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IN THIS ISSUE

In This Issue **continued on next page**

Nursing shortage puts patients at risk and creates liability problems

Recruit nurses aggressively, make sure they stay

The health care industry is abuzz about the ongoing nursing shortage, and risk managers can expect the problem to land at their doorstep with an intimidating thud. A shortage of nurses in your facility will inevitably lead to a decline in patient care, some experts say, and that can only lead to an increase in the liability risk.

Risk managers must take notice of the nursing shortage and prepare for its effects, says **Geri Amori**, PhD, ARM, FASHRM, risk manager with Fletcher Allen Health Care in Burlington, VT. Amori also is president of the American Society for Healthcare Risk Management (ASHRM) in Chicago. Amori notes that the nursing shortage actually consists of several related problems, all of which can create liability if left unchecked.

First, there are not enough people newly trained in nursing and ready to enter the work force. Second, too many nurses currently in the work force are leaving or on the verge of leaving. And third, health care organizations are scrimping on nurse staffing levels, putting as few trained nurses on the job as possible to keep their personnel costs low. Only some of those factors are within the hospital's control, but Amori says risk managers should be motivated by the possibility of declining patient care.

"The big question is what is the right amount of nurses to take care of patients?" she says. "That's a loaded question. Too few nurses certainly creates a risk because you have sicker patients in hospitals these days, no doubt about it. Consequently, the

In This Issue **continued from page 61**

COMING IN FUTURE ISSUES

- Hospital settles after inadequate pain management
- Decimal point error kills girl with overdose
- Husband cannot overrule durable power of attorney
- Tips for designing risk-sharing arrangement
- HCFA says pain care will be assessed in surveys

level of care needed is more intense. So we really should have more nurses on the job today than ever before."

Risk managers must jump into the fray

Nurse staffing levels can be a contentious issue within health care organizations, a tangle of budget constraints, union demands, and differing views on clinical needs. It is understandable that risk managers would not be eager to jump into the fray, but Amori says you must.

"Having too few nurses creates risk because your nurses are tired," she says. "People can only deal with a certain amount of stress before they lose it and cannot think clearly, [and they] can't think with precision. Even if the number of nurses were OK, the intensity of the work today means we are still at increased risk. Couple that with double shifts and mandatory overtime, and you've got a real problem."

The risk is more than just theoretical. A hospital in Wichita, KS, recently paid $2.7 million to avoid a trial on allegations that a nurse shortage nearly killed a patient. The patient, a 63-year-old woman, entered Wesley Medical Center in 1998 for lung problems and soon went into a coma. **Brad Prochaska**, JD, the woman's attorney, says the lawsuit alleged the hospital did not have enough nurses on staff to check the patient's condition frequently, allowing her to rapidly deteriorate. At least one hospital administrator publicly admitted that the facility did not meet its own nurse staffing guidelines for significant periods of time, and hospital records filed with the court indicated the short-staffing was a chronic problem and well-known within the facility. The plaintiff originally sought $10 million in damages from the hospital but settled for $2.7 million, and the plaintiff insisted on no confidentiality agreement.

The same hospital now is facing more accusations. The family of a 55-year-old man claims he waited for more than an hour and 38 minutes in the hospital's emergency department while complaining of chest pains, then died before being examined. In court records, the man's family claims that even when he collapsed and a nurse screamed for help, no one else arrived until a family member went down a hallway pleading for assistance. The case is pending.

There seems to be little doubt that having too few nurses on the job can harm patients. The American Nurses Association (ANA) recently

released the results of a study documenting that hospitalized patients have better outcomes in hospitals with higher staffing levels and higher ratios of RNs in the staffing mix. The study was done by Network Inc., a hospital and health care research organization. ANA president **Mary Foley**, MS, RN, says the connection is clear.

"Patients fare better when RNs play a significant role in their care," Foley says. "The study confirms what we have known experientially for years and what a decade of various studies has shown: RN care makes the difference in reducing complications and allowing patients to be discharged from the hospital on time and on the path to recovery. However, when RN care is reduced, patients suffer."

Tracking outcomes

The study tracks five adverse outcomes measures that can be mitigated if adequate nursing care is given. Those measures include: length of stay (LOS), pneumonia contracted while in the hospital, postoperative infection, pressure ulcers (bed sores), and urinary tract infections contracted while in the hospital.

Using hospital and Medicare data from nine states, the study correlates those five adverse outcomes measures with RN staffing levels and overall hospital staffing levels. All five measures are markedly decreased with higher levels of RN involvement in patient care.

"Shorter lengths of stay and fewer complications translate into lower hospital costs," Foley says. "Not only do patients fare better, but hospitals can actually save money by using highly skilled nurses in adequate numbers. It makes no sense for hospitals to cut RN staff or replace RNs with unlicensed assistive personnel who lack the education and judgement of RNs."

The ANA released the study's findings at the Nurse Staffing Summit, held recently in Washington, DC.

"Many hospitals are experiencing a shortage of nurses that affects the quality of patient care," Foley says. "Hospitals in part created that shortage by trying to cut costs by reducing their RN staffs through attrition or layoffs in the mid-'90s. What many hospitals are doing now to address the staffing situation is mandating overtime — forcing RNs to work extremely long hours. But forcing RNs to work excessively over time is unsafe for both nurses and patients. In reality, mandatory overtime is often a business strategy to cut costs, since hospitals pay fewer benefits and do not have to keep a reserve of RNs available to address a fluctuating patient census."

The future may be worse than today. The nurse shortage in coming years will be even worse than current estimates, according to a nationwide survey released recently by the Federation of Nurses and Health Professionals, the 55,000-member health care division of the American Federation of Teachers. The survey found that one in five nurses plans to leave the profession within the next five years because of poor working conditions. **Sandra Feldman**, president of the American Federation of Teachers and the Federation of Nurses and Health Professionals in Washington, DC, says risk managers must look beyond the current state of affairs.

"According to this survey, one in five nurses now working is seriously considering leaving within the next five years," Feldman says. "This foreshadows an even more serious and widespread crisis in health care than previously believed."

But Feldman says the survey also suggests a solution. The nurses threatening to leave say they

HRM goes on-line with debut of web site

As an added value for *Hospital Risk Management* subscribers, we now offer free on-line access to www.hrmnewsletter.com. The new site features current and back issues of *HRM* and *ED Legal Letter*, also from American Health Consultants.

Also included on the site and in its archives are links to every article published in *HRM*'s *Legal Review & Commentary* supplement from January 1999 to present.

There also are links to every article published in *Healthcare Risk Management*'s *Patient Safety Quarterly* and *Patient Safety Alert* supplements from January 1999 to present.

HRM's 2000 salary survey also is available in its entirety. The 2001 salary survey will be available in November.

Find links to other web sites that are essential references for risk managers. There also is a guide to upcoming conferences and events of interest to risk managers.

