was employed by the hospital, by relying on what it called the "totality of the circumstances," including the actions/inactions of the hospital regarding an explanation of the hospital's arrangements with the physicians.

The court said the hospital was obligated to give notice to the patient "that [the hospital] is not the provider of care and that the care is provided by a physician who is an independent contractor and not subject to the control and supervision of the hospital."

That decision prompted Indiana hospitals, like many before them and many after, to implement boilerplate disclosures to all patient that their physicians may be independent contractors and the hospital wasn't responsible for their actions. Problem solved, at least for a while. Now case law is leaning toward a higher bar of "meaningful notice," Jones explains. That change means that simply giving patients notice about independent physicians isn't enough. The hospital has to convey this message in a way that is meaningful to the patient and likely will result in actual understanding of the distinction.

Change Is Likely

Actual case law and expectations will vary from state to state, but Indiana tends to follow rather than establish new standards, Jones says, so other states are likely to be at least as far ahead in changing vicarious liability. States in which the old independent contractor assumptions still are valid likely will make the same changes in the near future, she says.

"Five years ago, the hospital could just keep its head down, knowing you're in the case at least through the panel process, but after that, hospitals would be able to get out of the case," Jones says. "That's not the way it's going anymore. It's becoming easier and easier to keep the hospital in the lawsuit."

Hospitals across the country may have brought this situation on themselves, at least partially, by using boilerplate disclosures that were so general and written in such legalese that they had little impact on the patient. It was just another form to be signed, and courts are now saying that the issue is too important to be addressed in that manner, Jones says.

She advises risk managers to conduct a thorough review of these forms and assess whether a court could find the language too vague. In most cases, the hospital would be well-advised to develop a more specific and clear disclosure, she says.

"It needs to be very specific, to the point where it names each physician who is an independent contractor," Jones says. "We also may see hospitals require independent physicians to take responsibility for this by having their patient sign specific consent forms before they can provide care at the hospital."

Emergency Care Excluded

In addition, Jones points out that the whole disclosure form argument goes out the window in the case of emergency care. Whether you end up with a signed document or not from an emergency patient, courts are unlikely to accept that the patient truly understood the distinction and consented to care by an independent contractor, she says.

Vicarious liability cases will center on this issue of whether patients received "meaningful notice," and plaintiffs' attorneys will seize on this argument to keep the hospital's insurance policy in play, Jones says. She encourages hospitals to put the onus on physicians as a requirement for working at the hospital.

"A separate consent form for each physician is good practice because, in many cases, the doctor has been treating the patient for months and then brings them to your hospital," Jones says. "You can require the consent form before they even enter the hospital. It's set in stone. How can you say it was not meaningful notice at that point?"

SOURCE

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Drug Diversion Sting Goes Wrong And Privacy Is Questioned

(This story first was published as breaking news on our publisher's web site, AHCMedia.com. Follow breaking news there and also on Twitter @HospitalReport.)

A California hospital was trying to do the right thing when it set up a video camera to catch drug diversion, but it may have ended up violating patient privacy when the cameras recorded patient care and explicit images.

Sharp Grossmont Hospital in La Mesa, CA, mounted video cameras inside computer monitors attached to mobile anesthesia machines in its ORs in July 2012, in an effort to detect someone stealing sedatives from the carts, according to a statement released by the hospital. The surveillance continued for a year until administrators realized the footage included women undergoing cesarean sections. The patients did not know they were being recorded, the hospital stated.

The cameras caught an anesthesiologist putting bottles of drugs in his pockets, according to the report. The hospital suspended the anesthesiologist but lifted the suspension the next day when the anesthesiologist claimed that the sedative propofol was in short supply and physicians routinely saved bottles for emergencies, according to the hospital report.

The Medical Board of California investigated and filed a formal accusation against the anesthesiologist. When his defense attorney requested access to the hospital recordings, he received 77 and found identifiable images of women in the ORs, according to the report. The hospital reports that there are approximately 14,000 video clips in all.

The hospital issued a statement acknowledging the breach of privacy and said it intended to send only clips that did not include patients in the room. The hospital writes that it will notify patients after reviewing the clips and matching them to surgery schedules.

The California Department of Public Health released a statement saying it is investigating the incident as a possible violation of the Health Insurance Portability and Accountability Act. ■

Settling Too Soon? Expect Long-Term Consequences

Taking a malpractice case to trial is never something you look forward to, but settling the case is not always the best alternative. Knowing when to settle, and when not to, can be critical in minimizing your losses from a malpractice allegation, says **Catherine J. Flynn**, JD, an attorney with the law firm of Carroll McNulty and Kull in Basking Ridge, NJ.

