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November 2000 • Vol. 22, No. 11 • Pages 121-132

IN THIS ISSUE

In This Issue **continued on next page**

With ABC camera crews in house, Johns Hopkins limited its risk of liability

'Hopkins 24/7' shows unprecedented media access

The popularity of reality television is leading to more and more requests for media access to health care facilities, sometimes far beyond just a reporter hanging around the emergency room. The recent experience of Johns Hopkins Hospital in Baltimore raises serious questions for some risk managers, but it also may show how the situation can be managed by a risk manager and legal counsel working closely together.

Johns Hopkins was the recent subject of a six-hour, prime time, ABC News mini-series that garnered substantial publicity because of the way the hospital granted unprecedented access to the facility, its staff, and patients. It is not unheard of to have a camera crew in clinical care areas, but Johns Hopkins granted the ABC team virtually free reign to go wherever it wanted, 24 hours a day for three months in fall 1999. Because of the expansive nature of the videotaping, it was impossible for the hospital to have a public relations or risk management representative escorting the camera crews.

The ABC crew videotaped patients during emergency care, psychiatric patients during counseling, and staff during candid moments of reflection, anger, and self-doubt. The unusual access posed many potential threats to patient confidentiality, but the risk manager and legal counsel at Johns Hopkins tell *Healthcare Risk Management* they are satisfied with the way their precautions worked.

"Our primary concerns were privacy and confidentiality, above everything else," says **Meg Garrett**,

In This Issue **continued from page 121**

Correction
In an August story on determining brain death, *HRM* mistakenly used the term EKG when discussing how to determine brain death. The correct term should be EEG.

Coming in December and January:
Coverage of the American Society for Healthcare Risk Management conference

RN, MED, JD, senior counsel for the hospital. "We give very decent access to local television crews on a regular basis, but nothing like this. This was a very unusual project, and because of that, we had to come up with some procedures that we don't normally use." **(See story, p. 125, for more on those procedures.)**

Some risk managers see a problem

ABC wanted to obtain footage showing nearly every facet of patient care at the hospital, plus behind-the-scenes snippets of life among the Johns Hopkins staff. The ABC production team convinced leaders at Johns Hopkins that it had good intentions and could provide a realistic portrait of life at the respected hospital, but only if it had much more access than a media crew might normally expect.

The ABC team gained the support of a number of prominent physicians and other staff at the hospital, but Garrett worried about how such free access could threaten patient confidentiality, and she was concerned about the other risk management implications of allowing members of the media to run around the hospital unleashed.

Her concerns were shared by **Rick Kidwell**, JD, director of risk management. "From a risk management standpoint, you're not supposed to have any visitors running around the hospital on their own, much less media with cameras," he says.

Some risk managers say they were quite troubled by what they saw on "Hopkins 24/7," partly because of the message it could send to the health care community and the public at large. **Sandy Mahon**, vice president for risk management and quality assessment with Program Beta, the risk pool for hospital districts in California, based in Alamo, coordinates risk management activities for 77 hospitals. She says she would discourage any of her hospitals from allowing such widespread media access.

"I'd call it a form of sensationalism, and it puts health care in a media slot," Mahon says. "I think in the long run it will definitely erode good professional practices. This is not an appropriate way to do business."

Mahon notes that patients traditionally have assumed that the hospital is a private place of sorts where they can expect some degree of confidentiality at all times and complete confidentiality in some situations. But with more hospitals

agreeing to let media film in emergency situations and similar private moments, Mahon says there may be a trend toward seeing health care as entertainment.

"That, frankly, is a big worry of mine," she says. "It erodes some of the traditional barriers to patient privacy, the way those cop programs with cameras in people's homes erode the idea that you have any privacy at home. It's kind of a sad reflection of where we've gone for entertainment as a society."

Others could follow Johns Hopkins' lead

Mahon says she is concerned that other health care workers will get the idea that if a respected institution like Johns Hopkins allows cameras in private situations, then protecting patient confidentiality must not be so important. That attitude change isn't likely to happen overnight, she says, but it could happen over time.

"It gives the health care employee one more excuse to bend the rules, to lose that sensitivity to the laws that protect the patients and their rights within the hospital," she says. "People working at hospitals get a message from this kind of show, and it's not good."

Mahon's concerns are shared by **Janet Tokos**, RN, coordinator of risk management for Wellstar Health System's Physicians Group in Marietta, GA. She tells *Healthcare Risk Management* that she also would discourage granting widespread media access to private patient situations.

"There is a presumption by patients that the hospital is a private area where private things happen, and they may not like it if someone comes in the room with a camera, even if they ask permission before filming," she says. "You run the risk of alienating a certain part of your population. This sort of thing could have as many downsides as upsides."

Tokos and Mahon both expressed strong concerns about the validity of the consent granted by patients during the "Hopkins 24/7" taping. The Hopkins legal team, Garrett and Kidwell, developed a special consent form that the television crews could hand out to patients and have them sign before taping continued. **(See consent form, p. 124.)** A doctor or nurse would approach the patient along with the camera crew. With psychiatric patients, Hopkins required the attending physician to obtain the consent.

In emergencies and other situations in which the patient could not immediately provide consent, the camera crews were allowed to videotape and then seek consent afterward. "We made it clear that if they did not get consent, that videotape must never leave the premises here," Garrett says. "Amazingly, the patients were very willing. When I watched some of the things the patients allowed film crews in there for, I was surprised. The patients welcomed them with open arms."

ABC did not allow Hopkins to review the videotape or the finished product before it aired. But the producers agreed not to use any videotape of patients unless they had signed consent forms from the patient, guardians or, in some cases, the next of kin.

The hospital also tried to inform patients as early as possible that they might encounter the television crews. Placards were positioned at entrances and throughout the hospital reminding everyone that the cameras were present and that they could refuse to be taped. Garrett says she knows of only one patient who initially consented but then said she didn't want ABC to use the tape of her in a stressful situation. The tape was not used.

"If there was any doubt that the patient understood the consent form, the attending physician discussed it and decided whether the patient had a level of understanding," Kidwell says. "If there was any doubt, they didn't tape. They pretty much avoided the geriatric population because of it."

Was patients' consent valid? Some say no

Despite the precautions, Tokos and Mahon question whether patients could truly grant informed consent in some of the situations in "Hopkins 24/7" or in other television programs that follow patients from their first encounter with paramedics and into the ER. Even if they signed the forms, the patients may have felt they were expected to cooperate, or they may have just been too anxious, scared, and stressed to make a decision about waiving their privacy rights, the risk managers say.

"There's no question you could argue that the person was incompetent at the time to make that judgment," Tokos explains. "Is it ethical to approach someone who is in the middle of a situation like that for consent to something that really is superfluous? We have to worry enough about getting true consent for important things in those situations."

Mahon agrees, saying she doesn't think such consent is truly valid when patients are anxious

ABC NEWS AND JOHNS HOPKINS HOSPITAL

AUTHORIZATION FOR RELEASE OF INFORMATION AND DEVELOPMENT AND RELEASE OF MEDIA MATERIALS

NAME: _____
HISTORY #: _____
(IF PATIENT)

I understand that, with the cooperation of Johns Hopkins Hospital, ABC News (a division of the American Broadcasting Companies, Inc. ["ABC"]) is engaged in gathering videotaped footage for a documentary series on the day-to-day activities at the hospital. The nature of the project has been explained to me. On my behalf or on behalf of the individual named above for whom I am authorized to make healthcare decisions, I _____ [insert name] hereby authorize the use of the patient's/my name and the making of photographs/videotape/motion pictures/drawings/voice recordings and/or other media materials (hereinafter "media materials") by the staff, employees or agents of ABC news.

I further authorize The Johns Hopkins Hospital, The Johns Hopkins University and Johns Hopkins Office of Communications and Public Affairs to release information, if applicable, concerning the patient's/my hospitalization and/or treatment.

I authorize the use of such information including information provided by me or Johns Hopkins Hospital or any of its agents for use by ABC News for this documentary and/or in material promoting the program(s) for dissemination by broadcast, cable, videocassette, and/or any other media. I understand that the media materials are the property of ABC and I relinquish any rights that I may have to the media material. I understand that there will be no financial compensation for such appearance.

