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INSIDE

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OB Risk Reduction Focuses on Nurses, Detailed Timelines

Obstetrical malpractice claims make up only a portion of all cases, yet they demand an undue amount of attention from risk managers and defense attorneys. The tragedy of an injured child can pose a challenge to defending or settling the case, one reason the payouts can be far higher on average than other claims.

While much of malpractice prevention efforts focus on physicians, nurses can be at risk of malpractice charges in this specialty.

Obstetrics is the one nurse specialty consistently experiencing the highest financially severe payments in both past and present Nurses Service Organization (NSO)/CNA closed claim reports, says **Jennifer Flynn**, CPHRM, manager at Aon Affinity Healthcare Risk Management. The most recent report, published in 2015, includes an analysis of obstetrics-related claims and injuries. The authors studied a five-year view of closed claims with an indemnity payment of $10,000 or greater made on behalf of a nurse to an injured third party. *(See the stories on pages 41 and 42 for more on nursing risk management.)*

ON AVERAGE, NSO & CNA PAID $397,064 FOR OB-RELATED CLAIMS, WHICH IS MORE THAN DOUBLE THE OVERALL AVERAGE PAID INDEMNITY FOR ALL NURSE CLOSED CLAIMS.

Obstetrics-related claims accounted for 9.8% of all claims, Flynn notes. On average, NSO & CNA paid $397,064 for OB-related claims, which is more than double the overall average paid indemnity for all nurse closed claims of $164,586.

The high severity of OB claims reflects the lifelong medical cost for patients in a persistent vegetative state, who require ongoing nursing care, Flynn explains. Of all

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obstetrical injuries, fetal/infant birth-related brain injuries had the highest percentage of closed claims, representing 72.5% of all OB claims.

In all these cases, the patients argued the claims involved one or more of the following nursing errors:

- failure to timely report a complication of pregnancy/labor to the practitioner;
- failure to monitor and timely report the mother's and/or baby's vital signs;
- failure to identify and report observations, findings, or changes in condition;
- improper or untimely nursing management of an OB patient and/or complication;
- failure to invoke the chain of command.

Risk Reduction Tips for Nurses

Flynn notes that obstetrics, like some other specialties, involves unique nursing skills that create additional risks. She offers the following risk management recommendations for nurses working in higher-risk clinical areas:

- Follow established policies, procedures, and clinical protocols regarding the assessment and management of each patient's labor and delivery.
- Attain and maintain up-to-date knowledge and skills in the interpretation of electronic fetal monitoring tracings.
- Agree on and utilize common language and interpretation of electronic fetal monitoring tracings among all members of the patient care team, including, among others, physicians, nurses, and technicians.
- Maintain fetal and maternal monitoring during transport to diagnostic test locations or operating room and during the patient's preparation for a cesarean section.
- Document communication with other members of the healthcare team throughout the patient's labor and delivery.
- Understand and follow the nursing scope of practice requirements related to management of medications for cervical ripening and labor induction or augmentation.
- Know and follow the chain of command, as needed, to ensure timely and appropriate nursing and medical care.
- Utilize the chain of command to address medical orders outside the standard of care as defined by nursing and medical staff policies and protocols, professional guidelines, and/or the state nurse practice act.
- Participate in drills for the management of obstetrical emergencies, including uterine hemorrhage.
- Document in a timely manner all patient assessments, fetal tracing

EXECUTIVE SUMMARY

Obstetrics is a constant source of malpractice claims and some of the largest payouts. A risk management program should put special emphasis on this high-risk area.

- Risk management should focus on nursing, particularly in this field.
- Paid indemnity for obstetrics claims is twice that of other claims.
- Fetal monitor strips are key to many cases.

assessments, patient care services, and contacts with other healthcare professionals, as well as the patient's symptoms, responses to treatment, and complaints.

Fetal Monitoring Often at Issue

Fetal monitor strips feature prominently in many OB malpractice cases, Flynn notes.

"Nurses must carefully review fetal monitor strips throughout labor and delivery to monitor the health of mother and baby. If the nurse fails to properly monitor the mother's and baby's vital signs or fails to act swiftly once the fetus begins showing signs of distress, serious injury may occur, ranging from mild to traumatic," she says. "In the most severe cases, the baby may suffer brain damage from oxygen deprivation."

When a birth injury has occurred, the fetal monitor strips can be invaluable pieces of evidence — either in the defense of the defendant nurse or for use by the patient to show harm was done, Flynn says. They will show when the fetus went into distress and for how long. This information may be used to show that the nurse acted or failed to act to the distress in a timely manner. Additionally, fetal monitor strips become part of the medical record, therefore becoming part of the malpractice lawsuit, Flynn explains.

Risk in OB cannot be properly addressed until a system is in place for tracking and recording unusual occurrences, Flynn says. The most common method for describing untoward events is the incident report form, which should capture relevant, objective information regarding the event and surrounding circumstances, notify management of a potentially serious or litigious situation, and facilitate gathering of information that tracks and trends adverse events. *(See the story on page 40 for more on the importance of documenting the timeline in OB cases.)*

"Incorporating good, consistent risk control strategies and habits into your practice can help reduce or eliminate those risks," Flynn says.

> "INCORPORATING GOOD, CONSISTENT RISK CONTROL STRATEGIES AND HABITS INTO YOUR PRACTICE CAN HELP REDUCE OR ELIMINATE THOSE RISKS."

"Some of these recommendations made may seem like 'no-brainers,' but many times we see cases where these simple steps are not done at all or not done consistently across an organization, which leads to poor patient outcomes."

Zika Claims May Be Coming

The future may bring obstetrical malpractice claims related to the Zika virus, says **David E. Richman**, JD, a partner in Medical Malpractice Defense Practice Group with the law firm Rivkin Radler in Uniondale, NY. Zika is spread by mosquitoes in some areas and can be passed from a pregnant woman to her fetus. Infection during pregnancy can cause severe birth defects.