Hospitals typically take the position that if there is a meritorious claim, the best strategy is to settle the case and not go forward with litigation, she notes. That approach doesn't necessarily mean the hospital is admitting to a deviation from the standard of care; rather, it is acknowledging that the decision will be made by a lay jury and the ultimate outcome is uncertain. In some of those cases, settling is the right way to cut your losses.

However, that approach is not always the best. Settling the wrong cases and settling too soon can send the message that your hospital is weak and a soft target for predatory plaintiffs' attorneys, Flynn warns. Flynn and her colleagues encourage their hospital clients to take a stronger stand and refuse to settle if there is a legitimate defense to the claim. The strategy is all the more important as malpractice cases tend to involve higher stakes, with more money on the line, she says.

"If there is merit to the defense, we will take it to a jury," Flynn says. "The only cases in which we look for settlement are the really high-exposure cases where sympathy could overwhelm the jury, and there are not very many of those. The philosophy of not settling cases has been

EXECUTIVE SUMMARY

Settling lawsuits too often or too soon can backfire. The hospital may get a reputation as an easy target for plaintiffs' attorneys.

- Avoid settling malpractice cases too soon.
- A pattern of settling could encourage more lawsuits.
- The strategy could reduce frivolous lawsuits.

successful for 30 years."

Hospitals adopting this approach tend not to see many frivolous claims, Flynn says. Plaintiffs' attorneys have learned that the hospitals will not routinely settle small or frivolous claims and pursuing those claims to litigation is not worthwhile, she says.

The strategy appeals to many hospital administrators who resent having to settle cases in which they feel the hospital did nothing wrong, Flynn notes. Though the strategy works in the long run, administrators should understand that individual cases will require commitment to the expense of litigation, she says.

"These are significant cases, so going all the way to a jury will require experts and considerable time from your attorney team," Flynn says. "You also have to have attorneys willing to walk into the courtroom and fight for the hospital. That may sound counterintuitive, but there are attorneys who are predisposed to settling and not eager to go in the courtroom and obtain a verdict." ■

SOURCE

- **Catherine J. Flynn**, JD, Carroll McNulty and Kull, Basking Ridge, NJ. Email: cflynn@cmk.com.

AHRQ Tool Identifies Harm to Children in Hospitals

The Agency for Healthcare Research and Quality (AHRQ) has released a new "trigger tool" for flagging adverse events in children.

In a study published in *Pediatrics*, AHRQ introduces the Global Assessment of Pediatric Patient Safety (GAPPS) trigger tool, which it says can use electronic data to identify adverse events in pediatric patients. Trigger tools are commonly used to identify adverse events after they occur by scanning a health record system and flagging entries that indicate that an adverse event may have occurred, the study notes.

Most existing trigger tools are not designed for pediatric patients, AHRQ says. An abstract of the report can be accessed by readers online at http://bit.ly/1PeWOI5. ■

Use the Right Doctors and the Right Data To Improve Coverage in the ED

Having the right set of ED physicians will reduce the need for specialist coverage, says **Pascal Crosley**, DO, vice president of CEP America and medical director at St. Agnes Hospital in Baltimore, MD. The more experienced and skilled that the ED physicians are, the less often they will need to call in specialists, he says.

Top-tier ED physicians can cut in half the number of consults, he says.

"Without the right training, physicians will tend to over-consult," Crosley notes. "The more your physicians are able to address the patients' needs on their own, the less you will need to call in consultants, and that can significantly reduce the number of consultants you have to have on call. As it reduces the frequency with which those consultants are actually called into the hospital, you will also see more willingness to be on call."

Another strategy is fostering relationships with inpatient physicians who can make room to see ED patients first thing the next morning, Crosley says. Some patients in the ED need a specialist consult soon, but not necessarily within hours, he says. If you have inpatient specialists, such as hospitalists, who will agree to see those patients early the next morning, it may be possible to avoid waking a specialist to come into the hospital in the middle of the night. That situation, in turn, improves the chances that a specialist will agree to be on call for those patients who do need that care at an inconvenient time, he explains.

Innovative use of data also can help hospitals plan for ED usage and the related need for on-call specialists, says **Rich Krueger**, CEO of Hospital IQ, a company in Newton, MA, that uses predictive analytics to help hospitals with ED boarding and capacity planning. Patterns of use can

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help hospital administrators narrow down the safe limits for specialists on call rather than guessing or using generic benchmarks, he says.