I hereby release from liability ABC, The Johns Hopkins Hospital, The Johns Hopkins University, their agents, servants and employees from and against any and all claims, costs, expenses and damages arising out of the making of the media materials and the release of them or any information concerning me contained therein.

PRINT NAME: _____
SIGNATURE: _____
DATE: _____
ADDRESS: _____
_____
PHONE NUMBER: _____

If not patient, relationship to patient: _____
_____

INTERNAL USE ONLY:

Team: _____
Location: _____
Tape # _____

and in unfamiliar situations. She says the problem is even worse when the camera crew is allowed to tape in emergent situations and then obtain consent later.

"If you come into the ER with your drowned 3-year-old and the cameras are rolling, I think that's unconscionable," she says. "It's almost like they're taking advantage of someone at their most frail moment."

Tapes could pose liability risk in litigation

Tokos raises another worry — the possibility that footage from such a project could be subpoenaed by a plaintiff's attorney. Such candid footage, especially emergency scenes, could prove powerful in front of a lay jury. Just as with videotapes of surgery or childbirth, the footage does not have to show any wrongdoing to be damaging to the hospital's case. "Just the fact that you have blood and gore means the attorney can use it as an inflammatory agent with the jury," she says. "It might be showing a normal amount of blood and completely routine treatment, but the attorney can say, 'Hey, look at all that blood!' and 'Look at the way they're flopping his leg around.'"

Additionally, she questions whether staff would alter their behavior because they knew cameras were around. If they were self-conscious or distracted by the camera, their performance could be impaired, and the hospital would be liable for allowing the media access. Even if the camera does not affect patient care, the plaintiff's attorney still could make that argument for the jury.

Tokos and Mahon say they would not automatically refuse a request for media access similar to "Hopkins 24/7," but they would discourage the idea and insist on strict limitations. Many hospitals would be interested in such publicity, Mahon says, "but I'd remind them that their business is the delivery of health care."

Garrett and Kidwell say Hopkins administrators decided to grant the unprecedented access because they were sure the program would be educational and provide new insight into the real world of health care. "It seems there are a lot of these programs out there already," Mahon says. "I'm sure they had good intentions to be educational, but I think what they were seeking to do is not the same as the message that was conveyed to the health care community. I just hope the rank and file health care workers don't see it and conclude that privacy is no big deal and they can stop worrying about it so much." ■

Risk manager, counsel reduce the media risk

While the "Hopkins 24/7" experience may be an extreme way to accommodate the media in a hospital, the Johns Hopkins risk management team suggests that the lessons it learned could be applied on a smaller scale by other institutions.

There is a growing interest in reality programming and documentaries about medical care, so many hospitals may find similar requests for media access to off-limits portions of the hospital. At Hopkins, the risk management implications were addressed by **Meg Garrett**, RN, MED, JD, the hospital's senior counsel, and **Rick Kidwell**, JD, director of risk management. They say that such access does not have to threaten patient confidentiality as long as certain steps are taken to control the situation.

Lengthy discussions with the producers convinced Garrett and Kidwell that the project could be done without abdicating their responsibility to patient and staff confidentiality. But before the camera crews showed up, they put in place a number of protective measures.

The first step was to make sure the actual camera crews were screened carefully before Hopkins allowed them access to the hospital. Each crew member had to undergo a criminal background check and tuberculosis testing; they also had to visit the hospital's occupational health department for a primer on bloodborne pathogens and other safety concerns. The hospital put the camera crews through training similar to that required of hospital volunteers.

In addition, crew members had to sign a confidentiality agreement stating they would not divulge any information they gained during their stint at Johns Hopkins other than the information that made it to the television screen. The Hopkins staff clearly and firmly explained to the camera crews that they had to stay out of the way during any medical treatment. Their presence could never interfere in the slightest way with treatment. If it did, any staff member was empowered to order them out of the room.

The camera crews used small, handheld video cameras similar to the type used for home movies, so they were considerably less intrusive than a camera crew with a standard news video camera. Initially, crews were given access to the entire hospital except for the psychiatric unit.

"But after the project began, psychiatry complained that they were at a disservice and not able to give their message about mental health," Garrett says. "I was reluctant, but I agreed to let the filming happen there, too. We agreed that they could film only in rooms, never in a hallway. They ended up using film from a group therapy session where all the individuals agreed to be filmed." That agreement led to a powerful segment in the broadcast that followed a young woman with anorexia nervosa.

Here are some of the other rules Hopkins used:

- Any staff member could refuse to participate and be videotaped. To alert the staff about the project, Hopkins sent a letter explaining all the details. **(Excerpts from the letter appear on p. 126.)**
- ABC had to obtain consent from any patient whose image would be used in the program. Hopkins kept a copy of each consent form.
- The production team had to meet with Garrett or Kidwell, and sometimes both, each morning at 11 to discuss how the project was going. At those meetings, they would discuss any concerns that had been raised by the Hopkins staff and hash out any difficulties.

M&M session posed special risks

One bone of contention was the hospital's morbidity and mortality (M&M) session. ABC wanted to tape the session to show how the doctors critiqued each other and analyzed cases. Many of the physicians, including the chief of surgery, supported the idea, but Garrett and Kidwell had serious misgivings.

"It was a real risk. We had a lot of discussion about that, knowing that it would waive the peer review privilege if the session was aired," says Kidwell. "We decided it was more important that the public knows how this takes place than to preserve the peer review."

Kidwell and Garrett agreed to allow the camera crews into the M&M session, but they urged the physicians to be careful about selecting the cases to discuss on camera. Because the physicians would be giving up a valuable defense for any information revealed at the session, the risk manager suggested they avoid any cases that might result in litigation.

"We made it clear that the physicians had a right to come or not come to that M&M, but we did not have anyone who refused to participate," Garrett says. "What ended up in the broadcast was very fragmented anyway, with just bits and

pieces of discussion edited together. It would be very difficult to attribute any of the discussion to a particular case. We haven't had any claims for the cases discussed in the M&M."

Even with all the precautions, Garrett and Kidwell say they were apprehensive about watching the program when it aired. They did not know ahead of time what vignettes would make the cut and how ABC would portray the Hopkins staff and patients. There were some moments that were very revealing, such as parents dealing with the loss of a child and the doctor who decided to quit because of the heavy workload, but Garrett and Kidwell say they were pleased with the outcome of the special project.

"The feedback has been very positive," Garrett says. "Some people were disappointed that the nurses didn't get much attention at all, and some said there was too much attention to female physicians in the ER. Mostly people were just upset that they didn't get on the program."

Everyone's curious

The risk managers still say they would be wary about allowing access to another television crew, and they caution that the "Hopkins 24/7" project worked only because they were so careful about overseeing the visitors. The Hopkins risk management department is getting a lot of queries about the broadcast, so it offers these suggestions to risk managers considering a similar project, even on a much smaller scale:

- **Work only with professional journalists who have a good reputation.** Garrett and Kidwell say they were impressed with the attitude shown by the ABC production team, in particular, their respect for the work done at Hopkins and their willingness to work discreetly. The fact that the production team had experience in health care reporting was a plus.
- **Establish ground rules before granting any access.** Set the boundaries and limitations. No hospital can allow media to have completely unfettered access, so make sure the producers know upfront exactly what is expected.
- **Communicate frequently and clearly.** Daily meetings are best for any project that goes beyond a single day in the hospital. Deal with any problems in real time, rather than letting them wait.
- **Work closely with legal counsel.** The risk manager and legal counsel should jointly make many of the decisions about what will and will not be allowed. ■

Johns Hopkins worked to assure confidentiality

These are excerpts from the letter sent to staff at Johns Hopkins Hospital on Aug. 10, 2000, by **Edward Miller**, MD, dean of the medical faculty and chief executive officer of Johns Hopkins Medicine, and Ronald Peterson, president of the hospital.