Click on the User Login icon for instructions on accessing this site. ■

would consider staying if improvements are made, including better staffing levels, more flexible schedules, and higher salaries.

"Hospitals have to do what it takes to retain the nurses they have, try to bring back those who left in frustration, and recruit new people into the profession," she says.

According to the U.S. Department of Labor, an additional 450,000 registered nurses will be needed through the year 2008. Feldman says the newly discovered group of highly discontented nurses would exacerbate the already acute demand for more nurses.

Half of nurses think about getting out

The survey, conducted by Peter Hart Research, interviewed 700 current direct-care nurses and 207 former direct-care nurses. These are some more highlights of the survey:

- **Half of nurses think about leaving.** Fifty percent of current nurses say they have thought about leaving nursing. This number excludes those expected to retire. Current nurses under age 40 are nearly as likely to have thought about leaving nursing as their over-50 colleagues.
- **One-fifth expect to quit soon.** One in five current nurses, or 21%, say they expect to leave nursing within the next five years. These nurses, ages 18-59, plan to leave, not because they want to retire, but because they are fed up with working conditions.
- **But they could be persuaded to stay.** Three-fourths of the 21% who expect to quit say they would consider staying if improvements were made. Increasing staffing, better hours, and higher salaries were the top reasons for staying.
- **They blame stress, irregular hours, and low morale.** More than half, or 53%, of current nurses say the job has become too stressful and physically demanding. Twenty percent of current nurses say they would rather have a job with more regular hours. Among former nurses, the results vividly show declining working conditions. Of the nurses who left nursing at least five years ago, 11% say it was because of stress and the physically demanding nature of the job. Of the nurses who left less than four years ago, the percentage for that reason jumped to 35%.

Among current nurses, 68% say morale is fair or poor. The situation is most severe among hospital nurses, with 74% reporting fair or poor morale. Among those nurses who say they might leave the profession, 81% report fair or poor morale.

- **If I knew then what I know now . . .** Nearly half, or 49%, say they would have pursued a different career if they were just starting out. The situation is worse among those already considering a change, with 75% saying they would have chosen a different career.
- **Not enough nurses.** Of all the problems facing nurses, the No. 1 issue is staffing. Sixty-six percent say large patient loads are a fairly or very serious problem, and 65% say understaffing is especially problematic since patients are sicker. Sixty-four percent say they don't have enough time to spend with patients, and 60% note the paperwork burden.

Potential leavers

In the survey, those on the verge of leaving nursing were called "potential leavers." These are the changes that they said would convince them to stay: Better staffing ratios (87%); more patient time (81%); more input in decisions (79%); raise salaries (76%); provide performance bonuses (71%); more flexible schedules (69%); more part-time options (63%); continuing education funds (61%) and better health coverage (60%).

Feldman says risk managers concerned about the effects of a nursing shortage should work for a legislative ban on mandatory overtime as well as federal standards for health care staffing levels in hospitals and other health care facilities. She says such improvements will improve the quality of life for nurses and therefore tend to keep them on the job, but health care facilities don't have to improve conditions purely for altruistic reasons. Improving conditions for nurses will improve patient care, she says.

Her point is supported by research from the Harvard School of Public Health in Boston. New study results show a strong relationship between nurse staffing levels and better patient outcomes. **Jack Needleman**, MD, and colleagues analyzed 1997 data from more than 5 million patient discharges from about 800 hospitals in 11 states. The research revealed that a higher number of registered nurses was associated with a 3%-12% reduction in the rates of five different adverse outcomes: urinary tract infection, pneumonia, shock, stomach bleeding, and longer LOS.

Higher staffing levels for all types of nurses to a decrease in adverse outcomes of up to 25%, according to the Department of Health and Human Services, which funded the study. The authors say the findings have broad implications

for policy-making, data collection, and research. **John Eisenberg**, MD, director of the Agency for Healthcare Research and Quality, one of the study's sponsors, says the number of nurses on the job is only part of the equation.

"We need to know more not only about how nurse staffing affects quality, but also about the working conditions in which nurses provide care," Eisenberg says. "Excellent nurses may have difficulty providing excellent care if they are working in conditions that are not conducive to quality care."

Act now to head off problems

Amori says it can be difficult to make a direct correlation between a single medical error and nursing shortages, but the bigger picture is clear.

"You can't say that the fact that we had a medical error is directly attributable to the nursing shortage, but we can assume there is a correlation with hours worked, number of nurses on the floor at one time, and so on," Amori says. "Patients are far more likely to be harmed if we don't have enough nurses caring for them. The environment is not conducive to good care, and you also see an increase in the risk to nurses, more injuries there."

Amori suggests that risk managers assert their role within the health care organization to help solve the problem, stressing to administrators that there is a financial incentive for improvement. Consider how the organization structures rotation patterns, how much assistance you provide nurses with nonskilled tasks, and how much of a paperwork burden you place on the nursing staff.

"And of course, we have to ask if we are reimbursing our nurses properly. Do we give people incentives to go into nursing and remain in nursing, or do we teach them that nursing is a second-class activity?" Amori says. "We need to advocate for these things, not only because it is the right thing to do to treat them like human beings, but because there will be financial costs if we don't." ■

HCA faces more trouble, asks for Medicare funds

HCA-The Healthcare Co. is turning the tables on those who have prosecuted the company for years regarding its billing practices. The company has filed a counterclaim suit against the U.S. government seeking reimbursement for an unspecified sum of Medicare costs that have not been paid to the company since 1997.

The counterclaim asks the court for an order requiring the Health Care Financing Administration (HCFA) to reconcile at least 1,000 HCA Medicare cost reports dating back to 1994. The Justice Department recently filed civil complaints in eight whistle-blower lawsuits alleging hundreds of millions of dollars in fraud by HCA, the largest U.S. hospital chain. The complaints included the whistle-blower suits filed by two former HCA executives who have charged that the company engaged in widespread cost-reporting fraud at Columbia/HCA Healthcare Corp, now HCA, and its subsidiaries.

The Justice Department said the claims were not covered by the agreement HCA reached last year to pay a $745 million civil settlement and $95 million in criminal fines to resolve some of the allegations arising from an investigation started in 1997. The more recent lawsuits involved payments of kickbacks to physicians to increase the numbers of government-insured patients, the inflation of hospital cost reports to increase Medicare and other government reimbursement, and kickbacks and inflated cost reports for wound care services.

The Justice Department filed in federal court a document of more than 1,000 pages detailing a huge scheme by HCA to defraud the Medicare system of more than $400 million by making false claims in its annual "cost reports." The complaint is the latest salvo in a eight-year government investigation of Medicare cost-reporting fraud by HCA and its related companies that was sparked by two *qui tam* whistle-blower lawsuits.

