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INSIDE

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HMOs, hospitals: Brace for an onslaught of lawsuits from patients' bill of rights

Patients' rights will have a trickle-down effect

With the debate over the patients' rights bills making its way through Congress, risk managers may find it easy to assume that the controversy only affects them from a distance. After all, the debate is about provisions that will enable or limit lawsuits against health plans.

Hospitals and other health care providers are not directly affected, right?

Dead wrong, say risk managers and other experts. The patients' rights bill, no matter which version is finally enacted into law, will result in a dramatic increase in lawsuits, they predict. The managed care organizations will be the most severely affected, but hospitals will feel the trickledown effect.

Brace now for the onslaught, warns **Leilani Kicklighter**, RN, ARM, MBA, DFASHRM, president of the Kicklighter Group consulting firm in Tamarac, FL, and a past president of the American Society of Healthcare Risk Management.

"It is a mistake to say this is about managed care organizations and the patient and not our responsibility," she says. "Risk managers should be following this very closely to see what finally develops."

Bills in the homestretch

The House and Senate both have been debating patients' rights bills for months, with critics alleging they would open the floodgates to trial lawyers seeking to sue health plans and employers for denial of service and other wrongs. The House passed patients' rights legislation that included limitation on managed care organizations' liability, and congressional leaders indicated that the House and Senate would soon work out a compromise bill that could become law.

Under the House version, all Americans with health insurance would be guaranteed coverage for emergency room care, treatment by medical specialists, and access to government-sponsored clinical trials. Patients denied

coverage would be able to appeal the refusal to an outside, independent expert and be guaranteed a quick response. The bill also allows patients to sue for punitive damages only in cases in which the insurer disobeyed an appeals board ruling, and the award would be limited to $1.5 million.

Lawsuits would be brought in state courts but under *federal* rules. Democrats have argued that state courts should hear the cases under their own rules, but Republicans balked at that provision because state courts tend to be more favorable to plaintiffs than federal courts.

The patients' rights bill passed earlier by the Senate has similar protections for the patient but has no limit on monetary awards and does not impose federal rules on the state courts.

With passage of some version of the patients' rights bill seeming inevitable, risk managers should start studying the possible scenarios and determining how they will affect their own hospital operations, Kicklighter says.

Though providers are not specifically named as the responsible parties, she points out that the intertwining of providers and insurers these days make it impossible to separate their duties, she explains.

Where the concerns are

Much of the risk manager's concern should be directed to the multiple state and federal requirements for patient's rights, Kicklighter says.

When a patient's rights bill is finalized, it will be added to existing state requirements and other federal requirements in the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) Conditions of Participation and various other regulations that may apply to your organization, she says.

"Risk managers need to have someone designated to put all these requirements side by side and see just what you're responsible for doing," Kicklighter says.

"You have to compare the parts that are the same and see what your state requirements might require you to do other than what's in the federal plan. You'll find plenty to do in terms of educating patients about their rights, for instance," she says.

Be careful not to be thrown off by the wording that puts the responsibility on the insurer, she says. In the real world, the provider often is the insurer's agent and will be held responsible by the courts for informing patients about their rights and remedies. You're taking a big risk if you just say, "That's the managed care organization's job," and leave it at that.

"It's just like the *Wickline* case in California when a case reviewer said the patient had met criteria for discharge, and the doctor discharged, but then the patient suffered complications," she says. "The court held that the practitioner was an independent practitioner and had a responsibility to keep the patient in the hospital. I think the same premise would hold here, and the court would say the provider had a responsibility to make sure the patient knew his or her rights regarding denial of service, for instance."

Informing patients about their rights is one major way in which hospitals may be involved in the patients' rights requirements, Kicklighter says. And that leads to a slew of questions about how to provide that information to a multilingual, sometimes illiterate, population.

"Years ago, we had patient relations personnel who greeted patients, but most places have done away with that," she says. "There will have to be accountability. You'll have to have one person, even if it is the risk manager, who is accountable for making sure patients are notified of their rights."

Trial lawyers will find a way

A patient's rights bill is almost certain to result in more lawsuits against providers, says **Allan Morphett**, JD, MA, CHSP, a risk management safety specialist with Farmers Insurance Healthcare Professional Liability in Idyllwild, CA.

"I understand the necessity for having the right to sue corporate entities when the patient thinks care is denied or improper, but I think people might run away with this as an opportunity they didn't have before," he says. "There are

COMING IN FUTURE MONTHS

- Clarification on EMTALA applications
- Bigger award from jury than judge?
- Insurers pushing for more shared risk
- Reducing costs for contract review
- In-house counsel vs. outside help

Hospital denies role in PA court action

A risk manager at the University of Pittsburgh Medical Center (UPMC) hospital tells *Healthcare Risk Management* that the hospital did not encourage the husband of a patient who is a Jehovah's Witness to seek a legal remedy about using blood products on his wife.

Bill Shaffner, JD, associate counsel and director of risk management at UPMC, says the hospital was only a third party waiting for instructions.

The flap revolves around whether UPMC agreed to perform a liver transplant on a Jehovah's Witness without using blood products and if the husband tried to circumvent the patient's wishes and her written declarations.

The plaintiff's attorney alleged that the hospital helped the husband get around the patient's wishes. **(See *Healthcare Risk Management,* August 2001, p. 90.)**

"The husband initiated an inquiry as to whether any local counsel would be willing to represent him in that situation, but I honestly don't know whether he obtained his counsel from the staff at the hospital or how that came about," Shaffner says. "But I know we did not in any way affirmatively solicit him to get involved with counsel or seek any sort of court intervention with respect to her wishes. Our staff were not actively encouraging him."

Though Shaffner and the plaintiff's attorney are on opposite sides of the case, they agree that it would be improper for the hospital staff to actively encourage a family member to usurp a patient's clear wishes. The risk manager says he sees a distinction between simply providing information when asked about local attorneys and actually suggesting or encouraging court action.

"Legal issues aside, I don't think that's the proper role for a hospital," Shaffner says. "But I don't see any problem if they just answered his question, rather than saying, 'If you love your wife, here's what you should do.' I appreciate that it's a slippery slope, but I think it's a legitimate distinction nonetheless." ■

going to be mistakes, and until there is a shift in people's perceptions, any opening provided by the law will result in more lawsuits. We have to start teaching the public that every mistake doesn't mean you've won the national lottery."

Any lawsuits aimed primarily at health plans are likely to include hospitals and other providers, says **Mohit Ghose**, an analyst at the American Association of Health Plans in Washington, DC.