"In the next few weeks, people all over the United States will see advertisements for HOPKINS 24/7, a six-hour, prime time, ABC News mini-series focused exclusively on Johns Hopkins Medicine and filmed here, virtually around the clock, over a three-month period last Fall. Although we will not see the series until it airs, in accordance with ABC News practices, we have seen some of the promotional materials. The portrayal of Hopkins is by many accounts heroic, and we're extremely enthusiastic about the documentary. . . .

"Because of the exceptional access ABC News was given to our educational, research and clinical activities, we also want to tell you why we granted such unhindered access, what we hoped to achieve and how we managed some of the risk we knew this project might carry. First and foremost, you should know that even though we had no right of review of what ABC taped, we — and ABC — were exquisitely sensitive to issues related to patient privacy and confidentiality. As you watch the programs, keep in mind that we insisted upon and secured absolute protection of our patients' privacy at all times. We required ABC to obtain written consent from any patient appearing in the broadcast, or in the 10 additional hours of programming that will appear on the Discovery Health cable channel sometime next year.

"ABC News selected Hopkins, out of a field of five other academic medical centers, to become the centerpiece of efforts to explore the work and 'culture' of academic medicine in America because of our reputation for advancing knowledge and bringing it quickly to the bedside, our world-class clinicians and scientists, our commitment to our community, our stellar nursing and ancillary services, and the credibility that Hopkins Medicine can bring to medical statesmanship on a national and even international scale.

"As for the reasons we agreed to join with ABC

in this project, we believe that participation carries the potential to give Hopkins, and academic medicine, a colossal platform for advocacy. We have the qualities and the confidence to let the world see what we do, and to leverage what people see to explain better medicine's challenges and our solutions. It's almost certain that when we see the series on television, there will be things that — had we had any control — we would have wanted to be portrayed differently. But from what we've seen so far, and heard from the ABC producers, the documentary appears to show very dramatically and accurately our concern for issues critically important to us: urban health initiatives that improve the health of our community; lack of health insurance coverage for the working poor and indigent; continued and increased public and private funding for teaching and research; the rigors of training doctors who can meet the demands of the 21st Century, and the challenges of delivering on the public's demand for medical miracles in a financially constrained environment." ■

OIG issues voluntary compliance guidance

The Department of Health and Human Services' Office of Inspector General (OIG) has issued final guidance to help physicians in individual and small group practices design voluntary compliance programs.

"The intent of the guidance is to provide a road map to develop a voluntary compliance program that best fits the needs of that individual practice," Inspector General **June Gibbs Brown** said in releasing the guidance. "The guidance itself provides great flexibility as to how a physician practice could implement compliance efforts in a manner that fits with the practice's existing operations and resources."

Brown said the OIG hopes to encourage physician practices to adopt the active application of compliance principles rather than implement rigid, costly, formal procedures. The goal of the guidance is to show physician practices that compliance can become a part of the practice culture without the practice having to expend substantial monetary or time resources, she says.

"The OIG believes the great majority of physicians are honest and committed to providing high-quality medical care to Medicare beneficiaries," Brown said.

Under the law, physicians are not subject to civil, administrative, or criminal penalties for innocent errors or even negligence. The government's primary enforcement tool, the civil False Claims Act, covers only offenses that are committed with knowledge of the falsity of the claim or with reckless disregard or deliberate ignorance of the truth or falsity of a claim. The False Claims Act does not cover mistakes, errors, or negligence. The OIG is very mindful of the difference between innocent errors ("erroneous claims") and reckless or intentional conduct ("fraudulent claims"), Brown says.

The goal of the guidance is to show physician practices that compliance can become a part of the practice culture without the practice having to expend substantial monetary or time resources.

Unlike other guidance previously issued by the OIG, the final physician guidance does not suggest that physician practices implement all seven standard components of a full-scale compliance program. While the seven components provide a solid basis upon which a physician practice can create a compliance program, the OIG acknowledges that full implementation of all components may not be feasible for smaller physician practices. Instead, the guidance emphasizes a step-by-step approach for those practices to follow in developing and implementing a voluntary compliance program. As a first step, physician practices can begin by identifying risk areas that, based on a practice's specific history with billing problems and other compliance issues, might benefit from closer scrutiny and corrective/educational measures.

This is how the OIG describes the step-by-step approach: 1) conducting internal monitoring and auditing through the performance of periodic audits; 2) implementing compliance and practice standards through the development of written standards and procedures; 3) designating a compliance officer or contact(s) to monitor compliance efforts and enforce practice standards; 4) conducting appropriate training and education on practice standards and procedures; 5) responding appropriately to detected violations through the investigation of allegations and the

Compliance programs now the norm, survey shows

Compliance programs in the health care industry are now the norm, according to the *2000 Profile of Health Care Compliance Officers,* an annual survey conducted by the Health Care Compliance Association (HCCA) in Philadelphia and Walker Information, a consulting company.

The survey results show that health care organizations have made compliance programs part of their day-to-day operations — 98% of health care organizations surveyed report they have a corporate compliance officer (CCO), while 100% have conducted formal compliance training for employees. There's more good news for the compliance profession: The percentage of health care organizations with active compliance programs in place has increased from 55% in 1999 to 71% in 2000.

"We're very close to market saturation for compliance programs," says **Brent Saunders**, immediate past president of the HCCA. He worked with Jeff Marr of Walker to develop the survey.

Who got the survey?

The surveys were sent to 3,429 health care compliance professionals in June 2000, and 715 were completed and returned to Walker for tabulation. That represents a 21% response rate. HCCA has been tracking the compliance field's progress by conducting an annual survey since 1998.

Results show 57% of CCOs have their own departments with budgetary responsibilities and staff. As may be expected, larger organizations, those with more than $600 million in revenues, are more likely to report separate compliance departments: 78% have stand-alone departments. The average annual budget of compliance departments is $292,990, while the average budget for payers is $466,670, and the average compliance department budget for providers is $280,940.

The salaries of CCOs are broken out according to geographical regions, education, organization size, and payer/provider. This year, the average salary of a CCO is $89,500 for providers and $99,060 for payers. In organizations with 5,000 or more employees, the CCO's average salary is $125,090; the average for CCOs with doctorate degrees is $128,096. The average salary of CCOs in the West is $95,270, while the average salary in the Northeast is $89,410. The average age is 46.2; 56% are female, and 44% are male; close to 60% have advanced degrees; and 59% are part of the organization's senior management team. ■

disclosure of incidents to appropriate government entities; 6) developing open lines of communication, such as community bulletin boards and discussions at staff meetings, to keep practice employees updated on erroneous or fraudulent conduct issues as well as compliance activities; 7) enforcing disciplinary standards through well-publicized guidelines.

A glance at the final guidance

The final guidance identifies four specific compliance risk areas for physicians. They reflect areas in which the OIG has focused its investigations and audits related to physician practices: 1) proper coding and billing; 2) ensuring that services are reasonable and necessary; 3) proper documentation; 4) avoiding improper inducements, kickbacks, and self-referrals.

Recognizing the financial and staffing resource constraints faced by physician practices, the final guidance stresses flexibility in the manner a practice implements voluntary compliance measures. The OIG encourages physician practices to participate in the compliance programs of other providers, such as hospitals or other settings in which the physicians practice. A physician practice's participation in such compliance programs could be a way, at least partly, to augment the practice's own compliance efforts.

Needs of larger practices

The final guidance also provides direction to larger practices in developing compliance programs by recommending that they use both the physician guidance and previously issued guidance, such as the *Third-Party Medical Billing Company Compliance Program Guidance* or the *Clinical Laboratory Compliance Program Guidance,* to create a compliance program that meets the needs of the larger practice.

The final guidance includes several appendices outlining additional risk areas about which various physicians expressed interest, as well as information about criminal, civil, and administrative statutes related to the federal health care programs. The guidance also includes information about the OIG's provider self-disclosure protocol and Internet resources that may be useful to physician practices.

The final physician guidance is available on the Office of Inspector General's Web site at www.hhs.gov/oig. ■

Quorum settles fraud cases for $95.5 million

Company says enough is enough

Quorum Health Group in Brentwood, TN, announced recently that it has reached understandings with the Department of Justice to recommend agreements to settle two qui tam lawsuits.