"We may see cases coming out of patients with Zika, most likely related to the diagnosis and what advice is given to the parents in regards to potential termination of the pregnancy," he says. "There are a lot of issues with false negative and false positive results, and the histories being taken of patients. I think the risk management community needs to be aware of this cutting-edge issue and take steps to communicate with the clinical staff."

Richman also cautions that providers still must be on guard for one of the worst challenges: the obstetrical patient with little or no prenatal care, who now becomes the physician's responsibility at time of birth. It can be worthwhile to support community intervention programs for these patients to educate them about the need and availability of prenatal care programs, he says.

Cesarean sections are another common point of contention, but not always just whether the procedure was clinically necessary, notes **Bobbie Moon**, JD, shareholder with the law firm of Sandberg Phoenix & von Gontard in St. Louis. She recently worked on a case in which neither of the plaintiff's expert witnesses would say the standard of care required a cesarean section, but they were critical of the defendant physician for not explaining the risks and benefits enough, implying that the patient may have chosen to undergo an elective cesarean section if she had fully understood.

"I think that argument went over the jurors' heads to some degree, but the informed consent issue is an angle that works around what you absolutely had to do," she says. "Some plaintiffs' attorneys are getting around the idea that doctors can't predict the future with absolute

certainty by saying you needed to let the mom know. We're seeing more and more detail on that. Did you tell the mom she was having decelerations and this might mean a problem in the future? They ask, 'Doesn't the mom deserve that information?'"

Moon worked on another case in which the plaintiff's attorney questioned why the mother was not informed about certain alarms being turned off during her labor.

"It's all about what did you tell the mom," Moon says. "There's not a very good documentation often about physician or nurse discussion of risks and benefits. Pitocin is always a nightmare, so it would be helpful if your protocol had the nurse take time to document that she discussed the risks with the patient and the patient understood the doctor thought this was best for her at that time."

Texting also is becoming an increasingly common element in malpractice cases, says **Maureen Barnes**, vice president of risk management and patient safety at Cassatt Insured Group, a captive insurance group in Malvern, PA, that provides risk management and patient safety programs to its member hospitals and physicians.

With the timeline so crucial in most OB cases, plaintiffs' attorneys often obtain text records to prove their case or dispute testimony about the timing of events, Barnes says. The texts sometimes lead the plaintiff's attorney to segue into the audit trail for the electronic medical record (EMR).

"If this physician is going to say he was called away to another delivery at a certain time, the metadata for the EMR ought to be able to support that," she says. "It creates a behind-the-scenes story of who entered what in the record at what time. Sometimes, that is good for us, showing the physician was acting on available information at the time, that the lab result everyone is focusing on actually wasn't available to the physician at that critical time." ■

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Careful Log of Time, Incidents Can Be Crucial to Defense

OB malpractice cases often hinge on the fine details of when certain events happened, when steps were taken, and how much time passed before clinicians intervened to protect the patient. That is why OB teams must be fastidious about documenting the treatment process, says **David Waxman**, JD, partner in the litigation group of the Chicago law firm Arnstein & Lehr.

"When a team response is called for in labor and delivery, it often involves multiple providers working simultaneously. Thereafter, providers should promptly chart their care, and when and how that care was delivered," Waxman says. "Should that care ultimately be addressed in a medical malpractice case, those chart entries are often the primary, if not sole, basis for a lawyer to establish the narrative on how the patient was treated."

Although everyone remembers events differently, it is in the hospital's best interest that these reports be consistent in describing what happened and when, Waxman says. Thus, when team care is provided, assigning someone with primary responsibility for keeping time and noting when particular events occur is important.

It also is prudent for hospitals to encourage immediate post-event follow-up for the providers to review what occurred and when it occurred before they document their care, he says. Such follow-up discussions are likely to be discoverable, so it is critical that quality-related discussions be deferred to an appropriate forum where privilege will shield such discussion, he says.

"Hospitals are forced to thread the proverbial needle in creating policies which address these post-event, pre-charting discussions. On the one hand, coordination is to be encouraged, and to the extent practicable, the descriptions of what occurred should not only be accurate but should also be

consistent," Waxman says. "Yet, the hospital cannot be so heavy-handed in addressing these discussions as to snuff out differing recollections and create anything that could be criticized as a 'conspiracy of silence.'"

Using a dedicated timekeeper can go a long way toward eliminating otherwise avoidable conflicts between the notes of the various providers, he suggests. Engaging in an open and forthright post-event discussion may also serve to reduce inconsistency in chart entries, and allow for a narrative to be created in defense of the care.

"However, policies governing these discussions will also be discoverable, and policies which unduly stifle individual recollection in the pursuit of charting with one voice will ultimately backfire and will undercut the credibility of the providers' notes and any narrative based on those notes," Waxman says. ■

SOURCE

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Nurses Should Understand Their Risk in OB Malpractice

It is critical for nurses to adhere to specialty standards and recommendations to avoid legal action in case of a patient injury, says **Jennifer Flynn**, CPHRM, manager at Aon Affinity Healthcare Risk Management.

To increase patient safety and reduce liability exposure, she encourages nurses to take the time to understand the risks that confront today's nurses, standards of care related to their professional practice, and the legal principles of malpractice. Standards of nursing practice derive from facility policies and procedures, job descriptions, national, state, and specialty professional standards, state nurse practice acts, and expert nurses, she notes.

Malpractice is negligence, misconduct, or breach of duty by a professional person, such as a nurse, that results in injury or damage to a patient, she explains. In most cases, it includes failure to meet a standard of care or failure to deliver care that a reasonably prudent nurse would have delivered in a similar situation.

Nurses can benefit by taking a proactive approach to examining current practices and direct risk control efforts toward statistically demonstrated areas of loss, Flynn says. She suggests starting with these key areas as a starting point to assess and enhance risk control practices:

- Know and comply with your state scope of practice requirements, nurse practice act, and facility policies, procedures, and protocols.