"The language in the bills may exclude physicians and facilities, but no matter what the language, you're always going to be pulled into these cases. Trial lawyers already are fond of including everyone they can think of," he says. "This is going to create vicarious liability for everyone. This is not just a threat to health plans."

The malpractice industry

The patients' rights bill will complicate and expand the medical malpractice industry, Ghose says, especially if the state court/federal rules provision makes it to the final version. He suggests that health care providers could see not just more lawsuits, but a different animal altogether.

"They're creating a whole new type of lawsuit. Health plans are going to go on the defensive in a big way, with books about 500 pages long to explain explicitly what is excluded under their plans," Ghose says. "Some very innovative trial lawyers are at work already figuring out ways to capitalize on this, and I have no doubt that they will find ways to litigate a lot of cases. We've always maintained that there is the potential for lawsuits to absolutely explode and bankrupt the system."

Karen Ignagni, president of the American Association of Health Plans, says health plans may be hit hard by the first wave of lawsuits, but no one will be left unscathed.

The patients' rights bill "promises to unleash a Pandora's box of liability that would leave no part of the health care system unaffected: Consumers, doctors, hospitals, employers, and health plans are all at risk," she says. "With respect to liability in this bill, we may well be looking at only the tip of the iceberg."

Hardly anyone is arguing that there won't be an increase in lawsuits. Even the strongest

advocates of the patients' rights bills acknowledge that there will be more lawsuits; they just contend that the lawsuits are justified. Regardless, Ghose says the increase in activity will be felt across the board in health care.

"We've already seen reports from some health plans that their malpractice insurance is going up 300%," he says. "We're seeing colossal risks in insurance costs. Will the insurers leave premiums alone for doctors and hospitals? I doubt that." ■

Nurse whistle-blowers protected by court ruling

You cannot require nurses to speak about a malpractice case through your hospital attorneys, according to a recent court ruling that gives substantially more protection than nurses have had in the past for on-the-job whistle-blowing. Observers are saying it is a big step forward in encouraging nurses to speak up when they see problems that can threaten patients.

The Third Judicial District Court in Washington, DC, provided protection for six registered nurses who acted as whistle-blowers against a physician who allegedly acted incompetently and unprofessionally, and whose actions, according to the plaintiffs, resulted in the death of a patient.

Judge **Thomas Cornish**, JD, granted the plaintiffs' motion for rules governing the questioning of nurse witnesses. The American Nurses Association (ANA) had filed an amicus brief in support of the nurses, in which the association detailed the importance of the Code of Ethics and patient advocacy in the context of nursing practice. ANA's argument was presented by the association's nursing practice counsel, **Winifred Y. Carson**, JD.

The general counsel for the ANA, **Alice Bodley**, JD, says the ruling gives nurses more protection.

Nurses can't be bullied

Carson tells *Healthcare Risk Management* that the case sets a precedent and risk managers should take notice. The judge's ruling makes clear that hospitals cannot bully nurses into keeping quiet about legal disputes, she says.

"Sometimes hospitals do think they can compel nurses not to be truthful about matters related to medical malpractice," she says. "They will tell the nurses to forget it or encourage them to have selective memory. It's been our experience that nurses will go along with it sometimes because they fear retaliation from their employers."

The six nurses involved in the case are, or had been, employees of Memorial Medical Center in Las Cruces, NM. Based on ethical grounds, they testified in support of the patients in a lawsuit brought by Thomas Smith and Irene Dockray against Lorraine Martinez, DO. Martinez is accused of negligence and incompetence involving Smith's wife, Deborah, who died from sepsis after Martinez allegedly failed to treat her. She also is accused of permanently harming Dockray during a medical procedure.

"There had been numerous complaints about how she handled patients in the past and in this case," Carson says. "The nurses were asked about past and present complaints, and the hospital didn't want to speak to past complaints so they were telling nurses they couldn't speak about past complaints or their specific concerns about this physician."

The nurses felt compelled to provide pertinent information because they thought the physician could be dangerous to patients, Carson says. But even those no longer employed by the hospital felt pressured to keep quiet because the small community offers little employment for nurses. Going against the hospital's wishes could make life difficult even for the ex-employees, Carson says.

"They wanted to say, 'You can't speak on your own even if you don't work for us any more.' It got in the way of fully investigating the case," she says.

'A major victory for nurses'

The court ruled that Memorial Medical Center could not require its employed nurses to speak only through or with hospital attorneys. Over the hospital's objections, the judge included a charge nurse within the scope of the court's protective ruling for the staff nurses. In addition, the court held the hospital accountable for any retaliation against the nurses, stating that retaliatory action will be considered contempt of court.

New Mexico Nurses Association president **Judith Dunaway**, RNC, MSN, HNC, says the ruling is a major victory for nurses.

"This case sends a message in New Mexico and throughout the country that nurses can and will stand up and make their concerns known about inadequate or deficient patient care," she says.

"The nurses tried to work internally through the hospital system, but that system didn't work. When nurses express concern over inadequate care, their concerns should not be ignored." ■

Practices that could improve patient safety

A new federal report identifies dozens of evidence-based practices that could improve patient safety, including a number that investigators say are not routinely performed in hospitals and other health care institutions.

The 640-page report, *Making Health Care Safer: A Critical Analysis of Patient Safety Practices,* was released by the federal Agency for Healthcare Research and Quality (AHRQ) in Rockville, MD, Investigators with AHRQ reviewed scientific literature to identify practices that are proven to be effective and believed to represent a significant opportunity for improving patient safety. The report mainly deals with hospital care but also includes care delivered in nursing homes, at ambulatory care sites and by patients themselves in managing their care.

Clear opportunities

Eleven of the practices highlighted in the report are called "clear opportunities" to improve patient safety but AHRQ says they are not routinely performed. They include administering antibiotics before surgery to prevent infections, using ultrasound to help guide the insertion of central intravenous lines and to prevent punctured arteries, and giving surgery patients beta-blockers to prevent heart attacks.

AHRQ investigated the issue in response to recent concerns about medical errors, generated in part by the 1999 Institute of Medicine's (IOM) report, *To Err is Human: Building a Safer Health System.* That report highlighted the risks of U.S. medical care and estimated the magnitude of medical errors-related deaths at 44,000-98,000 deaths per year.

The IOM report has come under fire by critics who say it overestimated the problem. **(For more on that development, see p. 102.)**

The AHRQ investigators defined a "patient safety practice" as "a type of process or structure whose application reduces the probability of adverse events resulting from exposure to the health care system across a range of diseases and procedures."

Its report notes that researchers now believe that most medical errors cannot be prevented by perfecting the technical work of individual doctors, nurses, or pharmacists. Improving patient safety often involves the coordinated efforts of multiple members of the health care team who may adopt strategies from outside health care.

