AMERICAN HEALTH CONSULTANTS

On-line: www.hrmnewsletter.com

Healthcare Risk Management™

Celebrating our 24th year as your best source of risk management information

24th year

## INSIDE



**APRIL 2002**

**VOL. 24, NO. 4 (pages 37-48)**

# A new era in liability means keeping criminal charges against docs at bay

*Trend continuing, but aggressive education efforts may reduce risk*

**Special Report: Criminal Charges in Health Care**

Not too many years ago, the worst thing a risk manager feared was a case of medical malpractice that could cost the health care provider millions of dollars. These days, the nightmare scenario involves the local prosecutor deciding that your doctor or nurse committed murder on the premises.

And oddly enough, exactly the same set of facts could lead to either scenario. The health care profession has been rocked in recent years by criminal charges against providers for situations that only recently might have been handled with a civil lawsuit or possibly an investigation by regulatory bodies. Some observers say the problem is overzealous local prosecutors who don't understand the practice of medicine and are more interested in making a name for themselves, while others say the cases represent legitimate responses by law enforcement.

Either way, the risk is significant for risk managers, says **Jane M. Orient**, MD, executive director of the Association of American Physicians and Surgeons in Tucson, AZ. Her group has been monitoring and protesting criminal charges against health care providers, and she says the past several years have seen a trend in which prosecutors consider criminal charges for cases they previously would have left for the medical community and the civil courts to sort out. In almost all cases, she says, the criminal charges are not justified.

"Doctors are the new scapegoats," she says. "I haven't seen any legitimacy to these cases except when the doctor clearly had the intent to hurt or murder people, and those cases are very rare. In most of these cases, you might argue that the doctor had a lapse in judgment or could have done better, but that's a far cry from the crime of intentionally trying to hurt someone."

One of the most disturbing parts of the criminal charges trend is the fact that even good care can land a health care provider in the pokey. Orient points out that some of the criminal charges arise from cases in which the

## Visit *HRM*, *ED Legal Letter* site

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

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* 2001 salary survey also is available in its entirety.

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. ■

provider clearly committed a medical error, though rarely with such gross neglect that criminal charges would be appropriate. Others result from situations in which someone alleges a medical error but the facts are debatable, and still others stem from care that most medical professionals would agree was proper.

Your local prosecutor, however, is not a medical professional. And that's where much of the problem comes from, Orient says. In some cases, the prosecutor hears of a death at a hospital because some particular allegation is unusual. Perhaps someone reports that the patient received a "large" dose of morphine shortly before death, or the death was "caused by a mistake." The prosecutor's interest is piqued, and without an adequate understanding of medicine and the health care community, the allegations take on more significance than they may deserve.

This is where risk managers may have some ability to defuse the situation. By stepping in at the right time, you might be able to explain that the morphine dose was large because the patient had terminal cancer and that it had nothing to do with the death. Or that there was indeed a "mistake" prior to death but that it did not cause the death. **(See p. 43 for more on how risk managers can ward off criminal charges.)**

Though criminal charges can devastate the individual health care providers, some risk managers may question how much they should be involved. After all, criminal charges are way beyond the control of a risk manager, right? Not really, says **Grena Porto**, RN, ARM, DFASHRM, senior director of clinical operations at VHA Inc. in Berwyn, PA, and past president of the American Society for Healthcare Risk Management. Porto has been disturbed by the recent trend toward criminal charges and she cautions that risk managers must get involved.

"If you have an employee engaged in criminal conduct, it creates a huge liability risk for the organization with D&O [directors & officers] exposure and other liabilities," she says. "And even when someone is only charged with a crime, you can't underestimate the damage to your organization's reputation. The media latch on to these stories — they just love them — and every time they report on it, they'll be standing in front of your hospital with your big sign behind the reporter."

### *Nurses and physicians at risk of prosecution*

Though most criminal cases seem to involve doctors, they aren't the only medical professionals at risk. In a Colorado case that highlighted the risk to nurses, a Denver prosecutor went after three nurses responsible for a medication error that caused the death of an infant. Miguel Sanchez was a healthy baby, born on Oct. 15, 1996, at St. Anthony North Hospital in Denver. But because his mother had a history of syphilis, a neonatologist prescribed a long-acting form of penicillin to ward off the infection. A series of mistakes led to the baby's death and the subsequent prosecution of three nurses on criminal charges, says **Pat McCadden**, RN, director of risk management at the hospital.