The government also filed separate complaints pursuing its longstanding investigation of the other outstanding civil issues confronting HCA: kickbacks and improper physician investment arrangements. If the cost-report case results in a victory at trial, HCA's liability could be more than $1 billion plus an undetermined amount in penalties because the lawsuits were brought under the False Claims Act. That federal fraud law provides that liable companies may be required to pay up to three times damages plus penalties of $5,000 to $10,000 for each false claim made to the government.

The complaint also includes allegations of

HCA cost-report fraud schemes for which the government has not yet determined its monetary losses. A former HCA management subsidiary pleaded guilty last December to criminal charges related to many of the schemes alleged in the current complaint. HCA paid $95.3 million to settle the criminal charges, but has not yet resolved its civil liability for cost-report and kickback issues. HCA's cost-reporting liability will be separate from and in addition to the $745 million civil settlement reached last year on other claims, explains **Stephen Meager**, JD, a San Francisco attorney with Phillips & Cohen, which represents the two whistle-blowers.

"The breadth of the allegations and the detailed calculations of Medicare's losses are a clear signal that HCA's problems with the government are far from over," Meager says.

HCA's costs

The government's analysis of HCA's cost reports finds that the company set aside reserves totaling more than $400 million from 1987 to 1997 to cover claims that it knew were not allowed under Medicare reimbursement regulations. Nearly 400 past and present HCA facilities made thousands of false claims, the government found. The scope of the fraud alleged in the government's complaint is "unprecedented," says **Peter W. Chatfield**, JD, a Washington, DC, attorney with Phillips & Cohen.

"But it is in many ways a very conservative estimate of the fraud," Chatfield says. "The Justice Department has given HCA the benefit of any possible doubt on tens of millions of dollars in highly dubious claims submitted, and reserved for, by HCA."

These are the government charges against HCA:

- Filed claims and received reimbursement for nonallowable costs such as marketing, advertising, and unrelated investments by mischaracterizing them.
- Billed Medicare for idle space in hospitals by claiming it was being used for patient care.
- Concealed overcharges and Medicare auditing errors that favored HCA facilities.
- Failed to implement Medicare audit adjustments in cost reports in subsequent years — continuing to claim costs that Medicare auditors previously had disallowed for reimbursement.
- Shifted costs to home health rehabilitation and other facilities that Medicare reimbursed at higher rates.

The government's amended complaint also reveals for the first time details of HCA's spinoff of 104 hospitals in 1987 to form HealthTrust Inc. The complaint alleges that Medicare unwittingly paid more than $100 million of the cost of that business deal. The chairman, CEO, and president of HCA at that time was its current chairman, Thomas Frist.

"The details provided by this complaint expose cost-report fraud to be an endemic HCA problem going back into the 1980s and not solely a product of the Columbia era," Meager says.

Columbia Healthcare Corp. merged with HCA-Hospital Corp. of America in 1994 to become the largest for-profit hospital chain in the country. HealthTrust Inc. was reacquired by Columbia/HCA in 1995.

The two whistle-blower lawsuits were brought separately by James Alderson, a former director of fiscal services with a small hospital in Montana, and John Schilling, a former reimbursement manager for Columbia in Florida. Alderson was the first person to file a False Claims Act lawsuit exposing HCA's broad-based cost-reporting fraud. Schilling was the key witness and provided essential documents in a criminal trial that resulted in prison sentences for two HCA executives in Florida.

The settlement

In October, the Justice Department and Quorum Health Group, the nation's largest hospital management company (formerly known as HCA Management), agreed to a $77.5 million settlement to resolve a whistle-blower case filed by Alderson for cost-report fraud.

Schilling also has filed a *qui tam* lawsuit against accounting firm giant KPMG for its role in facilitating the fraud at some HCA facilities. The Justice Department joined that lawsuit in December. Both HCA and Quorum routinely prepared two sets of cost reports, according to the whistle-blower lawsuits and the government: One contained "aggressive" claims to file with the government; the other — marked "Confidential" and never shared with Medicare auditors — was used to calculate funds to be held in reserve in case Medicare auditors ever caught a false claim and demanded the payment back.

Hospitals and other health care providers file cost reports with Medicare annually to get reimbursement for costs related to patient care, including expenditures for capital improvements — such as new medical equipment or bigger wards — and

some general administrative costs. Medicare pays a percentage of those costs based on the number of Medicare patients a hospital treats.

In a related matter, Quorum Health Care in Brentwood, TN, announced that it has completed its Medicare cost-report case settlement with the Civil Division of the U.S. Department of Justice. The tentative settlement was announced Oct. 2, 2000. The settlement consists of $82.5 million in compensation, plus interest and implementation of a corporate integrity agreement for five years.

In addition to resolving the government's claims against Quorum, the government has agreed not to pursue claims against current and former managed hospitals that take certain administrative steps. The company has consistently maintained that the settlement was not an indication of wrongdoing, but was in the best interest of the company, its associates, and shareholders. ■

Reader Questions

Condolences are fine, but be careful what you say

Reader question: What is the risk of having physicians express their condolences to the family after a patient dies? I know that the doctor shouldn't blurt out a confession that it's all our fault, but other than that, does it matter much what he or she says? Is it OK to actually send a written letter of condolence?

Answer: Expressions of condolence can be entirely appropriate, and the risk manager should avoid any tendency to be overprotective in this situation, says **Peggy Nakamura**, RN, MBA, JD, DFASHRM, executive director of risk management and associate counsel at Adventist Health in Roseville, CA. Nakamura also is a past president of the American Society for Healthcare Risk Management in Chicago.

While it is correct that the risk manager should help physicians and staff express their condolences appropriately, Nakamura says this is a situation in which you should think as a caring human being first and a risk manager second. The situation gets a little dicier when it is apparent that a medical error contributed to the death, or may have contributed, but even then Nakamura says an expression of condolence is appropriate.

"If you have had a physician/patient relationship up to the point that the patient dies, expressions of condolence will be welcome and appropriate," she says. "If it's a physician who has consulted in the last part of the patient's life, I don't think it means as much to the family. And above all else, whatever is expressed should be genuine and heartfelt."

New research suggests that a condolence letter could greatly improve relations between health care providers and the public, but it also says condolence letters are rare. (*NEJM* 2001; 342:1,163-1,165). While the authors of the study say any expression of condolence from the physician can help the patient's family cope with their grief, they say a written condolence letter is "a concrete gift that the recipient can read over and over." The researchers suggest that the doctor avoid shallow cliches like "it was meant to be" or "I know how you feel." And they also suggest that the doctor avoid discussing the patient's illness in detail because that may invite legal liability.

That, of course, is why many physicians and staff avoid contacting the deceased patient's family. They fear they may be opening the door to a lawsuit by an angry family. They think their risk manager wouldn't want them to say anything, that they are doing what the risk manager would suggest. Maybe, but not necessarily.