"You can look at your data and data from other providers and see, for instance, that if you have this one specialist on call for 12 hours, there is a 90% chance that any patient needing that type of care can be seen within two hours," he explains. "If that threshold is acceptable to you, you've reduced your risk to 10% with just one specialist, and you may determine that you don't have to recruit a second or third to meet the demand." That strategy also can be used to aggregate demand across several sites in a community also, Krueger says. "Usually EDs come up with their shift plans and try to line up on-call specialists to fill the shifts. There's often not a lot of science behind what the demand is going to be and what is a clinically acceptable wait time," he says. "The data can do that for you." ■

EXECUTIVE SUMMARY

Using the best emergency physicians and data can improve specialist coverage for the ED. Another strategy is to work with physicians for early exams the next morning.

- Calling in specialists less frequently will prompt more to sign up for on-call coverage.
- Skilled ED physicians will seek consults less often.
- ED usage data can help determine what specialists are needed.

SOURCES

- **Pascal Crosley,** DO, Medical Director, St. Agnes Hospital, Baltimore, MD. Telephone: (510) 350-2777.

New Standards Proposed for Patient Safety, Quality

The Centers for Medicare & Medicaid Services (CMS) recently proposed new standards intended to enhance patient safety and improve the quality of care in hospitals. Among several initiatives, the rule seeks to reduce overuse of antibiotics and implement comprehensive requirements for infection prevention.

Hospitals could save up to $284 million annually under the new rule, CMS said. The rule also would advance protections for traditionally underserved and often excluded populations based on race, color, religion, national origin, sex (including gender identity), age, disability, or sexual orientation, CMS said.

The proposed rule also requires critical access hospitals to implement and maintain a Quality Assessment and Performance Improvement (QAPI) program. A QAPI program monitors a hospital's care by collecting data to identify opportunities for improvement and develop corrective plans, CMS explained. Other hospitals participating in Medicare or Medicaid already maintain these types of programs, but the rule proposes extending QAPI to critical access facilities in rural areas.

The proposed rule marks the first time that CMS has proposed explicitly to prohibit hospitals that accept Medicare and Medicaid from discriminating against patients, said **Cara James**, PhD, director of the CMS Office of Minority Health, in a statement accompanying the announcement. "We know that barriers still remain in accessing quality care for communities that have been traditionally excluded or underserved," James said. "This proposal reinforces the principle that access to needed health services should not be blocked because of discriminatory practices."

The proposed rule would make clarifications to current requirements, including that all patient medical records must document discharge and transfer summaries, including any patient discharge instructions.

You may see the proposal at http://1.usa.gov/1Q1fAbE. Comments will be accepted until Aug. 15, 2016. Submit comments at http://go.cms.gov/1UsA65d. ■

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™

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CE/CME QUESTIONS

1. **Of the conducted 6,035 Emergency Medical Treatment and Labor Act (EMTALA) cases investigated by the Centers for Medicare and Medicaid Services from 2002 to 2015, what portion were found to have merit as EMTALA violations?**

   a. 20.4%
   b. 40.4%
   c. 60.4%
   d. 80.4%

2. **What is one conclusion from the *Moses vs. Providence Healthcare System* case alleging an EMTALA violation?**

   a. EMTALA never applies to inpatients.
   b. EMTALA can apply to inpatients.
   c. Only the patient has standing to file a civil suit alleging an EMTALA violation.
   d. A hospital cannot be held liable for an EMTALA violation by a physician.

3. **Which of the following is true regarding dementia patients, according to Ronald D. Adelman, MD, medical director of the Irving Wright Center of Aging and co-chief of the Division of Geriatrics Medicine and Gerontology at NewYork–Presbyterian Hospital?**

   a. Once dementia is diagnosed, clinicians should assume the patient is not capable of consent.
   b. Once clinicians determine that a dementia patient is not capable of making decisions, that status cannot be changed for any reason.
   c. Patients with dementia must be allowed to make decisions when they are able to, even if their condition changes.
   d. Patients with dementia cannot designate their own healthcare representatives.

4. **According to Catherine J. Flynn, JD, an attorney with the law firm of Carroll McNulty and Kull, what is one of the likely outcomes of refusing to settle most malpractice cases?**

   a. The size of awards will increase.
   b. Plaintiffs will bring fewer frivolous lawsuits.
   c. Plaintiffs will bring more small lawsuits and fewer large cases.
   d. Hospital administrators will oppose the strategy.