CONSULT WITH THE HEALTHCARE TEAM IN ACCORDANCE WITH STATE REGULATIONS REGARDING CONCERNS RELATED TO PATIENT CARE ISSUES.

- Follow documentation standards established by nurse professional organizations, and comply with your employer's standards.
- Document all patient-related discussions, consultations, clinical information, and actions taken, including any treatment orders provided.
- Document the nurse's clinical decision-making process.
- Maintain clinical competencies aligned with the relevant patient population and healthcare specialty.
- Develop, maintain, and practice professional written and spoken communication skills.
- Engage in timely and proactive discussion with members of the patient's care treatment team to ensure ongoing awareness of the patient's treatment plan.
- Timely and thoroughly report any changes in the patient's condition and/or response to treatment, and document such interactions along with any revisions in the treatment plan in the patient's clinical record.
- Emphasize ongoing patient assessment and monitoring.
- Consult with the healthcare team in accordance with state regulations regarding concerns related to patient care issues.
- Timely report to the treatment team, and document spoken and/or written discussions with the patient and authorized family members to ensure full team awareness of patient and family concerns regarding care and treatment. ■

Case Highlights Role of Nurse in OB Safety

Nurses play as much of a role in OB patient safety as physicians, notes **Jennifer Flynn**, CPHRM, manager at Aon Affinity Healthcare Risk Management. Nurses are perceived as highly skilled and educated professionals who are charged with making clinical observations, exercising discretion, and taking appropriate treatment actions based on a patient's changing clinical picture, she notes.

During labor and delivery, nurses working in this specialty area and involved in the birth are responsible for using professional judgment during treatment to ensure that the process goes as smoothly as possible, she says. One of the ways nurses can do this is by properly monitoring patients, timely reporting changes in the patient's condition, and taking appropriate actions when signs of distress are present.

Flynn notes the following case illustrating the important role of nurses:

A 38-year-old patient was admitted for a cesarean delivery of twins. The babies were delivered without incident, but the patient experienced excessive postoperative vaginal bleeding attributed to placenta accreta. An emergency total abdominal hysterectomy was performed to control the bleeding. After surgery, the patient, who appeared stable, was transferred to the ICU with blood pressure of 110/60 mmHg. The receiving ICU nurse had orders to transfuse the patient with two units of fresh frozen plasma and monitor vital signs every 30 minutes.

After the first unit of plasma was given, the patient's blood pressure was 108/59 mmHg. She was assessed by the attending ICU practitioner, who ordered a complete blood count to be conducted after the second unit of fresh frozen plasma. The ICU practitioner noted that the patient's post-surgical hemoglobin and hematocrit levels were 7.4 gm/dL and 22%, respectively. However, one hour after the second unit of plasma was given, the patient's hemoglobin was 5.9 gm/dL, and hematocrit was 17.7%.

The nurse documented the results in the health record but did not notify the ICU practitioner because he assumed the practitioner was returning to the unit to reassess the patient. Two hours after the second unit of plasma, the patient's blood pressure was reported as 63/21 mmHg. The nurse notified the on-call resident of the blood pressure and received an order for stat transfusion of two units of packed red blood cells. The blood bank records indicated that the blood was available 20 minutes after stat order was received.

One hour later, upon arrival of the oncoming shift, the ICU nurse reported to the oncoming nurse that the blood had still not been delivered. Even though both nurses were concerned about the situation, neither nurse called to ascertain the blood's location. Fifteen minutes into the oncoming nurse's shift, the administration of one unit of packed red blood cells was started. While the blood was transfusing, the patient went into respiratory distress, and the admitting ICU practitioner was notified.

Later that evening, the patient underwent a second abdominal surgery. Due to her extensive hypovolemia, she slipped into a coma postoperatively and currently remains in a vegetative state.

"During deposition, the admitting ICU practitioner testified that he was not informed of the second laboratory results or the patient's vital signs until the patient went into respiratory distress," Flynn says. "The claim asserted against our insured nurse settled for greater than $600,000."

Several other healthcare practitioners also were included in the lawsuit, but their settlement amounts were not available. ■

Commenting on Past Employee Behavior Is Thorny Issue

Inquiries about a previous employee or physician's performance at your hospital can put administrators in a difficult position. If the truth is not favorable and the hospital says so, the hospital could be liable for besmirching the person's reputation and interfering with his or her career. But if the hospital discloses nothing about the poor background, it could be liable for allowing that person to go on and harm patients at another facility.

Even a positive reference can come back to bite the hospital, so hospitals are forced to minimize their risk, says **Sanjeeve DeSoyza**, JD, partner with the law firm of Bond, Schoeneck & King in Albany, NY.

"Unfortunately, in our litigious society, employers must continue to be cautious in responding to reference

requests. A glowing reference for an incompetent clinician — issued in the hopes of moving that person on with minimal conflict — can create a host of new problems down the road if relied upon by a successor employer and harm later results," he says. "Similarly, a negative reference can come back to haunt an employer if unsupported or contradicted by the personnel file and other relevant evidence."

State laws on reference checks vary, DeSoyza says. For instance, New York law does not require that employers provide references for former employees and unlike several other other states, New York does not have a reference check immunity law. Most employers, including in the healthcare industry, limit information provided in response to reference requests on former employees, he says.

"This is driven in large part by concern about potential legal liability such as defamation, negligent referral, or retaliation claims. Responses by former employers are usually limited to name, dates of employment, and positions held," DeSoyza says. "Even for stellar employees, employers are reluctant to deviate from the 'name, rank, serial number' policy and provide a substantive reference out of fear of a discrimination claim by another employee who was denied a similar reference."

In many cases, the hospital can avoid providing negative information but refer the inquiry to the state or professional body that can, says **Max Gaujean**, JD, a malpractice attorney and founding member in the White Plains, NY, office of the Brown, Gruttadaro, Gaujean, Prato & Sastow law firm.