Nakamura says the risk of liability from expressions of condolence is not great unless medical errors were involved. When there is no suspicion that medical errors played a role, then physicians and staff should be free — even encouraged — to express their condolence to the family, she says. They should be cautioned not to state anything that implies that they or the facility is at fault, but a sincere expression of sympathy should not be discouraged, she says.

When a medical error is suspected, Nakamura says everyone must be more careful. But still, she says she would not suggest a physician or staff member refrain from expressing sympathy. The timing of the condolence is important, she says. It might be good to wait a few days so that the family has had time to absorb the loss, but she cautions that waiting too long can backfire. A condolence letter that comes too late can look like a defense strategy, rather than a sincere expression of concern.

Written expressions of condolence are more of a concern in this situation, because it could be used against the provider in a malpractice suit if it is not carefully worded. Nakamura urges all of her staff and physicians to consult with her before sending a letter of condolence.

"I've reviewed a number of letters for our medical staff. I've suggested wording changes, and I've suggested they not go too far and take responsibility for everything that happened," she says. "But I try not to go too far into a defensive mode, and I encourage them to focus on the sympathy, the human experience. Everyone wants to have the clinicians acknowledge that someone's death was noticed by them, that it wasn't just a normal day's work. They want to know that their loved one mattered." ■

Feds ask for guidance from IOM to fix oversights

The Department of Health and Human Services (HHS) has asked the Institute of Medicine (IOM) for independent guidance on ways to strengthen medical research oversight, with an eye toward possibly requiring some form of accreditation. The collaborative effort is in response to growing public concern over the safety of research subjects.

Working with the IOM is the first step in a two-year effort, the HHS reports. In a report recently released at a briefing in Washington, DC, the IOM Committee on Assessing the System for Protecting Human Research Subjects endorsed accreditation as a way to potentially improve the protection of human participants in research trials.

The IOM committee suggested that draft standards set forth by the National Committee for Quality Assurance (NCQA) could be used as a framework to develop accreditation standards for research oversight. The committee recommends that accrediting organizations be nongovernmental bodies whose standards draw on federal regulations, such as the NCQA's standards. They also recommend that the HHS commission perform studies to gather baseline data on the current research oversight process and consider launching pilot accreditation programs.

The IOM study will continue for another 18 months, during which time the committee will look at the whole system of human subject protection more generally rather than focusing just on accreditation. A final report is due in 2002.

"The responsibility for protecting research participants looms especially large and is particularly complicated in clinical research, where risks are often highest, professional roles frequently conflicted, and ethical lapses most salient," **Daniel D. Federman**, MD, chair of the IOM committee, said in a National Academies press release. "Over the years, any number of attempts have been made to improve the quality of research oversight. The latest approach — accreditation — holds real promise." ■

Computerized scripts could reduce errors

Medical errors could be reduced dramatically in U.S. hospitals through the use of computerized prescription monitoring systems, according to a Harvard Medical School official. He predicts the systems could save tens of thousands of patients' lives each year.

The systems have proven their worth at Harvard. **David W. Bates**, MD, the chief of general medicine at Harvard's Brigham and Women's Hospital in Boston, says computerized physician order entry (CPOE) systems have helped two Harvard hospitals more than halve their prescription error rate and saved the facilities between $5 million and $10 million.

For any health care provider interested in cutting down medical errors, "This is something that should be in everybody's long-term vision," Bates says. He made his comments at a recent meeting of the National Committee for Quality Health Care in Washington, DC.

A report from the Institute of Medicine indicates that prescription errors are thought to account for at least 20% of the total patient deaths that occur in the United States each year, which is between 44,000 and 98,000. CPOE systems can reduce errors by storing detailed databases of all drugs doctors might order for patients. The computer system flags potentially dangerous drug interactions and also prevents physicians and pharmacists from accidentally ordering or delivering drugs in the wrong amounts. The system also is sensitive to similarly named drugs that can confuse providers anywhere along the medical chain of command. A computerized system also can

eliminate the hazards posed by doctors' illegible handwriting.

Despite those potential benefits, health care facilities have been slow to adopt the technology because it can be expensive and imperfect. But Bates says Harvard's $2 million CPOE system, under development since 1993, helped cut the error rate from 140 prescription errors to 25 errors per 100 patient-days.

"It's just an extraordinarily powerful tool," he says.

California law calls for all urban hospitals in the state to implement CPOE systems by 2005 and to have plans for implementation by 2002. The law gives no extra money to hospitals to pay for the systems, according to Bates. CPOE proponents would like Congress to offer federal tax credits or other incentives to hospitals that purchase the systems in the name of increasing patient safety. ■

Research group ranks state medical board disciplines

North Dakota seems to discipline a lot of its doctors. Based on data obtained from the Federation of State Medical Boards (FSMB) on the number of disciplinary actions taken in 2000 against doctors, the Public Citizen's Health Research Group has calculated the rate of serious disciplinary actions (revocations, surrenders, suspensions and probation / restrictions) per 1,000 doctors in each state and compiled a national report ranking state boards by number of serious disciplinary actions taken against them.

The calculation of rates of serious disciplinary actions (revocations, surrenders, suspensions, and probations / restrictions) per 1,000 doctors by state is created by taking the number of such actions and dividing it by the American Medical Association data on nonfederal physicians as of December 1999, then multiplying the result by 1,000 to get state disciplinary rates per 1,000 physicians.

Nationally, there were 2,746 serious disciplinary actions taken by state medical boards in 2000, up slightly from the 2,696 serious actions taken in 1999. However, there were more physicians practicing in 2000, and the rate per 1,000 physicians was essentially the same in the two years: 3.50 serious actions per 1,000 physicians in 1999 and 3.49 in 2000.

State rates ranged from 12.43 serious actions per 1,000 doctors (North Dakota) to 0.85 per 1,000 physicians (Idaho), a 14.6-fold difference between the best and worst states.

Public Citizen points out that if all the boards did as good a job as the lowest of the top five boards, the lowest rate for No. 5, Oklahoma being 6.68 serious disciplinary actions per 1,000 physicians or 0.668%, this would amount to a total of 5,255 (0.668% of 786,685 nonfederal doctors) serious actions a year. This is 1.9 times as many (2,509 more serious actions) than the 2,746 that actually occurred in 2000.

These were the bottom 15 states, those with the lowest serious disciplinary rates in 2000, starting with the lowest: Idaho (0.85 per 1,000 physicians), South Dakota (1.24), Hawaii (1.33), Delaware (1.39), Minnesota (1.53), Massachusetts (1.58), Illinois (1.67), Washington (1.78), Montana (1.91), New Mexico (2.13), Maryland (2.21), Nebraska (2.39), Texas (2.42), Kansas (2.53), and West Virginia (2.54). Of the 15 states with the worst disciplinary records, eight of them, Massachusetts, Illinois, Maryland, Washington, Minnesota, Kansas, Hawaii, and Delaware also were in the bottom 15 states in 1999 and 1998. In 2000, the bottom 24 states all had rates of serious disciplinary action that were one-half or less than the rate of all of the top five states.