One case involves Medicare cost reports and a second primarily involves allocation of costs at Flowers Hospital in Dothan, AL, to its home health services agency.

"The management and board of directors of Quorum continue to believe that at all times the company and its employees have operated in a proper and ethical manner," **James Dalton Jr.**, president and CEO of Quorum, said in announcing the settlement. "Nevertheless, we considered the amount of money and time the company has already expended in these matters and the additional resources needed to take the cases to conclusions in court and decided these agreements make business sense."

"The management and board of directors of Quorum continue to believe that at all times the company and its employees have operated in a proper and ethical manner."

The agreements are subject to the negotiation of terms of settlement agreements and corporate integrity agreements. The tentative agreements call for the company to compensate the government approximately $95.5 million, with interest accruing at 7.25% until resolution of final agreements.

The Medicare cost report settlement amount is approximately $77.5 million. The parties have agreed the settlement documents in the cost report case will be completed within four months. Quorum reports that the home health services settlement of approximately $18 million probably will be paid by the end of this calendar year.

An investigation at Flowers Hospital by the company uncovered alleged improper activities on the part of an employee, who was then fired. The company claims that it reported its findings immediately to the proper authorities. The qui tam suit involving home health issues was later filed by the former employee.

The company claims that it cooperated fully with the government in its investigation of the case.

Quorum Health Group Inc. owns and operates acute care hospitals nationwide through its affiliates. Quorum Health Resources LLC, a subsidiary, the nation's largest manager of not-for-profit hospitals, provides consulting services to hospitals. ■

JCAHO announces winners of the Codman Award

In recognition of excellence

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) announces this year's organization and individual winners of the fourth annual Ernest A. Codman Award to recognize excellence in the use of outcomes measurement to achieve health care quality improvement.

The recipients of the organization awards in the following categories are:

- **Behavioral health:** Lake Grove at Maple Valley, Wendell, MA.
- **Home care:** HomeReach, Worthington, OH.
- **Hospital:** Mission Hospital Regional Medical Center, Mission Viejo, CA.
- **Long-term care:** Kings Harbor Multicare Center, Bronx, NY.
- **Individual:** John W. Williamson, MD, is the individual award winner, in honor of his leadership role in promoting the use of performance measures to improve health care services.

Named for the physician regarded in health care as the "father of outcomes measurement," the Ernest A. Codman Award was created to showcase the effective use of performance measurement, thereby enhancing knowledge and encouraging the use of performance measurement to improve the quality of health care.

The award is available to the eight types of health care organizations accredited by the Joint Commission, in addition to individuals. A panel of national experts in quality measurement and improvement selects recipients of the award.

Dennis O'Leary, MD, president of the Joint

Commission, recently announced the award winners. Here are the specific achievements of the 2000 Codman Award winners:

❑ Lake Grove at Maple Valley reduced the use of physical restraint at the facility by nearly 70%.

This provider of comprehensive treatment services for sexually abusive youths sought to reduce the use of restraints. In addition to reducing restraint use, Lake Grove reported higher client satisfaction with quality of services, which was linked to a nearly 90% injury-free restraint use and all sustained client injuries requiring only minimal on-site first aid from facility nursing staff; a 55.2% decrease in on-the-job injuries; stabilization of occupational stress levels; a 44.3% increase in average length of employment; and an increase in client referrals.

The identification of restraint reduction as a performance improvement initiative in 1997 was based upon the recognition that restraint utilization is a high-risk activity that has the potential to harm the physical and emotional well-being of clients. Administrators determined that restraint use should be monitored, evaluated, and continuously improved to ensure the most safe, effective, and therapeutic techniques are used with clients during a behavioral crisis.

A thorough analysis of the processes leading up to the use of restraints yielded a realization that restraint frequency was symptomatic of several causal factors, including client behavior, staff competency, treatment planning, treatment and supervision methods, and the environment of care. When those factors were targeted for improvement, a statistically significant reduction in restraint frequency occurred.

❑ HomeReach, the home care division of OhioHealth, identified new ways to reduce accounts receivable days.

Reduction of accounts receivable days is important to the organization's clinical and financial performance because it enables HomeReach to improve its revenue realization and cash position, enhance opportunities for philanthropic programs, and retain market share.

The initiative resulted in a decrease in accounts receivable days from 116 days in July 1998 to 70 in December 1999. While timeliness improved, a billing audit showed billing accuracy remained greater than 99%. The average time of receipt of signed physician orders also decreased from 33.7 days to 22.4 days, and a recent physician survey showed 91% of the respondents agreed that they received patient information in a timely manner.

❑ Mission Hospital Regional Medical Center dramatically improved the clinical outcomes of patients sustaining severe traumatic brain injury.

Within three years of the project's beginning, 70% of the severe traumatic brain injury population experienced a good outcome to moderate disability; 15% sustained severe disability to persistent vegetative state, and 15% died.

That is a dramatic improvement compared with the previous three-year period, when 43% of the patients died and 30% suffered severe disability. Mission Hospital is one of 15 Catholic hospitals in the St. Joseph Health System in Orange, CA, sponsored by the Sisters of St. Joseph of Orange.

❑ Kings Harbor Multicare Center significantly increased visits to residents by families and friends.

The Transportation Links to Quality Care initiative also strengthened a program of resident trips, individualized excursions, and outpatient transportation. As a result, the facility saw a 50% increase in visits by family and significant others. Kings Harbor, a member of the New York Health Providers and Subacute Network, also reported a 10% to 30% increase in customer satisfaction for residents, families, and the community, as well as an increase from 291 admissions in 1997 to a projected 700 admissions in 2000.

❑ John W. Williamson, MD, is a pioneer in the field of health care outcomes research and has put that knowledge to effective use.

During the past 40 years, he has worked tirelessly to integrate continuing medical education, health services research, and medical informatics into the foundation of future outcomes assessment and improvement.

He served as a professor at the University of Utah School of Medicine and the Johns Hopkins School of Hygiene and Public Health, in addition to serving as a visiting professor of medicine at the Harvard School of Public Health. He also served as director of the Salt Lake Regional Medical Educational Center of the Department of Veterans Affairs and is the author of 114 publications in the field of care quality improvement. ■

Congress asked to open database to the public

In recent testimony before the House Commerce Committee, a widower said his wife would not have chosen the same doctor to perform a face lift, liposuction, and other procedures if she had known he had been sued for malpractice four times previously. His wife died during cosmetic surgery in 1997. The man was one of several people urging Congress to open to the public the government database that tracks disciplinary actions and malpractice payments by physicians and other health care providers.

"I firmly believe if I had been provided access to the National Practitioner Data Bank, it would have saved the life of my beloved Judy," he said. The California Medical Board ultimately ruled that the woman's doctor had been "grossly negligent and incompetent" in the death of Judy Fernandez and revoked his license.

What's in the data bank?

Two other people told the committee they had been victimized by doctors because they had no way of discovering adverse information in those doctors' backgrounds. That information is available in the National Practitioner Data Bank, created by a 1986 federal law requiring insurance companies, hospitals, and state and federal regulators to report malpractice payments and disciplinary actions against all health care providers. That information is not available to the public. The law prohibits public disclosure of identities of the providers, limiting access to insurance companies, hospitals, and federal and state health regulators.

Rep. **Tom Bliley** (R-VA), chairman of the House Commerce Committee, introduced legislation in September to open the database to the public and expand its reach to include all felony and some misdemeanor convictions of physicians. Bliley says doctors routinely require consumers to give patient histories before treatment, so patients should have the right to obtain physician histories before consenting to life-threatening procedures.

Democrats have accused Bliley of sponsoring the bill and using the hearing to punish the American Medical Association, the main doctors' lobby, for supporting patients' rights legislation that would permit lawsuits against managed care companies and health maintenance organizations. ■

Healthcare Risk Management® (ISSN 0199-6312), including **HRM Legal Review & Commentary**™, is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Healthcare Risk Management**®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). Hours of operation: 8:30 a.m. -6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $499. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $399 per year; 10 to 20 additional copies, $299 per year; for more than 20, call (800) 688-2421. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $83 each. (GST registration number R128870672.)