How to choose

The report reviews several practices whose evidence came from the domains of commercial aviation, nuclear safety, aerospace, and the disciplines of human factors engineering and organizational theory. Such practices include root-cause analysis, computerized physician order entry and decision support, automated medication dispensing systems, barcoding technology, aviation-style preoperative checklists, promoting a "culture of safety," crew resource management, the use of simulators in training, and integrating human factors theory into the design of medical devices and alarms.

The National Quality Forum in Washington, DC, plans to use this report to help identify a list of patient safety practices that consumers and others should know about as they choose a health care provider.

Seventy-nine practices were reviewed in detail. The following 11 patient safety practices were the most highly rated in terms of strength of the evidence supporting more widespread implementation. Practices appear in descending order, with the most highly rated practices listed first.

- Appropriate use of prophylaxis to prevent venous thromboembolism in patients at risk.
- Use of perioperative beta-blockers in appropriate patients to prevent perioperative morbidity and mortality.
- Use of maximum sterile barriers while placing central intravenous catheters to prevent infections.
- Appropriate use of antibiotic prophylaxis in surgical patients to prevent perioperative infections.
- Asking that patients recall and restate what they have been told during the informed consent process.
- Continuous aspiration of subglottic secretions to prevent ventilator-associated pneumonia.
- Use of pressure relieving bedding materials to prevent pressure ulcers.

Errors in the report on medical errors?

The Institute of Medicine (IOM) report on medical errors that caused such a stir was full of its own errors, according to a new analysis.

The IOM report overstated the degree to which the medical errors shortened patients' lives, says **Rodney A. Hayward**, MD, a co-author of the new study and a researcher with the Department of Veterans Affairs Center for Practice Management and Outcomes Research in Ann Arbor, MI (*JAMA* 2001; 286:415-420).

Eye of the beholder

In Hayward's study, "Preventability is in the Eye of the Reviewer," he studied the implications of a death described as "preventable by better care" in terms of the probability of immediate and short-term survival if care had been optimal, with 14 board-certified internists assessing the conclusions made by previous researchers. They studied 383 reviews of 111 hospital deaths at seven Department of Veterans Affairs medical centers around the country.

The internists determined that almost one-quarter of patient deaths were rated as at least possibly preventable by optimal care, with 6% rated as probably or definitely preventable. The reviewers' estimates of the percentage of patients who would have left the hospital alive had optimal care been provided was 6%. But after considering three-month prognosis and adjusting for the variability and skewness of reviewers' ratings, the clinicians estimated that only 0.5% of patients who died would have lived three months or more in good cognitive health if care had been optimal, representing roughly one patient per 10,000 admissions.

By contrast, the IOM report estimated that medical errors kill at least 44,000 people in U.S. hospitals each year, and possibly as many as 98,000. In hospitals alone, the IOM estimated that 7,000 die each year from medical errors. Hayward says that figure is probably too high because many of the patients would not have lived any longer if the error had not occurred.

The authors concluded that "previous interpretations of medical error statistics are probably misleading." ■

• Use of real-time ultrasound guidance during central line insertion to prevent complications.

• Patient self-management for warfarin (Coumadin) to achieve appropriate outpatient anticoagulation and prevent complications.

• Appropriate provision of nutrition, with a particular emphasis on early enteral nutrition in critically ill and surgical patients.

• Use of antibiotic-impregnated central venous catheters to prevent catheter-related infections.

Tilting to the clinical

AHRQ points out that the list generally is weighted toward clinical rather than organizational matters, and toward care of the very ill rather than the mildly or chronically ill. Although more than a dozen practices considered were general safety practices that have been the focus of patient safety experts for decades (i.e., computerized physician order entry, simulators, creating a "culture of safety," crew resource management), most research on patient safety has focused on more clinical areas.

In terms of the research agenda for patient safety, the following 12 practices rated most highly:

• Improved perioperative glucose control to decrease perioperative infections.

• Localizing specific surgeries and procedures to high-volume centers.

• Use of supplemental perioperative oxygen to decrease perioperative infections.

• Changes in nursing staffing to decrease overall hospital morbidity and mortality.

• Use of silver alloy-coated urinary catheters to prevent urinary tract infections.

• Computerized physician order entry with computerized decision support systems to decrease medication errors and adverse events primarily due to the drug ordering process.

• Limitations placed on antibiotic use to prevent hospital-acquired infections due to antibiotic-resistant organisms.

• Appropriate use of antibiotic prophylaxis in surgical patients to prevent perioperative infections.

• Appropriate use of prophylaxis to prevent

venous thromboembolism in patients at risk.

• Appropriate provision of nutrition, with a particular emphasis on early enteral nutrition in critically ill and post-surgical patients.

• Use of analgesics in the patient with an acutely painful abdomen without compromising diagnostic accuracy.

• Improved hand-washing compliance (via education / behavior change; sink technology and placement; or the use of antimicrobial washing substances).

AHRQ investigators say their report represents a first effort to approach the field of patient safety through the lens of evidence-based medicine. ■

Ruling: Patients must get results after complaints

A judge has ruled that a federal policy of withholding investigation results from Medicare patients who have filed complaints about doctors is illegal.

The advocacy group Public Citizen filed the case last year against the Department of Health and Human Services (HHS). The complaint stemmed from the agency's refusal to disclose investigation results to Kentucky resident David Shipp, who filed a complaint related to his wife's care in 1998 and 1999 at Baptist East Hospital in Louisville. HHS's Peer Review Organization (PRO) launched an investigation of three doctors, but refused to tell Shipp the results of the investigations of two of the doctors because the physicians did not consent to the disclosure.

The government argued that maintaining this confidentiality was consistent with the law and necessary for the PRO to perform its duties. Public Citizen contended that the policy violated the Peer Review Improvement Act of 1982, as amended in 1986, which states that PROs "shall inform the individual [or representative] of the organization's final disposition of the complaint."

The court rules

In the U.S. District Court for the District of Columbia, U.S. District Judge **Ellen Segal Huvelle**, found that the policy violated the statute and the intent of Congress. The judge found that an examination of the history, structure, and underlying purpose of the statute supported the finding that a PRO must inform complainants of the substantive dispositions of their complaints. She ordered HHS to amend the policy within 20 days.

Amanda Frost, JD, an attorney with Public Citizen Litigation Group, called the decision a victory for Medicare patients who are the victims of substandard medical care. "This decision means that the government can no longer hide doctors' errors from Medicare patients," she said. ■

Group says EMTALA violations frequent

Hospitals in nearly every state in recent years have violated a federal law prohibiting them from dumping patients, leading to people with medical emergencies being improperly screened or refused treatment altogether, according to a recent report from the advocacy group Public Citizen.