Breakdown of states

Public Citizen says these data raise serious questions about the extent to which patients in many states with poorer records of serious doctor discipline are being protected from physicians who might well be barred from practice in states with boards that are doing a better job of disciplining physicians.

"It is likely that patients are being injured or killed more often in states with poor doctor disciplinary records than in states with consistent top performances," the group says.

The top 10 states, or those with the highest rate of serious disciplinary actions per 1,000 physicians are: North Dakota (12.43 per 1,000 physicians), Alaska (11.47), Kentucky (8.51), Wyoming (8.10), Oklahoma (6.68), Utah (6.27), Arizona (6.18), Ohio (5.89), Georgia (5.35), and New York (5.08). Four of these 10 states (Alaska, Oklahoma, Wyoming, and Ohio) also were in the top 10 in 1998 and 1999, and one state, Alaska, has been in the top 10 for 10 straight years. Oklahoma, fifth this year, has been in the top 10 states for nine of

the last 10 years. Wyoming, fourth this year, has been in the top 10 for eight of the last 10 years and Ohio, eighth this year, have been in the top 10 for six of the last 10 years.

Only two of the nation's 15 largest states, Ohio, and New York, are represented among those 10 states with the highest disciplinary rates. Other large states such as Michigan and California (14th and 19th respectively in 2000) have shown improvement from 40th and 37th in 1991. But other large states such as Texas, Illinois, and Massachusetts (38th, 44th, and 45th in 2000) have not disciplined much of the last 10 years. ■

Aetna joins The Leapfrog Group for better health care

Aetna has become the first health care and group benefits company to join The Leapfrog Group, a consortium of Fortune 500 companies and other health care purchasers who have agreed to base their purchase of health care on principles encouraging more stringent patient safety measures. The Leapfrog Group is a market-based effort to improve patient safety across the nation by organizing the purchasers of group health care insurance.

"As a major employer, Aetna's interest in our employees doesn't begin and end with the workday," says **Elease Wright**, senior vice president of human resources. "We remain keenly aware of how an employee's overall health and well-being can affect his or her ability to contribute to our business. Clearly, The Leapfrog Group's mission to improve the safety of an employee's health care experience is far reaching as it enables employees to remain healthy and productive."

William C. Popik, MD, senior vice president and chief medical officer, says Aetna is joining Leapfrog as an employer, even though it is directly involved in securing health care for others.

"Although we're joining Leapfrog as an employer, Aetna has long been serious about encouraging patient safety on behalf of our more than 19 million health members," Popik says. "Our efforts already include myriad projects such as grants for academic research on medical errors and strategies to improve patient safety, and pharmacy programs that alert participating pharmacists to potentially harmful drug interactions. Now, we're complementing these existing initiatives by joining Leapfrog's campaign to create a safer health care experience for our employees."

On Aug. 10, 2000, Aetna announced $840,000 in research grants to five leading academic institutions to study issues such as improving surgical patient safety, infection control for long-term care facilities, and improving medication safety. Aetna also has implemented drug-to-drug and drug-to-disease pharmacy programs that integrate medical and pharmacy data in order to alert participating pharmacists to potentially harmful drug interactions at the point a drug is dispensed.

"In our role as a health care insurer, we will also promote awareness of the Leapfrog program among our participating hospitals and continue to develop additional patient safety enhancements for our existing programs," Popik says.

A 1999 report by the Institute of Medicine found that up to 98,000 Americans die every year from preventable medical errors made in hospitals. The Leapfrog Group is a Business Roundtable-sponsored commitment to mobilize employer purchasing power to initiate breakthrough improvements in the safety of health care for Americans. It is a voluntary program aimed at mobilizing large purchasers to alert America's health industry that big "leaps" in patient safety and customer value will be recognized and rewarded. The Leapfrog Group's approximately 80 members provide health benefits for more than 24 million Americans; Leapfrog members and their employees spend more than $45 billion on health care annually.

Aetna is the nation's leading provider of health care and group benefits, serving more than 19 million health care members, 14 million dental members, and nearly 12 million group insurance customers as of Dec. 31, 2000. ■

Thompson announces HHS patient safety task force

Health and Human Services Secretary **Tommy Thompson** recently announced the formal establishment of a new Patient Safety Task Force within the Department of Health and Human Services that will coordinate a joint effort among several department agencies to improve existing systems to collect data on patient safety. Thompson charged the task force with closely working with the states and private sector in this effort.

The federal agencies leading this effort include

the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), and the Health Care Financing Administration (HCFA).

What's needed?

The goal of the task force is to identify the data that health care providers, states, and others need to collect to improve patient safety. To begin this process, the task force released a contract request to develop a detailed plan on how to integrate the existing reporting systems in a way that minimizes burden, provides those who must submit reports an opportunity to learn, and improves the safety of health care services.

"Top-quality health care is a hallmark for America, and this administration is committed to patient safety and reduction of medical errors as a key priority," Thompson said. "As one part of our commitment, I am charging the Patient Safety Task Force to work thoroughly and expeditiously to improve our data and reporting systems. Working with our state and private sector partners, we can make much better use of the information we already collect, and we can translate that information into quality gains for patients. At the same time, we will streamline the reporting burdens that providers face today, and we will make important findings more accessible, more quickly to the providers who need to know."

CDC, FDA, and HCFA presently operate a number of systems to collect information that helps to monitor health care safety; compliance with existing regulations on blood products, devices, drugs;

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and the safety of patients in Medicare-funded institutions. Secretary Thompson has charged the task force with studying how to implement a user-friendly Internet-based patient safety reporting format. This will enable faster cross-matching and electronic analysis of data and more rapid responses to patient safety problems.

HHS' fiscal year 2002 budget proposal includes up $72 million, an increase of $15 million over fiscal year 2001, for efforts to improve patient safety and reduce adverse events. ■

Most docs and nurses witnessed medical errors

Nearly all doctors and nurses say they have personally witnessed a serious medical error, according to a survey recently released by the Robert Wood Johnson Foundation.

Ninety-five percent of doctors and 89% of nurses say they have witnessed major errors that threatened their patients' lives. Seventy percent of doctors and nurses, plus other health care providers, say they think fundamental changes to the U.S. health care system are needed in order to improve the quality of care they deliver to patients. For another 11%, the system's flaws are so large that they say only a complete overhaul will be effective.

The survey involved 600 doctors, 400 nurses, and 200 top-level hospital executives from around the nation. The survey defined quality health care as care that is safe, effective, timely, patient-centered, efficient, and equitable.

Based on those criteria, 58% of those surveyed said the quality of health care in the United States is good or fair, and 2% said it was poor. Only 42% said U.S. health care is very good or excellent.