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

Jury Awards $6 Million to Woman Due to Mislabeled CT Scan

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News: A woman arrived at the ED of a hospital and was complaining of abdominal pain. ED staff ordered a CT scan of the woman's lower abdomen. The radiology department reported that the woman's CT scan indicated a perforated bowel and/or appendix. However, the CT scan that the radiology department reported actually was that of another patient and had been incorrectly labeled as the woman's CT scan. A surgeon reviewed this mislabeled CT scan and then informed the woman that she needed to undergo immediate, life-saving surgery. Despite the fact that the surgeon could not locate any signs of a perforation in the woman's abdomen during surgery, he performed an appendectomy. However, the woman continued to suffer from severe and chronic abdominal pain. Months later, hospital representatives informed the woman of the mislabeled CT scan and said that they were unable to locate her CT scan. The woman and her husband sued the hospital. They argued that due to the hospital's failure to correctly label and identify the woman's radiology scans, the woman underwent an unnecessary appendectomy that resulted in nerve damage and lost wages. Following a trial, the jury returned a $6 million verdict in favor of the woman and found that the hospital violated its standard of care.

A SURGEON ... INFORMED THE WOMAN THAT SHE NEEDED TO UNDERGO IMMEDIATE, LIFE-SAVING SURGERY.

Background: In 2009, a woman went the ED of a hospital due to severe abdominal pain. Her symptoms included vomiting, nausea, fever, coughing, and vaginal bleeding. The on-call physician examined the woman, determined that she had tenderness in the lower right quadrant of her abdomen, and ordered a CT scan. Several hours later, the radiology department informed the ED staff that the woman's CT scan returned abnormal and displayed extravasation of contrast in the lower pelvis, which indicated a perforated bowel and/or appendix. However, the CT scan that the radiologist reported was a mislabeled CT scan of another patient's abdomen.

In reviewing this mislabeled CT scan, the radiology department also reviewed the woman's demographic information, which included past medical history, clinical findings, and a prior CT scan taken in 2007. This demographic information revealed that the woman had undergone a previous cholecystectomy, and the surgical clips used in the procedure could be viewed in the 2007 CT scans. However, the mislabeled CT scan from 2009 displayed a body with an intact gallbladder. The mislabeled CT scan was sent to the ED, where it was reviewed by a surgeon. The surgeon then

Financial Disclosure: Co-author Jamie Terrence, 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.

notified the woman that she would need immediate surgery to save her life.

The woman relied on the surgeon's statements and agreed to have an exploratory laparotomy, during which the surgeon could not locate any abnormalities in the woman's abdomen. Despite the fact that the surgeon could not find any perforations or extravasation of contrast, he performed an appendectomy on the woman. Following her surgery, the woman continued to experience chronic and severe abdominal pain around her incision site that worsened with bending.

The woman continued to suffer from severe and chronic abdominal pain following this procedure.

A few months later, the hospital informed the woman that the mislabeled CT scan belonged to another patient and the hospital could not locate the woman's CT scan. The woman and her husband sued the hospital. They argued that the woman underwent an unnecessary appendectomy due to the hospital's failure to correctly label the woman's radiology scans. As a result of the unnecessary procedure, a nerve near the woman's incision site became entrapped, which caused the woman to experience severe pain when she moved. They also argued that the hospital failed to provide the woman with hospital personnel who could competently identify radiology films. Finally, they argued that the hospital failed to implement adequate policies to ensure that radiology films are properly identified.

The lawyers for the hospital argued that while a hospital employee did mislabel two CT scans, the woman's chronic abdominal pain is a pre-existing condition that is unrelated to the appendectomy. The attorneys for the hospital also argued that this was an isolated event and that because the hospital had no prior history of problems mislabeling radiology films, the hospital did not have actual or constructive knowledge that their radiology polices and protocols were deficient. After a jury trial, the jury returned a $6 million verdict in favor of the woman and held that the woman's injuries were caused by the hospital's failure to adhere to the proper standard of care.

What this means for you:
This case illustrates the vital degree of diligence that healthcare providers must practice in the care and treatment of their patients. Patient identification is a National Patient Safety Goal from The Joint Commission. Every hospital employee, including radiology technicians, is trained to use two patient identifiers before performing any procedure, including radiological procedures, on a patient. Correctly labeling specimens, radiographs, scans, etc., is also part of the patient identification process.