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Requirements revised for restraints and seclusion

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has adopted revised requirements for restraint and seclusion in hospitals that rely on JCAHO accreditation for Medicare deemed status purposes.

The revisions state that hospitals wishing to use accreditation to qualify for Medicare certification must comply with the Health Care Financing Administration's (HCFA) "one-hour rule." That rule requires that a physician or other licensed independent practitioner conduct a face-to-face evaluation of an individual placed in restraint or seclusion for behavioral health reasons within one hour of the initiation of the intervention.

United States Postal Service

Statement of Ownership, Management, and Circulation

1. Publication Title	2. Publication No.	3. Filing Date
Healthcare Risk Management	0 1 9 9 - 6 3 1 2	10/19/00
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$499.00

7. Complete Mailing Address of Known Office of Publication *(Not Printer) (Street, city, county, state, and ZIP+4)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta,
Fulton County, GA 30305

Contact Person: Willie Redmond
Telephone: 404/262-5448

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not Printer)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do Not Leave Blank)*

Publisher *(Name and Complete Mailing Address)*
Brenda Mooney, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and Complete Mailing Address)*
Lee Landenberger, same as above

Managing Editor *(Name and Complete Mailing Address)*
Coles McKagen, same as above

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
American Health Consultants	3525 Piedmont Road, Bldg. 6, Ste 400 Atlanta, GA 30305

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☐ None

Full Name	Complete Mailing Address
Medical Economics Data, Inc.	Five Paragon Drive Montvale, NJ 07645

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates.) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☐ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526**, September 1998 *See instructions on Reverse)*

13. Publication Name: Healthcare Risk Management
14. Issue Date for Circulation Data Below: November 2000

15. Extent and Nature of Circulation			Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies *(Net Press Run)*			1946	1718
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	1586	1518
	(2)	Paid In-County Subscriptions *(Include advertiser's proof and exchange copies)*	0	0
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	9	9
	(4)	Other Classes Mailed Through the USPS	0	0
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*			1595	1527
d. Free Distribution by Mail *(Samples, Complimentary and Other Free)*	(1)	Outside-County as Stated on Form 3541	0	0
	(2)	In-County as Stated on Form 3541	0	0
	(3)	Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail *(Carriers or Other Means)*			17	17
f. Total Free Distribution *(Sum of 15d and 15e)*			17	17
g. Total Distribution *(Sum of 15c and 15f)*			1612	1544
h. Copies Not Distributed			334	174
i. Total *(Sum of 15g, and h.*			1946	1718
Percent Paid and/or Requested Circulation *(15c divided by 15g times 100)*			99	99

16. Publication of Statement ofOwnership
Publication required. Will be printed in the November issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: Publisher
Date: 10/19/00

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PS Form **3526**, September 1999 *(Reverse)*

The new JCAHO requirement is effective immediately. The HCFA requirements relating to use of restraint and seclusion were issued in an interim final rule that became effective in August 1999. HCFA issued interpretative guidelines for these requirements in June 2000. In May 2000, JCAHO released new standards for the use of restraint and seclusion.

Those standards restrict the uses of restraint and seclusion for behavioral health reasons to emergency situations in which there is an imminent risk that individuals may physically harm themselves or others. Even then, restraint is to be used as a last resort.

The standards become effective Jan. 1, 2001, and contain requirements for the ongoing assessment and re-evaluation of patients in restraints that are more rigorous than those set forth in HCFA's regulations. They emphasize educating staff on how to avoid the need for restraint and how to use restraint properly when it cannot be avoided. ■

Healthcare Risk Management's
Legal Review & Commentary™
A Monthly Supplement

Patient develops AIDS phobia: $25,000 settlement

By **Mark K. Delegal**, Esq., and **Jan Gorrie**, Esq.
Pennington, Moore, Wilkinson, Bell, and Dunbar, PA
Tallahassee, FL

News: While hospitalized, a woman stepped out of her bed and onto a glass capillary tube, breaking it. She brought suit against the hospital and its cleaning service contractor, alleging she had developed AIDS phobia. The hospital settled for $25,000. The court determined the suit against the cleaning company was insufficient to proceed.

Background: The patient said she stepped out of her bed onto a glass capillary tube and broke it. By being exposed to the blood the tube may have contained, the plaintiff asserted that she developed a severe phobia of contracting AIDS. Even though the hospital maintained that there was no evidence of blood on the tube, the hospital settled for $25,000.

With the hospital's settlement in hand, the plaintiff's case against the hospital's contracted cleaning service proceeded to trial. The matter was dismissed after the court determined there was no evidence to support a reasonable belief that the plaintiff was exposed to blood. The court noted there was no evidence that cleaning service employees had access to the capillary tubes or that they knew of the tube being on the floor near the plaintiff's bed.

What this means to you: On the surface, this seems a simple case about the necessity of educating and training staff on the proper handling and disposal of all medical waste. But the fact that this case got so far into the legal system gives rise to corollary issues such as the nature of contracted services and, more importantly, the role that patients' sensitivities play in the risk management arena.

"Obviously, there is the need to train and educate staff on the proper means of handling and disposing [of] medical waste, and this training and education must take place on an ongoing basis," says **Ellen L. Barton**, JD, CPCU, a risk management consultant in Phoenix, MD.

"It is not enough to think that once staff are instructed on policies and procedures, they will adhere to them. Given staff turnover and coverage by agency personnel, even the most routine functions such as the disposal of materials containing blood and blood products must be given again and again," she stresses.

Ensure contractors are educated, too

"The need for education and training also extends to subcontracted entities. If you are not providing them with the education and training needed to perform the job, then you must see to it that they are contractually bound to provide it themselves," Barton says.

"In this instance, had the capillary tube contained blood, and had they been called to site for clean-up, the contract cleaners would have been responsible for handing the medical waste. There is often the misperception that once a

responsibility has been contracted out, the liability is also transferred. This case demonstrates that this is not necessarily what happens.

"As seen in this case, even though the cleaning service was responsible for cleaning the floor, the court deemed that the cleaning people did not have access to capillary tubes nor had they been given notice by the nursing staff that something was on the floor that required their immediate attention," she says. "Thus, the court found no liability against the contractor. Meanwhile, the hospital settled prior to trial. Bottom line: Contracting out duties and responsibilities does not automatically translate to a transfer of liability."

Most important is the issue of patient sensitivity. There is a legal axiom that one takes the plaintiffs (or patients, in this context) as one finds them. Prior to admission or treatment, there is no way to determine all the nonclinical predispositions a patient may have. There will always be the instances of nuisance cases — someone out to make a quick buck through a frivolous claim. While that might have been an issue in this particular case, it cannot be assumed that everyone in the general public understands the risk (or the lack thereof) of AIDS as well as health care workers.

"Quite understandably, once staff were made aware of what happened to this patient, they probably dismissed it as 'no big deal.' With sufficient training and education on patients' sensitivities, one might have handled this situation differently and avoided the claim and settlement altogether," Barton says.

"This was not a case of injury to the body, but probably more of an insult to the patient's intelligence. Had the first or even subsequent health care workers on the scene fully explained the situation and perhaps solicited the patient's thoughts and suggestions as to how to avoid the incident in the future and brought in social workers and / or infectious disease experts to educate the patient on the risk of AIDS from the exposure, it might have been possible to avoid the exposure to the claim and settlement," she says.

"One should never underestimate the ability to mitigate claims by working directly and honestly with the patient, particularly in the instances where no real bodily harm is done."

Reference

Denise Heller v. Beth Israel Hospital and Marriot, New York County (NY) Supreme Court. ■

Malfunction leads to a death: $1.5 million verdict

News: Following a patient's successful surgery, his morphine pump overmedicated him, causing cardiac arrest. The Code Blue cart at the scene was missing two critical pieces of equipment, which resulted in a delay in care and, ultimately, brain damage and death. A Missouri jury returned a $1.5 million verdict against the hospital.