In its sixth in a series of reports on patient dumping, Public Citizen found that 527 hospitals violated the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA). Taking data from all six reports into account, more than one in five hospitals throughout the country have violated the law since it was passed. The data suggest that most hospital staff are familiar with the law but break it anyway, says **Sidney Wolfe**, MD, director of Public Citizen's Health Research Group.

"It's distressing that this law has been in place for 15 years and hospitals are still flouting it," he says. "The government needs to do more to force hospitals to comply. People shouldn't be denied desperately needed emergency medical care when they go to a hospital. Failing to impose fines on most hospitals violating the law amounts to an invitation to dump sick patients."

Some administrative problems

Most of the violations cited in the current report were confirmed in 1997, 1998, and 1999, although a few were confirmed in 1996 and 2000. Not all the hospitals violating the act actually dumped patients; some violations were administrative in nature, such as omitting documentation or failing to post signs spelling out patients' rights. The report lists the name of each hospital,

the nature of the violation, and any fines assessed against the hospital. Of the 500 hospitals that had confirmed violations in 1997, 1998, 1999, and were eligible to be fined, only 85 (17%) had been fined as of April 2001.

Highlights of violations

According to records reviewed by Public Citizen, hospitals in 46 states, as well as the District of Columbia and Puerto Rico, were cited for violations. States with no confirmed violations were Delaware, Hawaii, New Mexico, and Wyoming. Here are some of the report's key findings:

• For-profit hospitals had a significantly higher rate of violation (1.7 times higher) than not-for-profit hospitals.

• Up to one-third of surveyed emergency room registration staff recently told the U.S. Department of Health and Human Services' Office of Inspector General that patients might be asked for insurance information before a screening is provided or while it is taking place, and 35% said they contact health plans for authorization of screening exams at some point. These actions violate the law if they delay treatment.

• Hospitals are being fined more than in previous years. Civil money penalties increased from $130,000 in fiscal 1988 to more than $1 million in each of 1998, 1999, and 2000. However, most hospitals with confirmed violations are not fined.

Even when a hospital is fined, Wolfe says the amount is paltry.

"The sad truth is that it's cheaper for a hospital to break the law and pay a fine than to treat an uninsured patient," Wolfe says. "Hospitals know that the risk of getting caught is low and, even if they are caught, the risk of being fined is even lower, and the fines are minuscule compared to hospitals' operating budgets."

These are some of the more egregious examples of patient dumping in the report:

• A mentally retarded patient was brought by ambulance to Mercy Hospital in Merced, CA, with symptoms of abdominal distress and shortness of breath. An on-call surgeon repeatedly refused to come to the hospital to treat the patient, who subsequently suffered a cardiac arrhythmia and died despite a resuscitation attempt. Documentation revealed that the surgeon made disparaging remarks about the man's mental retardation, including the statement that "no one would miss him if he died." The man had lived in a board-and-care home for 15 years. As of April 2001, the hospital had not been fined.

• A woman who went to Baptist Hospital in Miami was found to have a large mass in her lower abdomen and an elevated white blood-cell count, indicating she might have an infection. She was admitted for surgery, but before it occurred, the surgeon asked her for a deposit. The woman said she didn't have the money, so the surgeon ordered the patient to be discharged. She left without receiving treatment. As of April 2001, the hospital had not been fined.

• A patient went to the emergency room of Houston Medical Center in Warner Robins, GA, vomiting blood and complaining of a loss of appetite and a swollen and painful stomach. The patient's symptoms indicated blood loss. He was treated with an IV solution, given prescriptions, and discharged. An ambulance returned him to the ER about five hours later, at which point he was in full cardiac arrest and died six minutes later. As of April 2001, the hospital had not been fined.

"The sad truth is that it's cheaper for a hospital to break the law and pay a fine than to treat an uninsured patient."

• Friends of a 15-year-old boy who had been shot in the abdomen dragged him into an alley next to Ravenswood Medical Center in Chicago and asked the hospital emergency room staff for help. The staff refused to go out to treat him or bring him into the hospital. After staff refused requests of police officers that repeatedly asked ER staff to come out and help, a police officer wheeled the boy into the ER in a wheelchair. Despite resuscitation efforts, the boy died. The hospital was fined $40,000.

Wolfe says that while the records reviewed by Public Citizen generally don't reflect the reason a patient was dumped, often it is because the patient was uninsured. The law prohibits emergency room personnel from delaying screening or treatment to ask whether a patient has insurance, but personnel still do. Further, some HMOs require preauthorization for exams or treatment, and some HMOs refuse to pay for emergency room treatment later if the patient is found not to have a condition that constitutes an emergency. This often means the hospital gets stuck with the bill, providing hospitals with an incentive to dump uninsured or poor patients. ■

Hospitals asked to report on efforts

The Leapfrog Group, a national coalition of major employers and public purchasers, is asking U.S. hospitals to voluntarily report whether they have put in place or plan to implement three leaps in the prevention of errors that researchers say can save up to 58,000 lives a year.

The on-line survey on the status of the standards is available to all hospitals but targets nonrural facilities. The three patient-safety standards endorsed by Leapfrog are:

- **Computer physician order entry:** Eliminates medication errors by having doctors in hospitals order tests and prescription drugs by computer instead of hand-written orders.
- **Evidence-based hospital referral:** Encourages patients to go to hospitals with better outcomes and, when outcome results are not available, uses volume of selected procedures where supported by science.
- **Intensive care unit (ICU) physician staffing:** Reduces ICU deaths over 15% by having ICUs staffed by physicians certified in critical-care medicine.

Research conducted by **John D. Birkmeyer**, MD, at Dartmouth Medical School, indicates that these three improvements could save up to 58,300 lives per year, and prevent 522,000 medication errors, if implemented by all nonrural hospitals in the United States. In California alone, that would translates to more than 7,000 lives saved and 63,000 medication errors prevented every year — one life and seven errors every hour.

In the survey, hospitals are asked whether they have implemented the standards or have made any plans to do so. Hospitals will be credited for interim steps toward implementation. Results will be published on the Leapfrog web sites and promoted by many individual Leapfrog purchasers. The Leapfrog Group is a growing consortium of 82 Fortune 500 companies and other large private and public health care purchasers providing benefits to 25 million Americans with more than $45 billion in health care expenditures. To participate in the survey or learn more about the Leapfrog Group, go to www.leapfroggroup.org. ■

HHS clarifies patient privacy protection rules

To calm some fears about the new Department of Health and Human Services patient privacy protections, scheduled to go into effect April 2003, the agency recently issued the first in a planned series of guidance documents. The guidance is intended to clarify the HHS's intent and dispel some criticism that the rules create some unwieldy conflicts in the real world.