The Robert Wood Johnson Foundation used the survey results to draw attention to a $21 million initiative it is starting along with the Institute for Healthcare Improvement designed to encourage quality improvement measures by hospitals and physician organizations. The plan will give organizations up to $3 million over two years to foster innovation in the delivery of accurate care, minimizing prescription errors, and cutting unnecessary or excessive care. The grant plan already has received 226 applications and expects to award the money by March 2002. ■

Difficult question? Let *HRM* answer

If you are struggling with a difficult question about your job, let *Healthcare Risk Management* find the answer.

Send your question to Reader Question, *Healthcare Risk Management*, P.O. Box 740056, Atlanta, GA 30374. Questions that may be of interest to other readers will be investigated by the staff of *HRM* and have an answer printed in a future issue.

We prefer that you include contact information in case we need clarification of your question, but anonymous submissions will be considered. ■

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

Male operating room technician inappropriately touched by male surgeon: $60,000 TX verdict

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

News: A young male operating room technician was catheterizing a patient when he was sexually assaulted by the attending surgeon. A jury awarded the plaintiff $20,000 for mental anguish and $40,000 in punitive damages.

Background: The young male operating room technician was showing another scrub tech how to insert a catheter into a completely anesthetized patient when the attending male plastic surgeon entered the room. The surgeon *allegedly* walked up to the operating table and proceeded to kick the operating room technician in the buttocks. The technician verbally asked the surgeon not to do that again. The surgeon countered by grabbing the technician's right breast, squeezing it twice, and saying, "My wife just recently divorced me, but I think that you will do just fine."

Following the incident, the technician claimed that he was depressed and feared working with the plastic surgeon again. Despite the presence of numerous witnesses, the surgeon denied that he kicked, inappropriately spoke to, or touched the technician. The surgeon said he had worked with the operating room technician for two years, and that at no time had the tech made any complaints regarding their working relationship.

Because the physician was not employed by the hospital, the facility was not named in the suit. However, the hospital's medical staff policy touting professionalism was used against the physician. The jury found in favor of the plaintiff and awarded him $60,000 in damages.

What this means to you: "All employees are entitled, by law, to a hostile-free work environment. And, a hostile-free work environment is not mutually exclusive to co-worker to co-worker or employee to employer relationships. The relationships covered address all persons with whom the employees come into contact with in the workplace. Thus, the hostile-free work environment covers contractors such as the surgeon may be categorized, as well as patients, guests, and vendors. The basic principle is that it is the company's obligation to keep employees free from hostile exposures during work," says **Alison M. Johnson**, human resources department member, Southeast Region, Motel 6/Studio 6 in Marietta, GA.

While the physician who was the perpetrator in this instance was not a hospital employee, he was an active member of the hospital's medical staff. There are other instances in which the physician could have easily been either an employee of the facility or contract provider that may have resulted in direct liability against the hospital.

"Based on the facts of the case, particularly given that the incident took place in the presence of several witnesses, the jury believed there was a case of sexual harassment between the employee and a contractor," Johnson says. "Because the staff physician was not a hospital employee, it may not

be the responsibility of hospital to provide the doctor with preventive education. That being said, in instances where there is a long-term employee/contractor relationship with the physician or a contract for services in place, the hospital would be well-advised to include those otherwise nonemployed persons in regular training and education on the subject of sexual harassment. The contractor could even be required to sign off on a sexual harassment policy that the hospital has in place for long-term contractors. In this instance, the facility did at least have a hospital bylaw that spoke directly to professionalism, and presumably the physician's conduct fell outside of that parameter. This has made an impact in the hotel/motel business and should work as well with hospitals, given that both are 24-hour/seven-days-a-week operations that involve regular contact between employees and nonemployees."

"Prevention is the best medicine" is an adage that holds true for sexual harassment in the workplace. "At a minimum, employees should be given continual training education on recognizing and reporting sexual harassment in the workplace. As far as this scenario is concerned, at the point that this employee or the witnesses reported it, the company should have stepped in, investigated, and provided feedback to the claimant on the outcome of the investigation. If there was evidence to substantiate a claim of a hostile work environment, the response provided to the claimant should have included how the hospital planned to handle the investigation. If there was no evidence of a hostile work environment, the feedback could have stated this. In either case, it is a good idea to document to the claimant that the company investigated and that the company appreciates the employee for following the company policy on reporting sexual harassment," Johnson says.

Reference

• *James Webber v. John Kendall Long, MD,* Harris County (TX), District Court, Case No. 1998-50328. ■

Discharged and readmitted for surgery: $125,000 in CA

News: A woman's physician sent her to the emergency department (ED) with severe abdominal pain. He admitted her for observation and discharged her two days later advising that she seek psychological counseling. The patient was readmitted the next day for emergency surgery to remove her obstructed small intestine. A settlement with the hospital and physicians was for $125,000.

Background: Shortly after relocating to Southern California, a 55-year-old homemaker and mother of one sought the help of a family practitioner for severe localized abdominal pain. After speaking with the physician on the phone and describing her history of reconstructive bowel surgery six years prior, the doctor said, "You probably have to go to the bathroom," and told her that if the pain persisted for an hour, she should go to the ED.

An hour later and still in pain, she went to an ED where she was met by her physician. Following the physician's examination, he stated that she probably had a nervous stomach and irritable bowel syndrome. The physician ordered a barium enema and admitted her to the hospital for observation. Shortly after being admitted, the patient began to projectile vomit. The physician prescribed Compazine but shared with the patient that he believed she "had caused the condition herself" and that she needed psychological counseling.

During the evening, nurses inserted a gastric tube to alleviate the uncontrollable vomiting and the woman experienced some relief once the tube was inserted. The family physician still believed that the symptoms were psychosomatic. However, a consulting physician thought that the patient might have stomach cancer. A gastrointestinal endoscopy was performed. The results indicated that a CT scan be performed and the small bowel be examined. However, no further tests were performed and she was discharged from the hospital.

Immediately upon arriving home, the patient began to projectile vomit in 10- to 15-minute intervals. Throughout the night, she took Compazine and Xanax when she could, but continued to throw up. Early the morning, she began to have difficulty breathing and her lips had turned blue. At 6 a.m., her family called 911. She was taken to the hospital and readmitted. She then had lost control of her bowel function and was unable to stand or walk. A CT scan was ordered by the consulting physician and performed the next morning. It revealed adhesions causing bowel obstruction of

the small intestine. She was experiencing acute renal failure was taken immediately to surgery.

As a result of the necrosis, the patient experienced permanent loss of approximately five feet of her small intestine and suffered postoperative emotional distress.

The plaintiff alleged that due to the prima facie evidence of her medical experience, the family physician failed to realize the full extent of her underlying condition. The fact that she shared with the physician her medical history, including the reconstructive surgery, should have been a red flag for a diagnosis of potential adhesions. The plaintiff maintained that the physician fell below the standard of care for not ordering the diagnostic tests prior to discharge.