A pharmacist misread the prescription and filled it for 10 times the proper dose, which got

### *COMING IN FUTURE MONTHS*

- Disclosing another doctor's mistake
- Are risk managers becoming obsolete?
- Waterborne pathogens a new risk for hospitals
- Screening out the employees who will make errors
- Keeping legal bills to a minimum

## Audio conferences target disasters, medical disclosure

Have you missed one of American Health Consultants' (AHC) recent audio conferences? If so, two upcoming conference replays offer another opportunity to take advantage of excellent continuing education opportunities for your entire facility.

• **Disaster Response at Ground Zero: How NYU Downtown Hospital Handled Mass Casualties With All Systems Down**, originally held on Jan. 10, takes participants to the heart of the World Trade Center disaster on Sept. 11. Just a few blocks away from the crash site, NYU Downtown was cut off from crucial lifesaving supplies and power, even as hundreds of injured came through the emergency department doors. HazMat teams on the roof of the hospital had to vacuum all of the debris out of air ducts to maintain air quality and keep generators running. Physicians and nurses had to balance urgent care with proper documentation. Learn how to prepare your facility for the unthinkable. The replay will be available from 8:30 a.m. on Tuesday, April 16, to 5:30 p.m. on Wednesday, April 17. Current AHC subscribers pay $249, which includes free CME and CE credit. The cost is $299 for nonsubscribers.

On April 23 and 24, **What to Say When Something Goes Wrong: Do the Right Thing When Trouble Strikes** also will be available for replay. This successful audio conference covers the major fear factors clinicians experience when confronting issues of medical disclosure. Learn benefits for patient and provider, as well as the risks of litigation and how to avoid costly legal battles. Free CE for your entire facility is included in the $249 fee for AHC subscribers.

To register for either one of these replays, contact American Health Consultants' customer service department at (800) 688-2421 or customerservice @ahcpub.com. ■

the nurses' attention when they prepared to administer the medication. Knowing the dosage was too high for the typical penicillin injection, one nurse consulted with a neonatal nurse practitioner. Together they surmised that the medicine was a newer generation of drugs that are administered differently. In reality, the baby's medication was intended for injection in the thigh muscle.

Confused by the dosage error, the nurses worried that such a large injection in the thigh would be especially painful for the infant. The appearance of the medication further confused the nurses because it was milky in appearance, and usually only clear liquids are administered in the veins. But some new opaque suspension drugs had recently been approved for intravenous use. The nurses checked two medical texts to see if the drug could be given intravenously, found no warnings against it, and decided to inject the penicillin into the baby's arm. They did, and the infant died from a heart attack one hour later. Though McCadden says the nurses were experienced and qualified, she concedes that they were wrong to proceed without clarifying the order with the physician.

The Colorado Board of Nursing suspended the nurse practitioner and placed the nurse who administered the injection on probation. The board dismissed charges against a third nurse, who was the infant's primary nurse.

The situation got even worse when the county district attorney decided the nurses should be charged with a crime. He submitted the case to a grand jury, which indicted all three nurses for criminally negligent homicide. Colorado state law defines criminal negligence as "a gross deviation from the standard of care that a reasonable person would exercise" and when that person "fails to perceive a substantial and unjustifiable risk that a result will occur or that a circumstance exists."

After much strife, the two nurses who were censured by the state board accepted a plea arrangement that keeps their records clear of the negligent homicide charges if they stay out of legal trouble for two years. The other nurse refused the plea arrangement and went to trial, where a jury acquitted her after 90 minutes of deliberation.

**Robert Grant**, JD, the district attorney, wrote an open letter to the nursing community before the case went to trial, in which he offered what he apparently intended as reassurance. "Nurses do not need to fear being prosecuted for simple mistakes," he wrote. "However, if their care falls to the level of criminal negligence, such as when a doctor's orders regarding the route of administration are knowingly changed without authorization, leading to deadly consequences, they cannot expect to be immune from responsibility."

McCadden was risk manager for the hospital at the time of the error and when the nurses were charged. She tells *Hospital Risk Management* that the experience opened her eyes to how capricious the law enforcement system can be, leaving her discouraged about what could have

been done better.

"If an error is made and death results, there could be a criminal investigation. That's the simple fact I learned," she says. "It just depends on the political atmosphere, your investigators, the district attorney, and their own hidden agendas. If they're overzealous and trying to make a name for themselves, they may play this situation to the hilt."