The HHS patient privacy protections were issued in December 2000 after Congress failed to enact legislative protections that it required of itself under a self-imposed three-year deadline. That deadline agreement was incorporated into the Health Insurance Portability and Accountability Act of 1996, requiring HHS to propose patient protections via regulation if Congress failed to pass legislative protections by December 1999.

Health care providers' misgivings became apparent when HHS received more than 11,000 separate questions on topics ranging from parental rights to medical research before the guidelines were even released. So when HHS issued the final rule in April, the agency said it would issue a series of guidance documents designed to clarify the rules before the rules take full effect on April 14, 2003. (The rules technically took effect in April 2001, but most covered entities were given until April 2003 to comply with the majority of the provisions.)

An opening step

In releasing the guidance document, HHS Secretary **Tommy Thompson** said it was "an opening step in helping physicians, health care providers, and health plans understand their obligations to patients under the rule." The guidance clarifies that hospitals will not be required under the regulations to build private, soundproof rooms to prevent conversations between doctors and patients from being overheard, he said. The guidance also clarifies that friends and family members still will be allowed to pick up a patient's prescription, as often already occurs, Thompson said.

Those were real-world concerns raised by providers and critics of the new rules. Thompson has previously said that he would propose modifications to ensure that pharmacists can fill a phoned-in prescription for a new patient, even

when the pharmacist does not have the patient's signed consent on file.

However, the clarification may not be enough to stop the criticism. A national physician group recently announced that it is suing the Bush administration's top health official to halt the new medical privacy regulations, calling them unconstitutional. The Association of American Physicians and Surgeons (AAPS) contends the rules would violate patient confidentiality and place burdensome new requirements on physicians.

The action follows a recent complaint filed by the South Carolina Medical Association, which contends that HHS created the patient rules "without any guidance whatsoever from Congress." In a complaint filed in U.S. District Court in Houston, AAPS claims the rules violate the Fourth Amendment by requiring physicians to allow government access to personal records without a warrant. They also illegally authorize the government to create a centralized medical records database containing personal information, says **Kathryn Serkes**, JD, public affairs counsel to the AAPS.

Serkes says forcing patients to surrender information to the federal government constitutes "an illegal search and seizure by the federal government." Doctors can be fined for withholding those records and the federal government can order physicians to refuse treatment to patients who won't consent to government disclosure, she says. AAPS also contends that the rules place on physicians an overwhelming burden for record-keeping, particularly for doctors in small offices.

A full copy of the first HHS guidance document is available on the HHS web site, www.hhs.gov/ocr/hipaa. ■

Doctor says she was fired for blowing whistle

A physician says St. Jude Children's Research Hospital fired her for reporting what she calls billing irregularities to federal authorities.

June Caruso, MD, was a pediatric neuro-oncology fellow at St. Jude in Memphis, TN, until she was fired in 2000. She recently filed a lawsuit alleging that she was fired because she provided information to federal authorities that resulted in an investigation by the Department of Health and Human Services' Office for Human Research Protections (OHRP) and Office of Research Integrity (ORI).

Caruso's main charge was that the hospital billed the government for electroencephalogram tests that were never read, interpreted, or recorded in patients' records. ORI closed its investigation without taking action against the hospital, but both ORI and OHRP are investigating whether Caruso was fired improperly.

OHRP reports that its investigation of St. Jude found problems with the hospital's handling of EEGs performed on research subjects and evidence that children were inappropriately enrolled into a cancer drug study. Caruso's court filings include a July 2001 letter to the hospital from OHRP in which the office outlines deficiencies in St. Jude's EEG procedures, such as five-year delays in entering EEG results into patients' records. OHRP says some EEGs apparently remained unread until they were dictated into the records years after they were conducted. A statement from St. Jude acknowledges some delays in the handling of EEGS, but says better procedures are in place now.

The OHRP letter also states that two children who did not meet eligibility criteria were enrolled in a cancer drug study without the approval of the institutional review board, but notes that the hospital has improved its procedures and investigators were satisfied with the changes. OHRP found no evidence of misreading of MRIs and misuse of radiation therapy for children with cancer.

Caruso's lawsuit seeks $12 million in damages and reinstatement to her position at the hospital. She claims that St. Jude's offered a severance package of $25,000, but insisted that she make no comments about patient care at the hospital. St. Jude's issued a statement denying that Caruso's firing was in retaliation for her report, saying the charge was "completely unwarranted." The hospital also set up their own committee to investigate the charge of retaliation. ■

Nursing home found liable for employee's assault

In one of the first cases brought under a state nursing home residents' rights law, a New Jersey elder care facility was found liable for an employee's sexual assault on a 70-year-old woman.

Ocean County Superior Court Judge **Frank A. Buczynski** recently held that Kensington Manor Care Center of Toms River violated the rights of a patient when certified nurse assistant Edward Argueta assaulted her. The patient also contends that a similar incident had happened two weeks earlier, yet she failed to report it because she felt ashamed.

Could the case be a signal?

The patient's attorney, **Alan M. Darnell**, JD, of the Woodbridge, NJ-based law firm Wilentz, Goldman & Spitzer, says the case could signal that courts are increasingly intolerant of such abuse. Darnell won a summary judgment under the state's Nursing Home Responsibilities and Rights of Residents Act. The court held as a matter of law that Argueta's conduct amounted to a violation of "the right to a safe and decent living environment and considerate and respectful care that recognizes the dignity and individuality of the resident."

Argueta plead guilty to the fourth-degree crime of assault on an institutionalized elderly person. He was sentenced to a noncustodial period of probation, during which he is unable to work as a health care provider in the state of New Jersey. A separate hearing will be conducted to determine damages to be awarded to the victim.

"Nationally, more and more cases have been reported where residents have been subjected to inhumane, humiliating, and painful treatment that deny the basic human rights guaranteed to them by this statute," Darnell says. ■

Use of bar codes urged for all drug packaging

In an effort to increase patient safety in hospitals and health systems across the country, the American Society of Health-System Pharmacists (ASHP) is urging the Food and Drug Administration to require drug manufacturers to print bar codes on all drug packages.

In a letter to Tommy G. Thompson, Secretary of the Department of Health and Human Services, ASHP stressed the immediate need for regulations requiring standardized machine-readable coding on all drug product containers, including single-dose medication packages used in hospitals. ASHP has concluded that manufacturers will not add codes to all medication packages in the foreseeable future without a federal mandate, says **Henri R. Manasse Jr.**, PhD, ScD, ASHP executive vice president and CEO.