Background: A 34 year-old police officer came to the hospital for elective lower back surgery to repair a ruptured disc. The surgery was a success. After surgery, the patient was placed on a self-dosing morphine pump. The pump was designed to allow the patient to self-administer morphine up to a specified limit as needed for pain and discomfort. The pump was programmed to deliver a maximum amount and no more, regardless of how many times the patient pushed the button.

Over the next 15 hours, he received 81 mg of morphine. While this is a healthy dose of morphine, it was not necessarily excessive. Over the same period, his oxygen saturation was not monitored and, allegedly, he had snored on and off throughout the night, which for him was unusual.

The morning after surgery, the patient was found in respiratory arrest. A Code Blue was called. The code team responded with the crash cart, but two pieces of critical equipment were missing from the cart — the Ambu bag and a backboard. The medical records indicated there was a six-minute delay from the time the code team realized the Ambu bag was missing and the time the patient was properly ventilated. A replacement backboard was retrieved in a similar time frame as the Ambu bag. The patient suffered severe brain damage and was pronounced dead that afternoon.

The plaintiff maintained that the patient was not appropriately monitored after surgery for signs of respiratory arrest and that his abnormal snoring should not have been dismissed. The plaintiff also claimed the hospital failed to ensure that proper equipment was on the crash cart.

The hospital countered that, despite the medical record notation, the response time to obtain the replacement equipment was only two to three minutes. A jury found the hospital at fault and awarded $1.5 million to be divided among the decedent's wife, three sons, and parents. The verdict has been appealed by the hospital.

What this means to you: Under the described chain of failures, it is interesting that this case was not settled prior to trial, particularly given the age and underlying condition of the patient as well as his vocation.

"An unexpected outcome of this magnitude on a young patient who entered the hospital for an elective procedure is devastating to the staff, particularly if there were policies and procedures that were not followed," notes **Lynda Nemeth**, RN, MS, JD, administrative director of quality and risk management for Norwalk (CT) Hospital.

"Generally, when a patient is on an automated pump that delivers analgesia, several safety factors are in place," she explains. "The pumps have delivery parameters and should have fail-safe mechanisms to prevent a bolus of medication to the patient. While it appears the 81 mg of morphine was not considered an overdose, was within the prescribed amount, and was not the result of machinery malfunction, there should have been clear guidelines for the monitoring of a patient on a patient-controlled analgesia pump.

"Minimally, vital signs should have been taken once a shift on a post-op patient. Whether this would include pulse-oximetry readings or blood gases would be a judgment call of the attending physician and bedside nursing staff as to necessity.

"As for the patient's snoring, even though there was no history of such, it would not be considered unusual for a patient to snore while asleep and doubtful if nursing staff would routinely check a patient's history as to snoring. It is not a standard question asked during the nursing assessment," Nemeth says.

Prior to code teams and code-card setups that included Ambu bags and backboards, patients found in cardiac arrest were resuscitated by putting them on a hard surface (the floor) and giving mouth-to-mouth resuscitation. Staff trained in basic life support, which is a requirement from the Joint Commission on Accreditation of Healthcare Organizations, are instructed in resuscitation.

"A code team, properly trained, should take immediate resuscitative actions and should not wait for missing equipment when other options are available," she says. "Further, in a code team response there should be a designated recorder whose responsibility would be to ensure accurate documentation of the time that code was called, response time of the code team, start time of the resuscitative efforts, medications and treatments given, and the time when efforts were discontinued because of a successful resuscitation or death.

"There should also be a check of the equipment and operational status of each code cart, minimally once every 24 hours and in high-risk / high-use areas, once a shift. Unfortunately, in this instance, once there was apparent failure in one system, it was followed by failure in another," she concludes.

Reference

Lisa Philpott vs. St. Luke's Hospital of Kansas and Reliable Health Care Inc., Jackson County (MO) Circuit Court, Case No. 98-CV-18845. ■

Failure to diagnose: $365,000 verdict

News: A man was hospitalized with severe cramps. Surgery was performed, but the patient died. The patient's family brought suit against the hospital and treating physicians. Prior to trial, the attending physician was dropped as a defendant, and the hospital settled for $140,000. This amount was subtracted from the eventual $365,000 verdict against the treating gastroenterologist.

Background: On Aug. 6, 1990, the 22-year-old was admitted to a family practice teaching hospital (one with family practice residents) suffering from severe abdominal cramps and bloody diarrhea. He had been that way for two days, and there was some indication he had suffered hemolytic complications from using prophylactics to guard against sexually transmitted diseases.

The attending physician was a family practitioner who consulted with specialists in gastroenterology, surgery, nephrology, infectious disease, hematology, and neurology regarding possible diagnoses. In addition, a senior resident, who was working with the attending family practitioner, examined the patient and noted that he might be suffering from antibiotic pseudo-membranous colitis and that a sigmoidoscopy would have been one of the diagnostic tools to rule this out. The family practice resident was an employee of the hospital.

The gastroenterologist, who had been consulted, decided a sigmoidoscopy was not necessary. Shortly afterward, the patient's cramping increased in severity. Surgery was performed Aug. 11, and his necrotic colon was removed. The patient died one day later.

The patient's estate brought suit against the hospital as the senior resident's employer; the attending family practitioner; and the gastroenterologist to whom the family practitioner had referred the patient. The plaintiff contended that had the sigmoidoscopy been performed, antibiotic-associated pseudo-membranous colitis would have been diagnosed and treated. Specifically, the plaintiff claimed the gastroenterologist deviated from the standard of care in recommending against the diagnostic test.

Expert witnesses disagree

Prior to trial, the family practice teaching hospital, which was part of a self-insured consortium of facilities, settled for $140,000. The plaintiff dropped the family practitioner as a defendant. Only the gastroenterologist stood trial.

At trial, the defendant claimed the sigmoidoscopy was not necessary, and the cause of death was hemolytic-uremic syndrome caused by *E. coli* 0157:H7 bacteria, which is incurable. Both plaintiff and defendant employed experts, who disagreed about the cause of death. However, given that the patient tested negatively for both antibiotic-associated pseudo-membranous colitis and hemolytic-uremic syndrome, the cause of death was the jury's call. The jury awarded the patient's family $365,000 against the gastroenterologist. It was offset by the hospital's settlement of $140,000.

What this means to you: At first blush, one may wonder what caused the hospital to settle and, conversely, what motivated the gastroenterologist's medical malpractice carrier to proceed to a costly trial.

"When determining whether or not to settle or try a case, at a minimum, several basic questions must be considered," states **Cliff Rapp**, director of risk management, south region, for ProNational in Coral Gables, FL. "First, what are the medical facts of the case? Second, was medical malpractice committed and, if so, to what degree and by whom? And, lastly, how costly will bringing the case to trial be as opposed to the jury verdict potential?

"While this is a vast oversimplification of the process — for each of the questions is actually significantly more multitiered and multifaceted — it frames the issues that each of the defendants in this case had to address before making the decision to settle or fight," he says. "Further underlying those decisions was the background knowledge that the base evidence in this particular instance did not lead to a clearcut answer — there was a death without the evidence to completely blame or exonerate.

"Because the autopsy results do not point to a clear good guy or bad guy with regard to whether or not malpractice has been committed, this question must be viewed in light of the other prevailing factors. As for the patient in this case, the demise of a young otherwise healthy person is never a plus for defending health care providers.

Both the range of the jury verdict and the potential for a verdict vs. the cost of a settlement must be carefully assessed by each individual defendant. This was probably the determinate factor in the differing decisions made by the hospital and the malpractice carrier," Rapp says.

The hospital's decision to settle may have been triggered by several economic issues, Rapp says. Apparently, the hospital was part of a newly created self-insurance pool and so might not have wanted to be the first with a potentially large verdict against it and cause the new entity to incur the upfront expenses of launching the requisite defense, he says. In addition, the hospital might have factored into the equation that it would be arguing against the diagnosis made by one of its employees, he adds. Even though that employee was not a specifically trained expert, the hospital would be hiring experts to contradict its own personnel.