"If you know that there was an incident that this potential employer will find meaningful, you don't have to tell them yourself if you know that it has been reported to your state's office of professional medical conduct or a similar body," Gaujean says. "That's the safest course of action. They can get the information and determine on their own whether that has bearing on the employment decision."

Healthcare employers in most states have reporting obligations regarding misconduct by certain employee classes, DeSoyza notes. In New York, for example, hospitals and other facilities must report certain incidents threatening patient care as well as professional misconduct by physicians and residents to the Department of Health's Office of Professional Medical Conduct.

There also are reporting obligations for certain misconduct by registered nurses, nurse practitioners, social workers, pharmacists, and other health-related professions, DeSoyza says. Additionally, he says employers can determine whether a prospective employee is on the federal Office of Inspector General's List of Excluded Individuals/Entities, thereby precluding collection of payment from any federal healthcare program such as Medicare for items or services furnished, ordered, or prescribed by that individual. *(See the story on page 45 for more on obligations to report.)*

Though the former employer can face liability from different angles, they almost always worry most about being sued by the former employee rather than third-party liability for negligent misrepresentation, says **David M. Aafedt**, JD, shareholder with Winthrop Weinstine law firm in Minneapolis.

"People are always playing it very close to the vest for fear of being faced with a defamation lawsuit," he says. "That's the case even though the truth is an absolute defense. As long as the information you are providing is truthful and not provided with actual malice, you will be protected. Nevertheless, you might still face litigation and nobody wants to have that out in the public arena with the potential for it blowing up into something no one anticipated."

Providing negative information about a past employee also can lead to litigation unrelated to claims of defamation, says **H. Carlton Hilson**, JD, an attorney with the Burr & Forman law firm in Birmingham, AL. If an employee leaves the hospital, willingly or otherwise, and finds out that a prospective employer was provided a negative review, that employee may be angered enough to bring up past grievances with the employer.

"It might be discrimination of some sort or other allegations that the employer mistreated him or her in a

EXECUTIVE SUMMARY

Commenting on a prior employee or physician's past behavior poses legal liability for healthcare providers. Providing only minimal information is usually the best course of action.

- Healthcare providers have no affirmative obligation to provide information on past employment.
- A signed release form and waiver of liability can make it possible to disclose information without risk.
- Inquiries can be directed to other sources, such as state offices of professional medical conduct.

way that is actionable," he says. "They may have left the hospital with no animosity, and the negative employment review might not be anything they can prevail on in court, but they're looking for a way to get back at the hospital."

Obtain Signed Release

A written release from the person in question can eliminate most of the risk, says **Sherry L. Travers**, JD, shareholder with the law firm Littler Mendelson in Dallas. In most cases, that should be easy to obtain because the job seeker wants to do whatever is necessary to get the job.

"That release would authorize a waiver of any claims brought against them related to information they asked you to release," Travers says.

The hospital is not at risk from not passing on information unless it was obligated by law, Travers says.

"There have been cases in which people tried to make that argument, that you should have told us about this person's employment experience, but the courts have recognized that is unworkable," Travers says. "You can't expect hospitals to expose themselves to liability like that without a legal obligation or a release from the former employee."

References should not be provided on a case-by-case basis, says **Wendy G. Adkins**, JD, partner with the law firm of Jackson Kelly in Morgantown, WV. Hospitals should adopt a uniform reference policy detailing what information is to be shared and specifically identifying who is authorized to provide such references on its behalf, she says.

"Any inconsistencies by a hospital on when it chooses to provide a reference, whether positive or negative, could be used to establish a prima facie claim of discrimination. Although patient safety concerns may provide a legitimate, nondiscriminatory reason, the cost of defending such a discrimination claim leads most employers to implement a neutral reference policy," Adkins says. "However, neutral reference policies are not risk-free. Neutral reference policies must also be applied consistently and not ignored by supervisors or managers outside of the human resources department. Hospitalwide education on any reference policy is critical to ensure consistent application."

Many states provide statutory protections to employers who provide good faith references for current or former employees to prospective employers, Adkins notes. The protections typically are limited to defamation or invasion of privacy claims. However, if a hospital wants to go beyond a neutral reference and report patient safety concerns, it should educate itself on the parameters of those protections, she advises. State statutes, or even administrative regulation by a state's department of labor, may provide the specific type of information that can be provided by an employer, the form in which the information must be provided, and the specific individuals with whom the information can be shared.

For example, Adkins notes that West Virginia Code §55-7-18a provides express statutory protections to employers who chose to share adverse information concerning current or former employees to a prospective employer. To be afforded statutory immunity from civil liability, an employer must provide a written reference, and a copy of the written reference must be provided to the current or former employee at the time of disclosure. Also, the reference must only provide "job-related information," specifically defined in West Virginia as concerning "a person's education, training, experience, qualifications, conduct, and job performance" and "offered for the purpose of providing criteria to evaluate the person's suitability for employment."

The good faith presumption afforded such a reference, however, may be rebutted if the information disclosed is knowingly false; disclosed with reckless disregard for the truth; deliberately misleading; rendered with malicious purpose toward the former or current employee; or disclosed in violation of a nondisclosure agreement or applicable law, Adkins explains.

A hospital should report on poor conduct or job performance that is well-documented and supported by some objective evidence such as annual evaluation ratings, acceptance of responsibility by employee, or patient complaint statistics, she says.

Even with a release, many hospitals are hesitant to provide negative information in response to requests for fear of liability or to avoid being sued by the physician for defamation, says **Pamela E. Hepp**, JD, shareholder with Buchanan, Ingersoll & Rooney law firm in Pittsburgh. Instead, hospitals have opted to provide basic information as to dates that the physician was on the medical staff but avoid answering questions related to quality, she says.

Hospital administrators commonly believe that such non-answers will appropriately send a red flag to the receiving hospital while avoiding explicitly making negative statements, she says.