That said, mislabeling events are not uncommon despite the training and education provided to hospital staff and physicians. Every physician, especially those practicing emergency medicine, should be keenly aware of this issue, as they do not have any familiarity with the patients they are evaluating and are critically dependent upon accurate information from the diagnostic studies they order. Healthcare providers also must be aware of any polices or protocols that may cause or increase the risk of harm to patients. It is essential that hospital personnel review a patient's radiology scans to confirm that the demographics of the patient are true and correct before beginning to interpret the images. Although these procedures take only a few moments, failure to adhere to them can lead to the events that occurred in this case.

Here, if the radiologist had compared the woman's CT scan from 2007, which showed surgical clips from a removed gallbladder, with the new CT scan from 2009, which clearly contained a gallbladder, the radiologist would have known that the new CT scan was not that of the woman. Unfortunately, radiologic result discrepancies are not uncommon. Interpretation of results can have a degree of subjectivity that must be dealt with, especially if the results do not match the clinical picture, as in this case. Even if the radiologist did not compare the 2009 image with the 2007 image, there was an opportunity to repeat the scan or order additional studies, such as an ultrasound or MRI to confirm the result of the CT scan, especially since the patient was not presenting with critical symptoms.

It is equally important that healthcare personnel report any incidents in which problems arise with patient care and take the necessary steps to remedy existing polices and protocols or implement new standards to ensure no repeated incidents. Here, although the surgeon who performed the laparotomy reported to the radiology department that his surgical findings did not support or comport with the radiological interpretation of the mislabeled CT, the hospital appears to have failed to file an incident report or conduct an investigation into the discrepancy.

It is extremely unusual for a hospital not to investigate an event of this kind. Moreover, it is against regulations from CMS, which could lead to the loss of the hospital's participation in the Medicare and Medicaid programs. This risk is

one most hospitals would never take. Because incident reports and internal investigations are protected from discovery in many states under various evidence codes, it is possible that these did exist, but were not disclosed to outside counsel. It is important to provide all documents to counsel and allow counsel to determine what is relevant and what must be produced to the other side or presented in court.

This case also discusses the role of expert witnesses in determining the expected levels of skill and knowledge that apply to medical personnel. The woman retained multiple surgical experts who determined that the proper standard of care, according to national standards, required that the hospital take certain measures to ensure that the CT scans were not mislabeled. The experts also were critical in establishing that the cause of the woman's prolonged chronic pain was due to complications that arose as a direct result of her unnecessary laparotomy. Therefore, it is important that healthcare providers are aware of the standard of care that applies to them under the law.

REFERENCE

Court of Common Pleas of Delaware County, Pennsylvania, Case No. 2011-007715 (April 29, 2016). ■

Improper Administration of a Drug Yields Verdict of $44.1 Million From Jury

News: In 2011, a 57-year-old woman was transferred to a hospital to treat a benign brain tumor. The hospital removed the tumor and prescribed heparin, an anticoagulant medication. However, staff failed to follow proper procedures in the administration of heparin over nine days. The hospital also stopped monitoring the woman's blood despite prior blood tests indicating that her blood was thinning at an increasing rate and becoming unsafe. After nine days of receiving heparin, the woman was found in a deep coma. The woman had a massive brain bleed, which resulted in brain damage with severe and permanent neurological and physical deficits. The woman and her husband sued the hospital and the attending doctor for malpractice. They argued that the nurses failed to properly follow one or more orders for administering heparin and also failed to recognize or report that the drug had been improperly administered. They also argued that the hospital failed to recognize the changes in the woman's blood that indicated the woman was at high risk of bleeding. Finally, they argued that hospital should not have stopped performing daily testing on the woman's blood because the hospital knew the woman was at risk of developing a brain bleed. The jury returned a verdict in favor of the woman for $44.1 million and found that the hospital and attending physician violated the standard of care.

Background: A woman drove herself to a hospital to receive treatment for a benign brain tumor. After the hospital removed the brain tumor, the hospital prescribed heparin, often used to prevent deep vein thrombosis (DVT), or blood clots that can occur in the legs of bedbound postoperative patients, or for prevention of pulmonary emboli, or blood clots in the lungs, of patients.

However, the hospital failed to follow proper procedures in the dosing and administration of heparin. For example, on one or more occasions, hospital staff administered heparin through an improper route in the woman's body, including her right arm at one point and a peripheral vein at another point. The hospital continued to administer heparin every eight hours over nine days. During the first six days, the hospital conducted partial thromboplastin time testing to determine how long it took for the woman's blood to clot. The test results showed that the woman's blood was moving from the low to high end of what is considered safe. On the sixth day, the hospital stopped testing the woman's coagulation.