"And, perhaps they thought that it would be perceived that somehow they were in disagreement with one of the members of their medical staff, who may, along with his practice, bring in a great deal of business to the hospital," he says.

On the other hand, according to Rapp, the physician's medical malpractice carrier may have been more motivated to take the claim to trial because there was no conclusive evidence implicating its insured as having committed malpractice. Without conclusive evidence against the physician, the insurer was obligated to defend him, he says.

"For a case resulting in the death of such a young person, the verdict was low, and so in retrospect, each defendant probably made the best choice," he concludes.

Reference

Jeffery Svoboda, minor vs. Dr. Philip Sweeney, M.D., Gastroenterology Services Ltd., Hinsdale Hospital, Du Page County (IL) Circuit Court, Case No. 94L-560. ■

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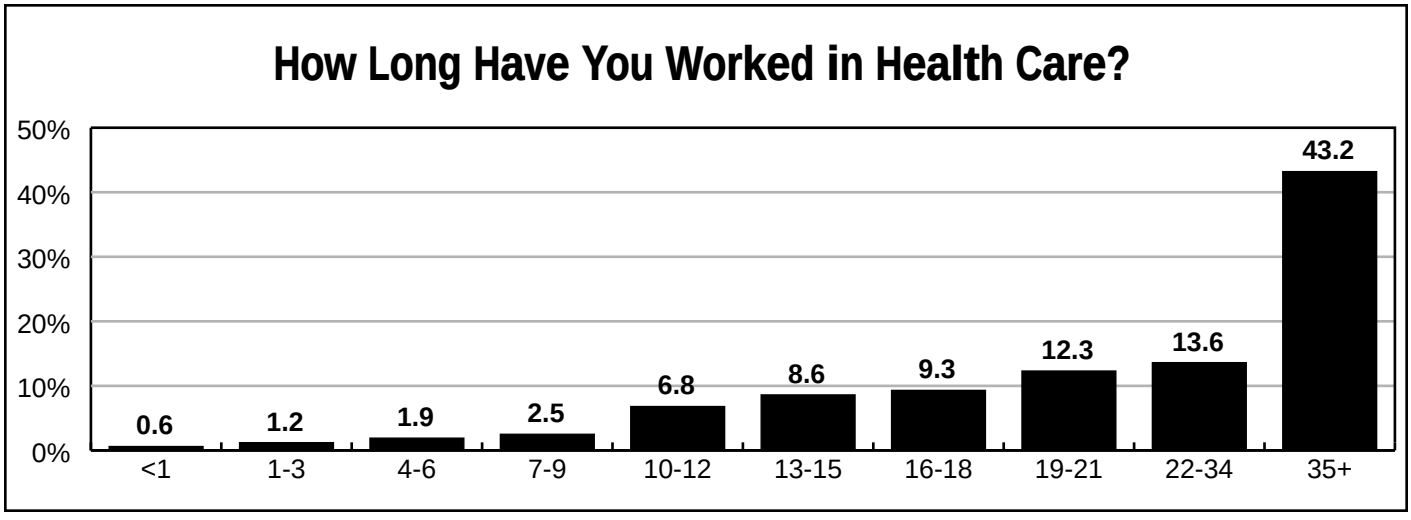
Opportunities improve for risk managers with right skills

The recent emphasis on error reduction in health care is creating new career opportunities for risk managers, with the overall outlook in the field considered promising. Income is holding steady for most risk managers, but it could increase in the near future as skilled risk managers become more valuable to employers, according to the exclusive 2000 *Healthcare Risk Management* salary survey.

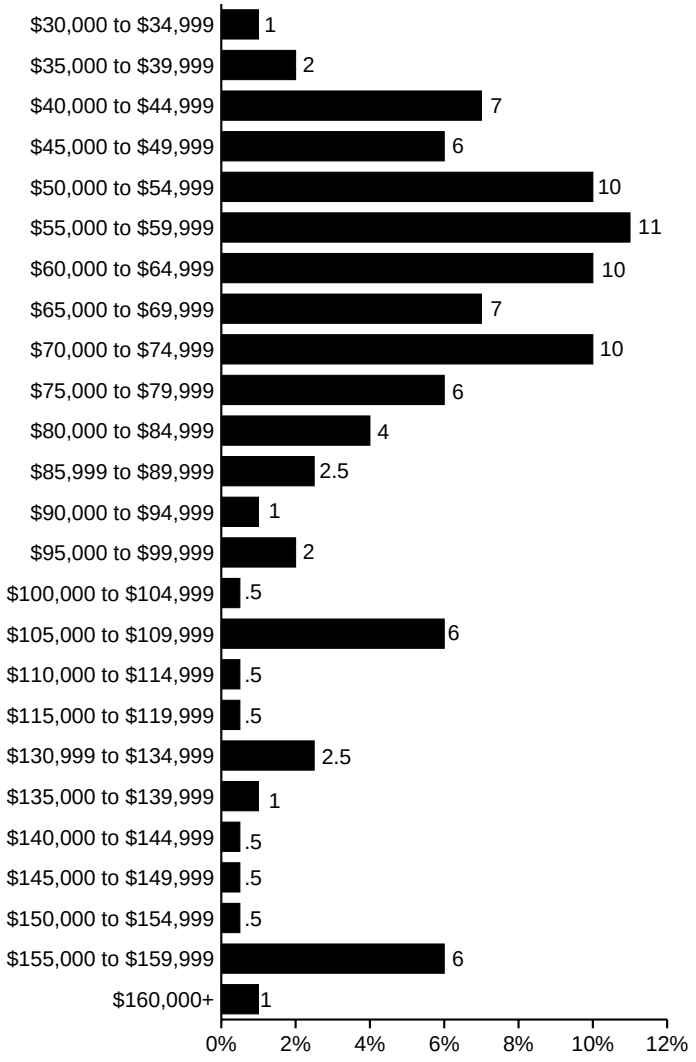
Income is holding steady for the third year in a row; 1998 and 1999 had shown just a slight upward trend. This year, directors of risk management report a median income of $62,500, the same as last year and the year before. The median income for directors of risk management was $57,500 in 1997 and $52,000 in 1996.

In 1998, observers suggested the fast rise in income was the result of dramatic changes in risk managers' job descriptions. The three years of the same results suggest that the market has adapted to the change in risk managers' roles and further increases are not expected in response to that factor.

As in recent years, the largest block of 2000 survey respondents report an increase of 1% to 3% in income from the past year. Three percent reported a drop in income; 15% reported no change; 42% reported a 1% to 3% increase; 28% reported a 4% to 6% increase; 9% reported a 7% to 10% increase; 1% reported an 11% to 15% increase; and 2% reported a 21% or more increase.



Annual Income



Missing categories indicate 0 responses.

About half report no change in staff size, with the rest split evenly between decreasing and increasing staff size. That is the same result seen last year. In the 1998 survey, 55% said there had been no change in their staff size, compared with 68% in 1997. In last year's survey, 23% reported an increase in staff size, compared with only 2% the year before.

This year's survey results continue to show a decline in the working hours for risk managers. Respondents report working a median of 41 to 45 hours per week, down from the 46 to 50 hours that were reported in 1998 and 1999. In the 1997 survey, 75% reported they worked 61 to 65 hours per week, way up from the 46 to 50 hours per week reported in 1996. Like the change in income, the decrease in overtime was attributed to the changes in job descriptions that had risk managers taking on new duties that might have been assigned to several other people in the past. The falling work hours suggest that the health care industry has accommodated the increased workload by taking on more staff or reducing the portion carried by the risk manager.

New opportunities on the horizon

The survey results may show a leveling of income and workload after recent years of increases, but the field is now ripe with career possibilities, says **Fay Rozovsky**, JD, MPH, DFASHRM, a risk management consultant in Richmond, VA. Rozovsky is president of the American Society for Healthcare Risk Management (ASHRM) in Chicago.

"Overall, this is a tremendous time of opportunity," she says. "We don't have enough qualified risk managers in the country, and all the focus on reducing medical errors will just increase the need for people with the right skills."