However, Hepp notes that a federal court in 2006 found a hospital liable for negligence and misrepresentation when it took such an approach and the requesting hospital granted privileges to the physician, an anesthesiologist who

had been terminated because of impairment.

"The case ultimately overturned on appeal the judgment against the hospital on the basis that there is no affirmative duty to respond to such requests, but the concern remains that other courts could similarly impose liability for failing to provide transparent information," Hepp says. "Suggested best practices are to obtain a specific release before responding, act in good faith and without malice, provide limited but factual and complete information, and where a National Practitioner Data Bank report has been filed, provide information that mirrors or is consistent with that response." ■

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The Joint Commission Requires Some Information

Courts have imposed a duty of care that hospitals must exercise in granting privileges, and The Joint Commission likewise requires hospitals to obtain references and information from other facilities with which the physician has practiced, says **Pamela E. Hepp**, JD, shareholder with the Buchanan, Ingersoll & Rooney law firm in Pittsburgh.

Hepp notes that reference requests may be received with respect to the potential employment of the physician (and seeking a reference related to that physician's prior employment with the hospital) as well as in the context of an inquiry related to the physician's medical staff membership with the hospital. Hospitals or health systems that employ physicians typically will have two sets of files — a human resources file containing the employment-related records, and a medical staff office file containing credentialing and peer review information regarding the physician's medical staff membership and privileges, she notes.

The Healthcare Quality Improvement Act (HCQIA) as well as applicable state peer review statutes may provide some limited immunity and protection for providing peer review information in response to those inquiries, Hepp says. It is these peer review statutes that result in each of these two offices or departments maintaining separate files because sharing of certain information by the medical staff office with human resources could waive the peer review privilege, she explains.

These peer review statutes generally provide some protection from disclosure of documents or information created by a peer review committee about peer review proceedings as well as immunity from liability for actions that are taken in good faith, Hepp says, after reasonable efforts to obtain the facts and after adequate due process was given, and such decision was not taken maliciously or in a discriminatory fashion.

"In order for the hospital to have such protections of the HCQIA, it must also report certain adverse decisions, or a physician's voluntary relinquishment of privileges in lieu of an investigation, that are based on clinical competence or conduct, and to the National Practitioner Data Bank," Hepp says. "State law may also require additional reports to be made to the state licensing board."

Given the peer review protection that exists, hospitals must take steps to ensure that the privilege is not waived before information is disclosed, Hepp says.

"The medical staff bylaws and application for appointment and privileges will typically include a release that authorizes the hospital to share information with and receive information from other facilities where the physician has practiced," she says. "But most will still want to obtain a separate specific release signed by the physician that has had an adverse action that authorizes the disclosure of information and that clearly states that such disclosure is not intended to waive the privilege." ■

Patient Complaints Tied to Worse Outcomes

Patient complaints can have a direct correlation with the quality of a surgeon's performance, according to a recent study. The more patients have complained about a surgeon, the more that surgeon is likely to have increased surgical and medical complications.

Risk managers already knew that patient complaints are associated with risk of medical malpractice claims, but it was difficult to gauge whether those complaints reflected poor performance by the physician or a spoiled relationship with the patient.

William O. Cooper, MD, MPH, of Vanderbilt University Medical Center in Nashville, TN, and colleagues used data from seven academic medical centers and included patients who underwent inpatient or outpatient operations, and examined complaints provided to a patient reporting system for the patient's surgeon in the 24 months preceding the date of the operation.

"Some patient complaints described behaviors that might intimidate or deter communication; others included patients' observations of a physician's disrespectful or rude interaction with other healthcare team members that might distract focus," the team reported.

Among the 32,125 patients in the study, 3,501 (11%) experienced a complication, including 5.5% surgical and 7.5% medical. The researchers found that prior patient complaints for a surgeon were significantly associated with the risk of a patient experiencing any complication, any surgical complication, any medical complication, and being readmitted. The adjusted rate of complications was 14% higher for patients whose surgeon was in the highest quartile of patient complaints compared with patients whose surgeon was in the lowest quartile.

"If extrapolated to the entire United States, where 27 million surgical procedures are performed annually, failures to model respect, communicate effectively, and be available to patients could contribute to more than 350,000 additional complications and more than $3 billion in additional costs to the U.S. healthcare system each year," the authors wrote. "Efforts to promote patient safety and address risk of malpractice claims should continue to focus on surgeons' ability to communicate respectfully and effectively with patients and other medical professionals."

An abstract of the study and a link to the full text is available online at: http://bit.ly/2lYMOvb. ■

Cloud Encryption Not Used Enough in Healthcare

A quarter of healthcare organizations do not use encryption to protect data in the cloud, leaving the electronic protected health information (ePHI) of patients at risk of exposure, according to a recent survey by HyTrust, a cloud control company in Mountain View, CA.

Thirty-eight percent of respondents said they had a multicloud environment and 63% of respondents said they were planning to use multiple cloud service providers in the future; 63% of healthcare organizations said they were using the public cloud to store data.

Data security was cited as the No. 1 concern by 82% of surveyed healthcare organizations, but even so, encryption is not always employed, says **Eric Chiu**, founder and president at HyTrust.

"For these care delivery organizations, choosing a flexible cloud security solution that is effective across multiple cloud environments is not only critical to securing patient data, but to remaining HIPAA compliant. However, the lack of encryption is a cause for concern."

Comprehensive Risk Assessment Needed

HIPAA rules permit the use of cloud services for storing and processing ePHI, but covered entities are required to conduct a comprehensive risk assessment to assess threats to the confidentiality, integrity, and availability of ePHI.

Covered entities must make sure that appropriate technical safeguards are employed to ensure the confidentiality of cloud-stored ePHI is preserved, and data encryption must be considered, Chiu notes. If a decision not to use encryption for cloud-stored data is made, the reason for that decision must be documented along with the alternative controls that are put in place to provide a similar level of protection.