The defendant primary care physician argued that the care and treatment rendered to the patient complied with the standard of care and that he appropriately relied upon the consulting physicians' opinions as to the need to order additional tests. While the consulting physicians did admit that discharging the patient prior to having the additional tests performed did fail below the standard of care, but that they did not have any knowledge of her discharge and that it was the primary care, admitting physician's responsibility to have ordered the tests. Regardless, all of the defendants maintained that plaintiff would have needed the same surgery anyway, even if the obstruction had been diagnosed 36 hours earlier. Ultimately, the hospital and consulting physicians were dismissed from the case and the family practitioner settled for $125,000 with the plaintiff.

What this means to you: This woman began her exchange with her family practitioner by describing her history of reconstructive bowel surgery, yet the practitioner dismissed her significant medical history and told her she "had caused the condition herself."

"Listen to your patients. Not all patients have the same tolerance for pain," notes **Cheryl A. Whiteman**, risk manager of Cigna Healthcare of Florida Inc. in Tampa.* "While the family practitioner's calling in consulting physicians was appropriate, his failure to follow their advice became problematic to his defense. It would be interesting to review the documentation in this case. It is prudent for the physicians to utilize different diagnoses so that anyone reviewing the record would understand which conditions were being considered as well as which one were ruled out as the result of the tests performed, consultants' conclusions, and the patient's evolving condition. Essentially, one wonders how the physician justified this patient's discharge in light of the facts presented.

"Based on the findings when the patient was readmitted with projectile vomiting, difficulty breathing, and acute renal failure as a result of bowel obstruction with necrosis, it would seem that he family practitioner and the referral physicians would have better served their patient had additional testing been performed during the first admission. Before assuming a psychological overlay, physical pathology must be considered, particularly as it relates to the patient's medical history, which in this instance should have raised a red flag. And, if the medical history did not raise the flag with the family practitioner, he should have at least shared the history with the referral physicians even if he discounted it himself," adds Whiteman.

"Under the facts of this particular case, the hospital was dismissed, but the lesson remains — listen to your patients. This is not only true for the treating physicians but all medical personnel. You never know when you may hold the key piece of information to facilitate the arrival at the appropriate diagnosis," concludes Whiteman.

*These comments do not necessarily reflect those of Cigna Healthcare of Florida Inc.

Reference

• *Anonymous Patient and Husband v. Anonymous Obstetrician/Gynecologist and Anonymous Hospital*, Indiana. ■

Homeless man dies on gurney: $2 million

News: A schizophrenic homeless man became unruly and was placed face down on an ambulance gurney and a backboard was strapped to him. He suffocated and died. An Ohio jury returned a $2 million verdict against the ambulance company.

Background: A 32-year-old, chronically mentally ill homeless man was brought to an emergency department (ED) on Christmas Eve after he threatened to kill his psychologist. At first,

the patient was calm and remained quiet, but became violent when the ED physician informed him that he would be committed to the county psychiatric hospital. It took six police officers and additional hospital security personnel to restrain him. He was involuntarily restrained to a gurney with four-point restraints within the ED security area.

A private ambulance company arrived, and the patient was given a sedative. Emergency medical technicians determined they would transport the patient face down on the gurney with a backboard placed over him, which was tightened down considerably. Police officers helped transfer him to the ambulance. Though Mr. Doe complained he was unable to breathe, a towel was loosely held around his mouth to prevent him from spitting and he was covered from head-to-toe with a sheet. No one evaluated his vital signs.

As Mr. Doe was wheeled out, the ED physician noticed that his arm just below the sheet appeared to be blue. The sheet was removed and Mr. Doe was found to not be breathing. He was pronounced dead. The county coroner determined that Mr. Doe died from positional asphyxia and that his death was a homicide. Local authorities felt there were no grounds for criminal prosecution.

The plaintiffs alleged negligence against the hospital, the ED physician, and the ambulance company that the hospital and ED physician had failed to follow appropriate procedures. The plaintiffs said the ambulance company caused the death by an unorthodox transfer method.

The defendant argued the man had died of a fatal heart arrhythmia and the damages were minimal. They pointed out that the decedent's mother also was diagnosed with mental illness, that she had given Mr. Doe up to her own mother (Doe's grandmother, now deceased) to raise, that Mr. Doe had spent most of his life in various institutions in involuntary placement, and that the total time Mr. Doe spent with his mother was less than six months in his life.

The plaintiffs settled with the defendant hospital and the ED physician and pursued the ambulance company, which said the decedent did not die of positional asphyxia. It was agreed to try the case in a summary jury trial with a binding high/low agreement. Following the presentation, the jury returned a verdict against the defendant for a total of $2 million. The sum of $1.6 million was allocated to the survival claim, and $333,334 was allocated to the wrongful death claim. The verdict was adjusted according to the agreed upon confidential high/low agreement.

What this means to you: "The severe restraint of the patient is unconscionable. It is difficult to believe that in this day and age, that a patient was treated with such force. The four-point restraint should have been sufficient under most circumstances, but it does not seem that any other interventions, such as counseling or medications were utilized," observes **July Davis**, director of Risk Management at Tallahassee (FL) Memorial Hospital.

"At our facility we utilize a team of PERP nurses to handle such situations. PERP stands for psychiatric emergency response program, which is staffed by nurses with specific training in the handling and care of psychiatric patients. We have found this approach to be particular effective with patients with no acute medical needs. By systematically triaging such patients using specialized documentation and protocols, psychiatric patients are generally responsive and assisted through counseling," adds Davis.

"Should particularly belligerent or unruly patients require additional interventions, the emergency room is equipped with a 'quiet room,' where psychiatric patients can be taken away from the mainstream noise and emergency room treatment, and in some instances may be given medications to calm, not sedate them. Here, we utilize the services of the security personnel who are expressly assigned to the emergency department. On weekends, the security team is augmented by off-duty law enforcement officers. The combination of internal personnel — PERP and security — are still unsuccessful at managing a patient, from time to time on-duty law enforcement officers may be called in for further assistance, which in extreme instances seems to be effective," notes Davis.

"Handling difficult psychiatric patients is a challenge for any institution, but having a series of safeguards in place should be helpful in managing most situations. The use of force may become necessary, but overt force and over-restraining should be avoided," concludes Davis.

Reference

• *Estate of Doe v. ABC Ambulance Corp., et.al.*, Lake County (OH) Court of Common Pleas. ■

Healthcare Risk Management™

Confidential Salary Survey

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

Instructions: Circle the appropriate answer directly on this form. Please answer each question as accurately as possible. If you are unsure of how to answer any question, use your best judgment. Your responses will be held strictly confidential. Do not put your name or any other identifying information on this survey form.