"We are talking about the last line of defense against making a dangerous medication error," he says. "This is the same technology that grocery stores use to ensure that the correct price is charged for your soda and pretzels. It's shameful that drug manufacturers are not universally employing bar codes to help protect the safety of patients.

"When hospitals know that standardized bar coding will be required on medication packages, we believe that they will move quickly to have scanners ready at patients' bedsides," Manasse says.

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On the web site, you'll also find links to every *Healthcare Risk Management* story since January 1999, updates on guidelines and regulations, and salary survey information. ■

The benefits of bar-coding technology are well-recognized. The 1999 Institute of Medicine report, *To Err is Human: Building a Safer Health Care System*, notes that bar coding is "an effective remedy" for medication errors when used to make sure the right dose is administered to the right patient.

In addition to improving patient safety, bar coding is said to improve the efficiency of drug product purchasing, storage, and distribution in hospitals, allowing more time for pharmacists to help counsel patients and monitor drug therapy regimens. ■

AHP settles fraud case with government for $7M

In an agreement that will settle false claims allegations, medical equipment and supply company American HomePatient Inc. (AHOM) and its HomePatient Delaware affiliate have agreed to pay the federal government $7 million.

The settlement was recently announced by the Department of Justice. It resolves allegations that the company submitted claims based on inadequate documentation or stemming from illegal patient referrals. **Stuart Schiffer**, JD, acting assistant attorney general for the department's civil division, says the federal government alleged that American HomePatient, based in Brentwood, TN, submitted claims for items and services based on falsified or inadequate documentation. It further alleged that the company billed the government for items and services it provided to patients "when, in fact, patients were referred to AHOM in exchange for illegal remuneration."

The company also overcharged Medicare, Medicaid, and TRICARE from Jan. 1, 1995, through Dec. 31, 1998, according to Schiffer. The case stems from charges brought by whistleblower Kenneth Hollis, a former employee, who will receive $1.17 million as part of the settlement. Hollis filed his suit in 1997 in U.S. District Court in Bowling Green, KY. ■

Healthcare Risk Management's
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Failure to monitor oxygen levels leads to brain damage: $2.7 million settlement in Kansas

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

News: A 63-year-old woman with pneumonia was admitted to a hospital and rendered brain damaged before her discharge. The failure to appropriately monitor the level of oxygen she was to have received resulted in acute respiratory arrest and hypoxia, which ultimately led to brain damage. She now requires 24-hour care and ultimately settled with the hospital for $2.7 million.

Background: The plaintiff / patient was admitted to the hospital with what was believed by the admitting physician to have been a simple case of pneumonia. By the time she was transferred from the emergency department to a noncritical-care bed, her condition had deteriorated. Over the course of the next three hours, it seems that the nurse violated the admitting physician's order to carefully monitor the patient. During this period, the patient nearly went into respiratory arrest and hypoxia due to an inadequate supply of oxygen. As a result of oxygen depravation, the plaintiff suffered permanent brain damage affecting her physical and cognitive abilities. While she can understand general information, she is unable to talk and requires around-the-clock care. In order to keep the patient from being institutionalized, her adult daughter quit working to care of her at home.

The plaintiff brought suit against the hospital, claiming that if the nurse had informed the attending physician of her critical change in condition, she would be healthy and living independently today. The plaintiff also contended that the hospital was woefully understaffed and her condition was not as carefully monitored as ordered by the physician. To illustrate the understaffing point, the plaintiff produced hospital documents and testimony from current and former hospital employees showing that the hospital was purposefully understaffed in order to increase profits. The plaintiff maintained that this purposeful understaffing by design exposed patients to potential injury.

The hospital defendant countered that it was the victim of a nationwide nursing shortage that is affecting all health care facilities. After the motion granting punitive damages was issued by the court, the hospital offered to settle with the patient for $2.7 million contingent upon the plaintiff signing a confidentiality clause. The patient refused to sign the gag order on the grounds that she wanted to convey her story to the media in hopes of pressuring the hospital into taking what the plaintiff believed would be corrective action. Otherwise refusing to settle with the defendant, the hospital conceded and removed the confidentiality clause. The next day, the story was on the front page of the local newspaper and appeared on television.

What this means to you: The national shortage of nurses and allied health professionals has

generally placed tremendous pressures on health facilities. Hospitals and nursing homes are being structured to do more with fewer staff.

However, in light of the shortages, purposefully understaffing appears counter to the otherwise creative means institutions are employing to proactively keep the staff they have and actively recruit others.

"The mere fact that there were hospital documents and testimony from former and current staff related to the purposeful understaffing of the hospital to increase profits did not leave the hospital with much of a believable defense. In fact, in most jurisdictions either the state health department and certainly the Joint Commission on Accreditation of Health Organizations [JCAHO] would be expected to investigate and sanction the hospital if these allegations were proven to be true," notes **Lynda Nemeth**, JD, RN, MS, administrative director of quality and risk management for Norwalk (CT) Hospital.

"The defense used by the hospital that it was 'merely a victim of a nationwide nursing shortage' is also untenable.

"Under JCAHO and most, if not all, state health department regulations, hospitals are required to have a staffing plan which meets the clinical needs of their patients and a contingency plan when they are unable to meet these demands. One option is to close beds or units when the facility cannot be staffed to provide for safe and effective nursing care.

"The facts of this case appear to be relatively clear cut in that the nurse failed to properly monitor the patient. If the nurse was unable to monitor the patient as per the specific physician orders and intervene when the patient was beginning to deteriorate, the nurse had a duty to the patient to report through the chain of command that she needed help. It is not clear in this overview as to whether the nurse attempted to obtain help and was unable to so, or whether the nurse was negligent in not recognizing how compromised this patient was and taking appropriate action," states Nemeth. "Given the facts in this case, the hospital got off easy if they only had to pay the damages, if the allegations were proven, they would most likely have lost JCAHO accreditation and their license to operate as a hospital."

Reference

• *Shirley Keck v. Wesley Medical Center*, Sedwick County (KS) District Court, Case No. 99C2307. ■

A newborn falls: $37,000 verdict

News: A first-time mother-to-be arrived at a hospital in active labor. As she reached the entrance to the labor and delivery area, she gave birth and the newborn fell to the floor. The jury found the hospital negligent and awarded the patient $37,000. The amount was reduced by $1,000 for the comparative negligence of the mother.

Background: When the expectant mother began experiencing signs of active labor, she contacted her midwife-clinician, who advised her to go to the hospital. Just as the pregnant woman reached the entrance to the labor and delivery area, she delivered the child, who dropped to the floor. The claimant contended, and the hospital defendant did not dispute, that the pregnant woman was not given instructions or a map on where to go when she arrived at the hospital. Nor was she given a tour of the labor and delivery area, although she had visited the hospital for many prenatal classes. The court found that there was no evidence that any preparation for the mother's arrival was made and accordingly found the hospital liable for ordinary negligence.