The U.S. Department of Health and Human Services (HHS) pointed out in last year's cloud computing guidance for HIPAA-covered entities that encryption can significantly reduce the risk of ePHI breaches. That said, HHS also explained that encryption alone is not sufficient to ensure the confidentiality, integrity, and availability of ePHI stored in the cloud.

Encryption may cover the confidentiality aspect, but it will do nothing to ensure that ePHI is always available, nor will it safeguard the integrity of ePHI. Alternative controls must be in place to ensure ePHI can always be accessed, while access controls must be used to ensure the integrity of ePHI is maintained. The use of encryption alone to safeguard ePHI may, therefore, constitute a violation of the HIPAA Security Rule, Chiu explains.

"Healthcare organizations that choose to use cloud services provided by a separate entity must ensure that the cloud service provider is aware of its responsibilities with respect to ePHI. Cloud service providers are classed as business associates of covered entities, and as such, they are required to abide by HIPAA rules," Chiu says. "Healthcare organizations must obtain a signed business associate agreement from each cloud service provider used, if the service is used to store any ePHI. HHS has also explained that even if ePHI is stored in the cloud and the cloud service provider does not hold a key to decrypt the data, the cloud service provider is still classed as a HIPAA-business associate." ■

$5.5 Million Settlement Related to Audit Controls

In a case that highlights the need for proper audit controls, Florida's Memorial Healthcare System (MHS) has paid the U.S. Department of Health and Human Services (HHS) $5.5 million to settle potential HIPAA violations. The health system also agreed to implement what HHS calls a "robust" corrective action plan.

MHS is a nonprofit corporation that operates six hospitals, an urgent care center, a nursing home, and a variety of ancillary healthcare facilities throughout the South Florida area. It also is affiliated with many physician practices.

MHS reported to the HHS Office for Civil Rights (OCR) that the protected health information (PHI) of 115,143 individuals had been impermissibly accessed by its employees and impermissibly disclosed to affiliated physician office staff. This information consisted of the affected individuals' names, dates of birth, and Social Security numbers. The login credentials of a former employee of an affiliated physician's office had been used to access the ePHI maintained by MHS on a daily basis without detection from April 2011 to April 2012, affecting 80,000 individuals.

"Although it had workforce access policies and procedures in place, MHS failed to implement procedures with respect to reviewing, modifying, and/or terminating users' right of access, as required by the HIPAA rules," HHS reports. "Further, MHS failed to regularly review records of information system activity on applications that maintain electronic protected health information by workforce users and users at affiliated physician practices, despite having identified this risk on several risk analyses conducted by MHS from 2007 to 2012."

In a statement accompanying the settlement announcement, Acting Director of HHS OCR **Robinsue Frohboese**, emphasized that organizations must implement audit controls and review audit logs regularly.

"As this case shows, a lack of access controls and regular review of audit logs helps hackers or malevolent insiders to cover their electronic tracks, making it difficult for covered entities and business associates to not only recover from breaches, but to prevent them before they happen," she said.

The Resolution Agreement and Corrective Action Plan are available online at: http://bit.ly/2lTte2A. ■

COMING IN FUTURE MONTHS

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- Informed consent forms often missing
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HEALTHCARE RISK MANAGEMENT™

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CME/CE QUESTIONS

1. **Of all obstetrical injuries, what had the highest percentage of closed claims, representing 72.5% of all OB claims?**

   a. Fetal/infant birth-related brain injuries
   b. Delayed cesarean section
   c. Ureteral injuries
   d. Erb's palsy

2. **According to Bobbie Moon, JD, how can a cesarean result in a malpractice claim that does not hinge on the timing of the procedure?**

   a. The plaintiff may argue that the patient was not adequately informed about risks and options.
   b. The procedure was performed by unqualified personnel.
   c. The procedure was unnecessary.
   d. The plaintiff may claim the patient refused the procedure, but it was performed anyway.

3. **What do most healthcare providers do when asked for references on past employees?**

   a. Provide a full and detailed reference if it is favorable.
   b. Provide a full and detailed reference regardless of favorability.
   c. Provide no information whatsoever.
   d. Provide only minimal factual information.

4. **Why do the medical staff office and human resources usually have separate files on physicians?**

   a. Sharing of certain information by the medical staff office with human resource could waive the peer review privilege.
   b. Most state laws require the duplicate files.
   c. Duplicates are kept for security in case one file is lost or damaged.
   d. Duplicate files facilitate faster access to physician records.

CME/CE 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.

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

Failure to Diagnose Case Settles for $8 Million

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News: In 2012, a man was taken to a hospital via ambulance after his legs collapsed, causing him to fall. The treating physician diagnosed the patient with paresthesia and dysesthesia, and discharged him soon thereafter. Less than two weeks later, the patient visited a registered nurse practitioner, who also sent him home. A third medical facility diagnosed the patient with spinal myelopathy and transverse myelitis, which rendered the patient quadriplegic. He was treated with high doses of steroids and requires constant care.

The patient filed a lawsuit in mid-2013 for medical malpractice against the first two medical facilities and the medical professionals who treated him. The case proceeded to a jury trial against one hospital, but the parties came to a settlement while the jury deliberated. The total economic benefit to the plaintiff, including medical bill waivers and multiple settlements, was approximately $8 million.

A THIRD MEDICAL FACILITY DIAGNOSED THE PATIENT WITH SPINAL MYELOPATHY AND TRANSVERSE MYELITIS, WHICH RENDERED THE PATIENT QUADRIPLEGIC.

Background: On May 3, 2012, a man presented to a hospital after falling in his driveway when his legs collapsed. The patient's treating physician allegedly neglected to order the appropriate diagnostic testing, and diagnosed him with paresthesia and dysesthesia. The man was discharged from the hospital shortly thereafter.