1. What is your current title?
   A. risk manager
   B. risk manager director
   C. vice president
   D. assistant administrator
   E. director/manager of quality outcomes
   F. medical director
   G. director of nursing
   H. other _____

2. Please indicate your highest degree.
   A. LPN
   B. diploma (3 yr)
   C. BS
   D. BA
   E. BSN
   F. MSN
   G. master's
   H. JD
   I. PhD
   J. other _____

3. Please indicate which of your certifications best represents your current position. (Choose only one.)
   A. ARM
   B. CHPA
   C. FASHRM
   D. MSM
   E. DASHRM
   F. other _____

4. Including your past and present employers, how long have you worked in positions with the same or similar responsibilities as your current position(s)?
   A. less than 1 year
   B. 1 to 3 years
   C. 4 to 6 years
   D. 7 to 9 years
   E. 10 to 12 years
   F. 13 to 15 years
   G. 16 to 18 years
   H. 19 to 21 years
   I. 22 to 24 years
   J. 25 or more years

5. Including your present and past employers, how long have you worked in the health care field?
   A. less than 1 year
   B. 1 to 3 years
   C. 4 to 6 years
   D. 7 to 9 years
   E. 10 to 12 years
   F. 13 to 15 years
   G. 16 to 18 years
   H. 19 to 21 years
   I. 22 to 24 years
   J. 25 or more years

6. What is your age?
   A. 20 to 25
   B. 26 to 30
   C. 31 to 35
   D. 36 to 40
   E. 41 to 45
   F. 46 to 50
   G. 51 to 55
   H. 56 to 60
   I. 61 to 65
   J. 66 or older

7. What is your sex? A. male B. female

8. What is your annual gross income from your primary health care position. Please exclude additional income from teaching, consulting, bonuses, etc. To answer this question, circle the correct salary.
   A. less than $20,000
   B. $20,000 to $24,999
   C. $25,000 to $29,999
   D. $30,000 to $34,999
   E. $35,000 to $39,999
   F. $40,000 to $44,999
   G. $45,000 to $49,999
   H. $50,000 to $54,999
   I. $55,000 to $59,999
   J. $60,000 to $64,999
   K. $65,000 to $69,999
   L. $70,000 to $74,999
   M. $75,000 to $79,999
   N. $80,000 to $84,999
   O. $85,000 to $89,999
   P. $90,000 to $94,999
   Q. $95,000 to $99,999
   R. $100,000 to $104,999
   S. $105,000 to $109,999
   T. $110,000 to $114,999
   U. $115,000 to $119,999
   V. $120,000 to $124,999
   W. $125,000 to $129,999
   X. $130,000 or more

9. If you or your company charges clients by the hour, please indicate the hourly amount. If you do not charge by the hour, please mark answer I.
   A. less than $30
   B. $31 to $50
   C. $51 to $70
   D. $71 to $90
   E. $91 to $110
   F. $111 to $130
   G. $131 to $150
   H. $151 or more
   I. do not charge by the hour

10. On average, how many hours a week do you actually work? (Regular hours plus overtime, regardless of whether you're paid extra.)
    A. less than 20 hrs/week C. 31 to 40 E. 46 to 50 G. 56 to 60 I. more than 65 hrs/week
    B. 20 to 30 D. 41 to 45 F. 51 to 55 H. 61 to 65

11. In the past 12 months, how has your salary or income increased or decreased?
    A. salary decreased C. 1% to 3% increase E. 7% to 10% increase G. 16% to 20% increase
    B. no change D. 4% to 6% increase F. 11% to 15% increase H. 21% or more increase

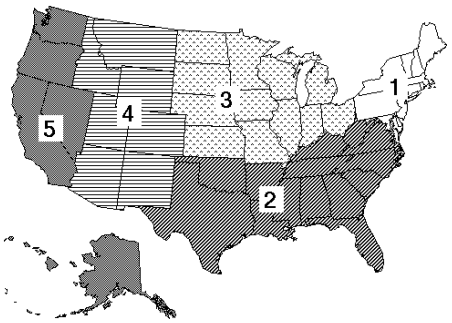
12. In the past 12 months, how has the number of employees in your company or department changed?
    A. increased B. decreased C. no change

Please rate the following benefits according to how important they are in determining your job satisfaction. Use the following scale, and be sure to mark the benefit's importance only if your employer currently provides that benefit to you. If your employer does not currently provide that benefit, or if your company has no benefits, mark 5.

	Extremely important		Somewhat important		Benefit not provided		Extremely important		Somewhat important		Benefit not provided
13. medical coverage	1	2	3	4	5	20. pension plan	1	2	3	4	5
14. dental coverage	1	2	3	4	5	21. profit-sharing plan	1	2	3	4	5
15. eyecare coverage	1	2	3	4	5	22. annual or semi-annual bonus	1	2	3	4	5
16. life insurance	1	2	3	4	5	23. elder care	1	2	3	4	5
17. 401k or other plan	1	2	3	4	5	24. maternal/paternal leave	1	2	3	4	5
18. child care	1	2	3	4	5	25. some freedom to choose work schedule	1	2	3	4	5
19. tuition reimbursement (including CE credits)	1	2	3	4	5	26. exercise facilities or health club membership	1	2	3	4	5

27. Over the last 12 months, has your contribution to the cost of your medical benefits increased, decreased, or stayed the same? (Don't include deductibles or copayments. If you don't contribute to your medical plan or don't receive medical benefits through your job, please mark either D. or E.)
    A. increased C. no change E. I don't contribute to my plan
    B. decreased D. I don't receive medical benefits

28. Using the map provided here, please indicate where your employer is located.
    A. region 1 C. region 3 E. region 5 G. other
    B. region 2 D. region 4 F. Canada



29. Which of the following best describes the location of your work?
    A. urban (within a large city) C. medium-sized community
    B. suburban (in a community within a metropolitan area dominated by large city) D. rural

30. Which best describes the ownership or control of your employer?
    A. college or university D. nonprofit (church-operated, volunteer, etc.)
    B. federal government (VA, military, and federal agencies) E. for profit (individual, private practice, or corporation, etc.)
    C. state, county, or city government

31. Which of the following best categorizes the work environment of your employer? Choose only one answer.
    A. academic C. city or county health department E. college health service G. hospital
    B. agency D. clinic F. consulting H. private practice

32. If you work in a hospital, what is its size? (If you don't work in a hospital, please mark J.)
    A. < 100 beds D. 301 to 400 beds G. 601 to 800 beds J. I don't work in a hospital
    B. 101 to 200 beds E. 401 to 500 beds H. 801 to 1,000 beds
    C. 201 to 300 beds F. 501 to 600 beds I. > 1,000 beds

Deadline for responses: August 1, 2001

Thank you very much for your time. The results of the survey will be reported in an upcoming issue of the newsletter, along with an analysis of the economic state of your field. Please return this form in the enclosed, postage-paid envelope as soon as possible. If the envelope is not available, mail the form to: Salary Survey, American Health Consultants, P.O. Box 740058, Atlanta, GA 30374.