Although the plaintiff's expert testified that the defendant failed to realize that the woman was in the final stage of labor and her delivery was imminent, the court found no evidence that accepted standards of care were violated. As such the court rejected the contention that members of the medical staff were guilty of malpractice. Thus, a decision was entered in favor of the claimant for $37,000, which was reduced to $36,000 for the woman's comparative negligence.

What this means to you: "If the plaintiff did indeed deliver *at* the entrance of the labor and delivery area, it is unclear what a tour of the facility or a map could have done to get the patient to delivery room much sooner," notes **Leilani Kicklighter**, RN, ARM, MBA, DFASHRM, president of the Kicklighter Group in Tamarac, FL.

"Had the mother-to-be, in fact, been given a tour and a map leading to where she was expected to present upon the onset of labor, it seems that in this instance it would not have mattered very much. Whether she had been shown the way to and instructed to go to the emergency department,

admitting, or directly to the maternity area, the patient she made it as far as she was going to go and not knowing where to present seems to have made little difference in the outcome. One can assume she did not enter the hospital through the emergency room, because we know according to COBRA, she would have been examined before transferring to the L&D [labor and delivery]. Obviously, since the patient delivered at the entrance to labor and delivery, how could anyone have been expected to have had the opportunity to examine her to make a determination that she was even in labor? Fortunately, the jury also believed that this lack of directions did not constitute medical malpractice, but if anything untoward or even unexpected occurs in a hospital, some fault will probably be found with the institution, and this case is no exception in that regard.

"It is customer as well as patient service to provide a tour and a map of a hospital when a person is going to have a baby or elective surgery. These are the instances in which you and the patient know that they will be presenting for admission. More specifically, because pregnancy and delivery are not usually states of illness, they are states of well-being and part of the natural evolution of life. Most hospitals deal with mothers / parents to be in an extremely customer-friendly manner. Hopefully, this defendant hospital will take a good look at the customer relations programs aimed at prenatal and labor and delivery patients, and, in particular, see fit to offer all prenatal patients maps and a tour as appropriate," concludes Kicklighter.

Reference

• *Sontania Bell, indiv. and as m/n/g of Ania Bell, inf v. State of New York,* New York County (NY) Supreme Court, Index No. 92843. ■

Infant dies of meconium: $9.6 million Illinois verdict

News: An incarcerated pregnant woman felt that she was in labor and asked that medical care be provided. A couple hours later, she was taken to the jail facility's medical clinic, where she was examined and discharged back to her cell. Almost immediately after her return, she gave birth to a baby girl. Despite the fact that the mother and newborn were immediately transported to the hospital, the infant died two days later of meconium aspiration. The jury awarded the infant's estate $9.6 million.

Background: The 34-year-old woman was arrested and placed in jail. At the time she was 39 weeks pregnant and had delivered her four prior children via cesarean. These facts were shared with prison personnel. Around 10 a.m. on the third day of her incarceration, the woman complained of lower back and abdominal pain. She told the guard that she was certain that she was in labor.

Shortly before 1 p.m., she was transferred to the jail's contracted health care services clinic, where she was seen by an internist. The internist examined the woman and while he found that she was in labor, the medical records showed that she was not dilated at the time of the examination. She remained at the clinic for observation for the next two hours. Then just before the physician's shift ended at 4 p.m., she was discharged and taken back to her cell. Prior to discharge, the internist did not re-examine her.

Fewer than 15 minutes after returning to her cell, she delivered her baby alone. The newborn girl hit her head on the floor during the delivery and aspirated meconium at birth. The mother and newborn were rushed to the hospital. The infant died two days later.

The defense contended there was no breach of the standard of care and that the clinic physician was not required to do a repeat cervical examination prior to sending the mother back to her cell. The defense further alleged that the child's cause of death was not meconium aspiration, as listed on the autopsy, but that death was due to persistent pulmonary hypertension.

The defense experts did concede that more likely than not the woman was in labor and

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Anyone wishing to be considered as a commentator for *Legal Review & Commentary* may contact:

• **Jan Gorrie** at (813) 639-9599 or send an e-mail to: jan@penningtonlawfirm.com. ■

dilated to 4 cm or less at the time she was placed back in her cell.

Prior to trial, the mother dropped her individual claim against the medical clinic and disclaimed her share of any recovery under the wrongful death act, which resulted in the information regarding her prior drug use being barred from introduction at trial. Her arrest when pregnant was for possession of heroin, but all of those charges against her were later dismissed. While the defendants did retain a medical toxicologist who was barred from testifying at trial because he could not state to any degree what role, if any, the mother's drug use played in causing the child's death. Ultimately, the jury awarded the decedent infant's estate $9.6 million; $7.2 million was for the wrongful death claim and $2.4 was for the survivor's pain and suffering.

What this means to you: "While there is no doubt that the $9.6 million verdict is excessive, there is also little doubt that the behavior of the jail's contracted health care services clinic was outrageous!" says **Ellen L. Barton**, JD, CPCU, risk management consultant in Phoenix, MD. The fact that this was the woman's fifth pregnancy with four previous cesareans clearly put the health care services clinic on notice that careful monitoring was certainly merited, needed, and required to be within an acceptable standard of care. It was clearly inappropriate for the internist not to examine the mother prior to discharging her from the clinic especially since the internist found her to 'be in labor before.' And, it was probably also inappropriate for the internist not to call in or at least consult with an obstetrician."

"Although this case involved a contracted health care services clinic, the risk management lessons are equally applicable to a freestanding medical clinic or an emergency room. Protocols and procedures should call for all obstetrical patients — especially those with known histories of previous pregnancies, cesareans, physical impairments, and anything that might indicate potential complications — to be monitored and examined at regular intervals in accordance with approved protocol specifications and most surely prior to discharge. Furthermore, protocols should specify when an obstetrician should be consulted and / or called in to evaluate the patient. Just as labor can arrest, so can labor progress, and it is the responsibility of medical professionals to assess a patient's status so that appropriate care can be rendered," adds Barton.