On May 14, 2012, he was evaluated by a registered nurse practitioner at a different medical facility for neck pain and weakness in his arms and legs. The patient failed to disclose the fact that he had been seen previously by another physician. Again, the patient was discharged, but with instructions to return in three months. On May 31, 2012, the patient went to yet another facility (an ED), where he was too weak to stand or walk. The man was then diagnosed with spinal myelopathy and transverse myelitis. The patient was treated with high doses of steroids and was diagnosed with quadriplegia that requires him to be under care 24/7.

The patient notified the defendants in April 2013 that he intended to file suit against them. He then filed a medical malpractice suit on July 23, 2013, against the two medical facilities, the treating physician, the registered nurse, and 10 defendants to be determined ("Doe defendants").

In his first amended complaint for damages, the patient alleged, among other things, that the defendants failed to order tests and MRIs, failed to consult experts, and failed to diagnose his condition. The complaint further alleged that, if the condition was timely treated, he would not be damaged. Prior to the suit, the patient

was hospitalized continuously for 10 months and eventually moved to a different state to receive care from his family. The plaintiff presented a damages calculation range of $20 million to $40 million for the first hospital. It is unknown what the plaintiff asked from the other defendants.

Before the case reached trial, the medical professionals and the second hospital settled with the plaintiff. Thus, the case against only the first hospital proceeded to a jury trial. The plaintiff presented eight experts at trial and the defendant utilized 11. While the jury was deliberating on Jan. 31, 2017, the hospital agreed to pay $5.25 million to settle the action. The plaintiff's attorneys mentioned that the total economic benefit that included the other settlements and medical bill waivers was close to $8 million.

After the settlement, the hospital's counsel told media that the care rendered by its staff was appropriate and that the case settled well for them since the bottom line was far less than the plaintiff's damages calculation. The approximate allocation of liability was 65% for the hospital and 35% spread among the remaining defendants in an unknown internal proportion.

What this means to you: This case demonstrates that a hospital that settles is better positioned to save face in terms of culpability. In this case, the hospital's attorney told media that the settlement was favorable given the plaintiff's demand. Additionally, because the case settled, the hospital's counsel issued a statement that the hospital's staff conformed with the applicable standard of care. This permitted the hospital to re-establish confidence in the public eye and mitigate any loss of goodwill caused by the suit. Even if a hospital has a strong case against a plaintiff, it may be a wise strategic decision to settle in order to avoid the risks of trial and costs of dealing with the appeals process. While costs may be awarded to the prevailing party on appeal, courts may have the discretion to deny some or all costs in the interests of justice. Even if a hospital is awarded its costs upon a successful appeal, enforcing the court order for fees can be impracticable or impossible given the financial status of the individual.

TO HEDGE AGAINST THE RISK OF MEDICAL MALPRACTICE SUITS, HOSPITALS NEED TO ESTABLISH PROPER PROCEDURES TO ENSURE MEDICAL PROFESSIONALS ADMINISTER DIAGNOSTIC TESTING.

Another interesting procedural characteristic of this case is the use of Doe defendants. It has been held that failing to include Doe defendants where they are allowed may constitute malpractice. The plaintiff in this case sued 10 Doe defendants, but there is no limit to the number of Does one can sue.

To hedge against the risk of medical malpractice suits, hospitals need to establish proper procedures to ensure medical professionals administer diagnostic testing. Misdiagnosis occurs in approximately 1 in 20 patients in the United States. Clearly, in this case, the medical professionals failed to assess the patient's symptoms thoroughly. While it is not unusual for a person to fall, especially during activities at home, there is usually an event, such as tripping or slipping, that causes it. However, if the patient states that his legs suddenly collapsed under him, a neurological source must be considered. Allowing the patient to leave without further testing can be considered negligent.

In addition to diagnostic testing, medical professionals need to inquire into patients' medical histories. Each patient interaction ought to involve a review of his or her history. Most hospitals not only post information about a patient's rights, but also their responsibilities. An important one is to inform their health providers about their medical histories. Had the patient here informed the second hospital about his fall, the nurse practitioner likely would have discussed his symptoms with her supervising physician.

Finally, after a patient is discharged, patients should be encouraged to follow up with their physicians if symptoms persist or worsen. In this case, the plaintiff argued that the medical professionals failed to consult a neurologist, neurointensivist, and/or neuroradiologist, and missed the opportunity to treat his transverse myelitis. Accordingly, hospitals should encourage medical professionals to consult experts to avoid missing an opportunity to cure diseases that quickly progress into untreatable phases. ■

REFERENCE

Los Angeles County Superior Court, Case No. BC516100, Jan. 31, 2017.

$1.2 Million Awarded in Fatal Injection Case

News: A 62-year-old woman was diagnosed with carotid artery disease in late 2006. She later presented to a Chicago hospital for a scheduled procedure, which involved an injection into her neck to numb the area. Immediately following the injection, the patient experienced breathing problems and went into cardiac arrest. The arrest caused her to suffer brain damage and put her in a comatose state. She passed away the next day at the hospital.

One of the woman's three children filed suit on behalf of her mother's estate, alleging that the physician and hospital caused her mother's injuries and untimely death. The estate asked for $3 million for the grief and sorrow of the adult children. Both sides engaged in a battle of the experts. After the five-day trial, the jury delivered a $1.2 million verdict in favor of the estate.

Background: On Oct. 3, 2006, a 62-year-old woman presented to a hospital in Chicago for a scheduled carotid endarterectomy after being diagnosed with carotid artery disease. An independent contractor anesthesiologist administered a local anesthetic block injection into the woman's neck to numb the area where the scheduled procedure was to take place. Just after the woman received the injection, she experienced breathing difficulty and eventually suffered cardiac arrest. The arrest caused an irreversible brain injury that left her comatose. The patient was resuscitated several times, but eventually passed away at the hospital the following day.