Rozovsky cites the recent report from the Institute of Medicine as the catalyst for a major new focus on medical errors. Health care employers are jumping on the bandwagon and promising to reduce medical errors, and Rozovsky says they are going to turn to risk managers to get the job done.

"We're still hearing about cutbacks in the field, but I think we're coming to the end of that," she says. "We have to start thinking about what it takes to get us on track to patient safety and error reduction, and the person with the skill sets for that is the risk manager. We've been doing it for 20 years."

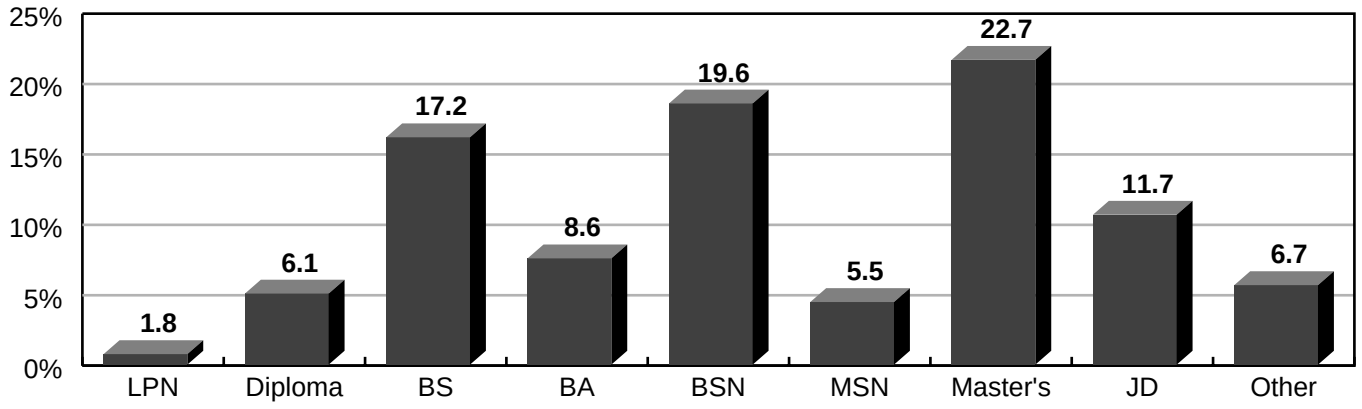
Bolster your organization

Similar thoughts come from **Leilani Kicklighter**, RN, ARM, MBA, DASHRM, assistant administrator for safety and risk management with the North Broward (FL) Hospital District and a past president of ASHRM. She says risk managers should look for opportunities to bolster their own efforts at reducing medical errors.

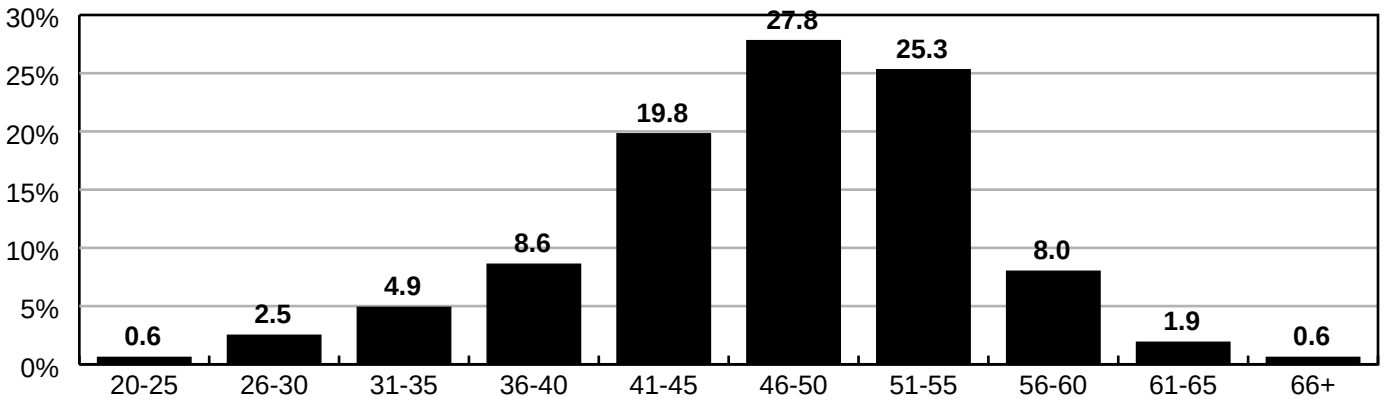
The Institute of Medicine report backs up everything risk managers have been saying all

(Continued on page 4)

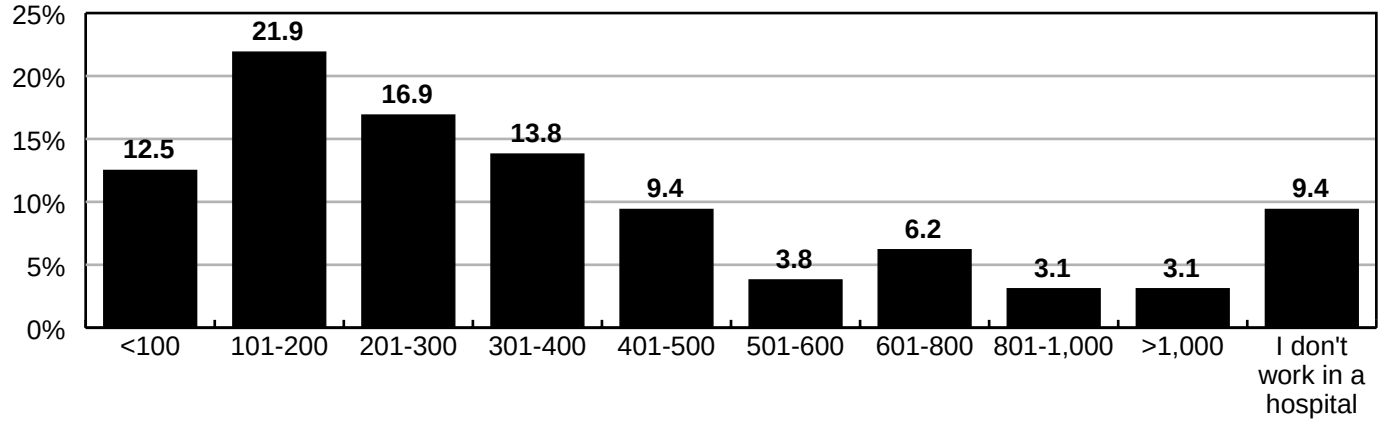
What is Your Highest Degree?



What is Your Age?



What Size Is Your Hospital?



along, she says. Kicklighter suggests that risk managers use the report, and all the surrounding publicity, to push for improvements that might have received a poor reception in the past.

"If a risk manager could turn this into a benefit for themselves to get risk management issues

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Rozovsky suggests that risk managers assess their skills and determine where they may need more education and experience.

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strengthened within the organization, [they] should take every opportunity to take advantage of it," she says.

Even with the focus on medical errors, Rozovsky cautions that employers aren't going to hand over the job to just any risk manager. She suggests that risk managers assess their skills and determine where they may need more education and experience.

"You will need a good knowledge base so you don't get dazed by epidemiology and evidence-based outcomes or regulatory compliance in risk management," she says. "Take a look at what your facility's needs are now and what they will be later. That's where you need to concentrate in terms of your own development."

Expect more opportunities

Rozovsky also suspects that career opportunities will come with another increase in workload. That is particularly likely if health care employers cannot find enough qualified risk managers to fill positions. Risk managers also may see an increase in outsourcing and contract work, she says.

"There are only so many hours for the delightful risk manager to do his or her work," says Rozovsky. "We might be getting to the point where we have to develop specific skill sets and break the risk manager's job down into manageable workloads."

Healthcare Risk Management mailed about 1,500 surveys to readers in the June 2000 issue. A total of 158 of them were returned, for a response rate of 11%. The results were tabulated and analyzed by American Health Consultants, publisher of *HRM*. ■