"In assessing whether or not to defend a claim, the pros and cons of your case must be carefully assessed. Clearly, the health care services clinic fell below the standard of care. However, this should be weighed against a potentially unsympathetic plaintiff given her history of drug abuse. However, the defense had obtained an inadequate expert along with the plaintiff counsel's procedural maneuvering prevented the jury from hearing much of the damaging information against the mother. Accordingly, all the jury found out was that the pregnant woman was arrested and incarcerated, but that all charges were dropped. Unfortunately, medical malpractice defense attorneys, just as physicians and providers who allegedly commit malpractice, are often judged in hindsight; and so it appears that the clinic would have done well to have hired the 'right' defense attorneys or not to have litigated this case at all, especially since even the defense experts conceded that it was likely the patient was dilated prior to being discharged — a fact that should have been shared with defense counsel prior to litigation. It is likely that if this case had been negotiated privately the patient's prior drug use might have been used effectively to reduce the settlement to a more reasonable amount," concludes Barton.

Reference

• *The Estate of Joyce Hughes, deceased minor v. County of Cook, d/b/a Cermark Health Services,* Cook County (IL) Circuit Court, Case No. 97L-12473. ■

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When the waters of the Ohio River started rising in Louisville, KY, in March 1997, **Janet Connell**, CMPE, practice administrator of Nephrology Associates of Kentuckiana knew there was a potential problem in the office. "We had had water coming through the sewers into the basement in the past from heavy rain," she says. "We weren't worried about floating away down the river, but it can be a real mess."

Connell and her office staff took precautions, learning from past mistakes that boxes shouldn't be kept on the floor. While she avoided part of the mess, however, Connell forgot one thing: The telephone connections were on the floor. "We lost our phones," she recalls.

It could have been much worse. Connell developed a plan when she joined Nephrology Associates. "I came from a practice that had a fire during the day when we were seeing patients," she says. While her old practice was prepared, the one next door was not and left patients in examination rooms during the evacuation procedure. "I knew the importance of having a plan and made sure that the staff did, too."

Roseann Gilchrist, practice administrator at Orthopedic Consultants Medical Group in Encino, CA, also benefited from good disaster planning. A year before the Jan. 17, 1994 earthquake in Northridge, her practice put together a safety committee in order to prepare a disaster plan. Although the practice is in a 12-story building constructed in 1980 according to strict earthquake guidelines, Gilchrist had no idea how it would fare until the quake hit.

Gilchrist's practice was fortunate. Aside from the inconvenience of disruption in phone service, which the practice handled by forwarding the phones to a physician's home telephone, nothing was severely damaged at the office. Within 48 hours of the quake, the practice reopened, rescheduling patients who missed their previous appointments.

But there were valuable lessons. Now, there are dedicated phone lines that are not part of the office switchboard that will allow both patients and staff to call in for information on the operational status of the facility. A message can be left on the lines or call forwarding implemented from an off-site location.

A disaster plan is only as good as its team, according to **Sheila Campbell**, financial counselor at Cardiology Consultants in Pensacola, FL. When she started working on a disaster plan in 1995, she involved staff from every department and from each of the three Florida offices. Included on her team were the following people:

- nurse practitioner;
- several nurses;
- medical assistant;
- medical records employee;
- billing representative;
- social worker;
- the assistant to the CEO.

"You have to have people on your committee from each part of the practice," Campbell advises. "No one person can think of everything for every function in your office."

As team leader, she wanted each member to research a specific area — for example, communications needs during an emergency. Once completed, several meetings were held to discuss and

revise the plan. The final version was then sent to the policy and procedure committee for discussion and on to the CEO for approval.

Gilchrist's safety committee also used people from each area of the practice — the medical staff, physical therapy, administration, and nursing. Each team member assessed his or her department's needs, responsibilities, and concerns during various emergency situations, she says. For example, the employee working in the back office at Gilchrist's office is responsible for patient evacuation. Physical therapy, which has some whirlpool facilities, has to turn off the water. The front office staff are responsible for the computers and other business equipment.

Once you have developed a draft plan, don't wait for a real emergency; test it regularly, Connell emphasizes. She holds regular unannounced monthly drills with staff, including physicians. They always happen while patients are being seen, however. While they don't have to leave the building, everyone is required to sign out at the door. The next day, the performance is discussed.

Most big office buildings have regular fire drills, and Gilchrist recommends full participation. Don't let staff get away with staying in the building and continuing to work, she says. She also schedules biannual drills herself, but warns doctors and patients ahead of time and allows patients to reschedule appointments if they want. After the drill, staff who don't perform as they should are written up, she says. Even physicians have had notes put in their files about poor disaster drill performances.

By discussing performance after a drill, you can make sure that the preparedness plan is a "living" document and not something filed away in a desk drawer. Campbell puts her plan in red folders and instructs staff to take them home. Prior to a drill, they are told one is coming up but not exactly when it will occur; she suggests that people go over their plans.

The drills at Cardiology Consultants primarily is a test of a phone tree system, she explains. The next day, when everyone is talking about the drill, there are usually people who were unaware it happened. "We try to figure out where the breakdown was and why they didn't get a message," Campbell says.

You can also learn from actual disaster experiences. For example, Hurricane Erin hit in August 1995, just after Campbell finished her plan. "We didn't do very well. Some people didn't get their phone calls," she recalls. But when Opal struck just weeks later, the plan worked much better. The communications went smooth, and everyone completed his or her tasks, she says. ■

Sources for help in creating a plan

Most people who create disaster plans for their practices go it alone. But there is help out there in developing plans. **Roseann Gilchrist**, practice administrator at Orthopedic Consultants Medical Group in Encino, CA, says she went to the California Occupational Safety and Health Administration in Sacramento with her draft plan. Other sources include:

- **Local fire or police department.** Fire or police personnel can often provide vital information, says **Sheila Campbell**, financial counselor at Cardiology Consultants in Pensacola, FL. For instance, her safety officer told Campbell that she should provide fire and police departments with up-to-date architectural plans of the building. Those can be loaded into a computer at the fire and police departments and assist fire fighters, search and rescue efforts, or attempts to secure a building that is under threat from an armed person, she says.
- **Local hospitals.** Campbell also used her local hospital emergency response committee in plan development. "They are almost always willing to share information with you," she says.
- **Specialty books, videos, and magazines.** Gilchrist says she made great use of Heaton Publications in Albertville, AL, which has a book, *OSHA Hazard Communication Plan Policy and Procedure Manual with CD*. The cost is $129 plus $5 shipping, and can be ordered by calling (800) 221-2469; web: www.medpass.com.Campbell says the Weather Channel offers videos on disasters that she uses as part of employee orientation. A list of videos and the order form are available by calling (800) 250-5985, ext. 20. She also subscribes to *Disaster Recovery Journal*, a publication which sponsors seminars twice a year on disaster preparedness.

  For more information, call (314) 894-0276; web: www.drj.com.
- **Liability insurance carriers.** Your insurance company also may have resources you can use, or it could ascertain whether your plan meets minimum requirements, Gilchrist says. ■