On Oct. 3, 2008, the administratrix of patient's estate, one of her three surviving adult children, filed suit against both the anesthesiologist and the hospital for wrongful death cause by medical malpractice. The administratrix alleged that her mother's death was caused by the anesthetic injection, which was allegedly wrongfully injected into one of the blood vessels in her mother's neck. The estate's complaint also alleged that the hospital and physician failed to properly manage the woman's medications both prior to and during the procedure. The hospital was sued under a vicarious liability theory, but the suit against the hospital was dismissed when it was determined the physician was not acting as an agent of the medical facility.

Ten years after the patient's death, the case was finally certified to proceed to trial against the physician. At trial, the estate's counsel alleged that the physician improperly administered the injection and inserted it into the patient's blood vessel in her neck. The estate's counsel further contended that the anesthesiologist strayed from the requisite standard of care by neglecting to ascertain whether the needle entered a blood vessel.

In response, the defense argued the physician did not inject the anesthesia into the patient's blood vessel and that his actions comported with the applicable standard of care. The defense also disputed the causation element, claiming the plaintiff's injuries were caused by an unrelated, intervening factor. To rebut the defense's causation claim, the estate maintained that the cardiac arrest occurred less than two minutes after the administration of the anesthesia.

The defense, however, offered evidence to indicate there was a 10- to 12-minute delay between the time of completion of the procedure and when the patient began to exhibit negative symptoms. The defense counsel further contended that the cause of the patient's respiratory failure was pulmonary embolism secondary to chronic atherosclerotic disease. The defense's expert opined that the pulmonary embolism was caused by the patient's deep vein thrombosis rather than negligent needle placement. Finally, the defense's anesthesiologist expert testified that "if the reaction occurred within one to two minutes of the injection, she likely arrested as a result of the injection." The expert then testified, "if she exhibited signs of arrest more than two minutes later, the reaction could not have been caused by the injection."

The trial lasted five days, and the jury deliberated for five and a half hours. The 11-member jury delivered a unanimous verdict in favor of the estate, and awarded each of the children $400,000 to compensate for their grief and suffering from the loss of their mother. The physician was insured, but it is unclear whether the coverage allowed for injuries caused by a physician's negligence.

What this means to you: This case shows the defendant's use of the timeless litigation tactic of delay. Of course, plaintiffs will argue that justice delayed is justice denied, but it is a useful defense strategy nonetheless. There are many methods that a defendant can use to prolong the litigation process and avoid outstanding judgments, and the defendant in this case used quite a few. In fact, the online docket needed to be divided into two different

sections to account for all of the documents filed in the case.

The case that ultimately proceeded to trial was not a particularly complex case, as there was only one defendant and one plaintiff (the estate). The trial required only three experts to testify. Clearly, this case was relatively straightforward — as much as litigations can be — but the discovery window lasted for years and was reopened after it initially closed. Furthermore, the case was continued for a case management conference an astounding 55 times. This shows that the defense did all that it could to prolong the litigation. These kinds of tactics can eat away at plaintiffs and the lawyers who represent them, who often operate on a contingency. It is important not to overplay this strategy, as eventually the judge may grow wise to what is going on and assess fees or costs against the defense to the plaintiff to compensate the plaintiff for improper behavior or unprofessional conduct by the defense.

On the front end of risk management, procedures must be established to ensure that medical professionals check patient history very carefully to identify chronic illnesses that may interfere with proper care. The CDC reported that 86% of U.S. healthcare costs are spent on treatment related to chronic diseases. In this case, the defense argued that the patient's death was caused by a chronic illness that was recently diagnosed. Even if that argument is true, the anesthesiologist and any other involved medical professionals should have reviewed her medical history to consider how the illness would affect the scheduled procedure. Perhaps this litigation would have been avoided if they had.

This case also illustrates the constant need for all physicians to double check the placement of needles for injections. When injecting into any area of the body, the very simple procedure of pulling back on the syringe to see if blood flows into the barrel takes about one second. If blood appears, the needle is most likely in a blood vessel and should be withdrawn before injecting. The needle is then reinserted in another area and checked again. Additionally, when using drugs that are potentially lethal if misdirected into a blood vessel, the physician should check and state "no blood return" to others in the room, thus protecting both patient and physician from harm.

THE CASE WAS CONTINUED FOR A CASE MANAGEMENT CONFERENCE AN ASTOUNDING 55 TIMES.

Note also that, in the complaint, the estate cited as a cause of the injury the fact that the anesthetic was "introduced into a highly vascularized area." The plaintiff's counsel hammered the point that the defendant anesthesiologist strayed from the standard of care by not checking the placement of the needle. Therefore, procedures must be implemented by medical facilities and associations to address the risk associated with improperly placed injections.

It is also important to consider jury selection issues when trying a case like this one. Approximately 10% of the American population suffer from trypanophobia, the fear of injections, and about 20% suffer from some degree of fear associated with needles and sharp objects. Thus, jury members who have such fear need to be weeded out immediately to prevent the potentially tremendous bias against defendants. One of the procedures that happens shortly before each jury trial is voir dire, in which the judge, the lawyers, or some combination have the opportunity to question jurors to bring such biases to light. It is critically important to take advantage of this opportunity. The last thing a defendant in this kind of case wants is a foreperson in the jury room trying to steer the jury toward a runaway verdict because of his or her own biases or phobias.

Finally, this case raises an issue related to expert witness testimony in medical malpractice suits. The defense's expert in this case testified that "if the reaction occurred within one to two minutes of the injection, she likely arrested as a result of the injection." He then testified that "if she exhibited signs of arrest more than two minutes later, the reaction could not have been caused by the injection." Professional experts who value their neutrality and are in the profession for the long haul will give opinions that may benefit both sides, depending on the state of the evidence. The timing of events during procedures is critical. Every drug provided must be documented with the exact time given. The exact time of the patient's cardiac arrest also must be included in the medical record. Finally, it is crucial to ensure your expert has a firm handle on the facts of the case and that those facts are accurate, as they will shape his or her opinion and could swing the whole verdict. ■

REFERENCE

Cook County Circuit Court, Case No. 14-L-752, Dec. 14, 2016.