On the ninth day, the woman was found in severe and deep unconsciousness. Additionally, the external drain that had been placed in the woman's brain showed bloody drainage. The same day, the hospital performed a d-dimer test to determine if there were blood clots in the woman's brain. After the test returned abnormal and the hospital detected a brain bleed, the hospital discontinued heparin.

The hospital then ordered a hematology consult, which determined that the woman's abnormal blood tests were caused by the "heparin effect," which is when patients' blood thins to the point at which they are at risk of bleeding and other complications. As a result of the woman's brain bleed, she experienced

brain damage and severe, permanent neurological and physical deficits. The woman and her husband sued the hospital and the attending physician for medical malpractice.

The woman's attorneys argued that the woman's blood began to thin to the point at which she was at risk of a brain bleed because this site recently had been surgically repaired, and they said healing of the blood vessels cut during the procedure had not completely taken place. The woman's attorneys said that the hospital should have recognized this risk and adjusted or stopped the use of heparin. They also argued that daily partial thromboplastin time testing and patient monitoring would have indicated that the cause of the woman's blood thinning was due to improper dosage and administration of heparin.

Lawyers for the hospital argued that the woman's brain bleed was caused by numerous complications from the initial surgery to remove her brain tumor. They also contended that the hospital staff followed proper dosing procedures in administering heparin and properly monitored the woman's blood. Following a 13-day jury trial, a verdict of $44.1 million was returned in favor of the woman. The jury found that the hospital and the attending physician were responsible for the woman's extensive injuries due to a failure to follow established patterns of care in the medical community.

What this means for you: This case is significant because it represents the largest medical malpractice verdict issued in Pennsylvania since 2014. This case also demonstrates that while it is routine within the medical community for doctors not to test a patient's coagulation levels after neurosurgery, such testing may be required if the patient is believed to be at a high risk for developing a brain bleed. Here, one of the attending doctors testified that the hospital performed partial thromboplastin time testing daily for the first six days after the surgery precisely because doctors believed she was at risk of developing a bleed. Although heparin is a widely used anti-coagulation medication, use of this drug also requires close monitoring to prevent the heparin effect. Therefore, it is imperative that healthcare practitioners avail themselves of the standard of care to which they will be held to then determine which protocols and testing are necessary. Despite the fact that the patient's clotting times initially were being maintained within the normal range, as long as the patient continued on heparin, the potential remained for the values to deviate from normal at some point.

This case also highlights the importance of proper standards in the postoperative care of a patient. Here, numerous nurses were responsible for overseeing the administration of heparin and recording these dosages in the woman's medical files. Heparin should be given subcutaneously in the soft tissue under the skin of the abdomen so that the rate of absorption into the bloodstream is controlled. However, these records indicate that nurses failed to recognize that other nurses improperly administered heparin and that they also failed to inform attending physicians of these occurrences.

It is equally important for attending physicians to supervise, review, and oversee all nursing and medical care, as well as the medications that are administered to patients in their care. In this case, attending physicians failed to review the nursing notes in the medical record, which revealed that heparin was administered contrary to their orders on at least two occasions. However, this practice is not unusual or a standard expectation for physicians. Physicians assume, perhaps incorrectly, that their orders are followed by nursing staff. Any deviation from those orders can be construed, especially in a courtroom, as nurses functioning outside of their scope of practice and in violation of their licenses. Also, postoperatively, the patient was at high risk for many complications, including cerebral hemorrhage, infection, cerebral edema, etc. There are other measures available to physicians to prevent DVTs, such as compression hose or sequential compression devices, neither of which compromises a patient's clotting factor.

This case illustrates the vital role expert witnesses play in establishing the proper standard of care in malpractice cases. In a "battle of experts," the expert who is more credible can shift the case. The hospital's expert testified that it was well within the standard of care for the hospital to stop testing the woman's blood daily because her blood tests were within the normal range. The expert testified that well before the brain bleed occurred, the woman suffered from post-surgery complications, including infection and swelling. Nevertheless, the woman's experts were successful in proving that the cause of the brain bleed was due to the failure to administer heparin properly and monitor its effects on a woman who was at an increased risk of developing a brain bleed. ■

REFERENCE

Philadelphia County Court of Common Pleas, Pennsylvania, Case No. 130901595 (April 27, 2016).