McCadden notes that criminal charges often arise when, because of some quirk or coincidence, law enforcement authorities get wind of a medical situation that typically would just be handled within the medical community or civil courts. At her hospital, a nurse on duty the night of the baby's death heard of the unusual incident and mentioned it to a relative in law enforcement. That person felt obligated to report the sketchy details to a superior, and pretty soon the ball was rolling.

Most risk managers will find themselves in a bewildering new world when criminal charges are filed, McCadden says. You must involve a criminal defense attorney as soon the local prosecutor shows any interest in investigating the case, she says. And your usual counsel may not be the right person if he or she does not have criminal defense experience. To some extent, you must hand the case over to more qualified hands once criminal charges are a possibility, but McCadden says the risk manager still will have a significant role to play.

"My involvement was in providing them the policies that applied and explaining to them how certain procedures worked, what safeguards we had in place," she explains. "I had to testify at the grand jury and in the criminal trial. We had three criminal attorneys, and it was my job to coordinate all of them. And of course we had the civil side of this going at the same time, so that was my job. And I also had to keep the administration and the board of trustees aware of everything."

In the Colorado case, McCadden's hospital had to first decide whether to defend the three nurses against the criminal charges. Typically, criminal charges are not covered under any malpractice insurance, and the employer is not obligated to provide any legal assistance. But McCadden says the hospital administration studied the issue and decided that the nurses had made a medical error and were not guilty of a crime, so it decided to pay for their legal defense. She says the hospital would not necessarily pay for the legal defense of an employee if it seemed the criminal charges were justified.

The trial experience also opened McCadden's eyes to a possibility she had never encountered with a civil malpractice case.

"One thing I learned that scared the hell out of me more than anything was that the quality peer review is not protected in a criminal case," she says. "So if you do a root-cause analysis or something like that, you would have to turn that over in a criminal case. In our case, they didn't know about it, so they didn't ask. They didn't ask, and we didn't tell." ■

## Pain management cases show the risk of opiates

An ongoing case highlights one of the worst fears of physicians — that they will be prosecuted for using narcotic pain medications with seriously ill patients.

In Utah, Robert Weitzel, MD, a board-certified psychiatrist, was taking care of geriatric psychiatric patients at Davis Hospital Layton, UT, in the winter of 1995-96 when several demented and highly agitated patients were admitted. The average age of the patients was 86, and many were seriously medically ill, with such problems as gastrointestinal bleeding, sepsis, cardiovascular disease, severe osteoarthritis, renal failure, and pneumonia. The families of four of the mentally incompetent patients were advised of the dire situation and requested withdrawal of medical interventions, while asking that the patients be kept comfortable.

**Special Report: Criminal Charges in Health Care**

Almost all previous treatments were stopped for those patients and were instead given moderate doses of opiates on Weitzel's orders, and nursing comfort care. None of the patients died immediately after receiving the opiates, but the four patients died soon after from their medical conditions, and another 91-year-old patient died soon after admission. She had been given morphine for evident severe pain. The five patient deaths grabbed the attention of the county prosecutor, who charged Weitzel with five counts of first-degree murder. The prosecutor argued that the patients did not need opiates for pain relief, despite evidence to the contrary, and that Weitzel knowingly and intentionally hastened their deaths with the medication. **(See p. 41 for**

**excerpts from a patient record.)**

Weitzel contended that he merely provided the necessary pain management for patients under his care, and that the opiates did not hasten their deaths. A jury convicted Weitzel of lesser charges of manslaughter and negligent homicide and sentenced him to up to 15 years in prison. After the conviction, it was discovered that an opiates and pain medication expert told the district attorney not to prosecute because no crime had been committed. The prosecution did not tell the defense of that recommendation, which resulted in a motion for a new trial.

After six months and a day in prison, Weitzel was released. He still is fighting attempts by the state to retry the case. Stripped of his medical license, he now waits tables at a restaurant.

Pain management is an area where many physicians feel they are on thin ice. Prescribe too liberally and be charged with murder or be investigated for drug trafficking. Prescribe too little and be charged with elder abuse or sued for malpractice. Too often, physicians react by being too cautious. **David E. Joranson**, MSSW, senior scientist and director of the Pain & Policy Studies Group and the Comprehensive Cancer Center at the University of Wisconsin in Madison has studied the problem and says there clearly is a chilling effect from cases that get the public's attention.

Physicians, nurses, and pharmacists often withhold opioids to avoid scrutiny for overprescribing, he says. Other organizations also have noted the problem, with the American Pain Society and the American Society of Addiction Medicine recently urging more attention to clinicians who play it safe by not providing pain medicines. They both caution that patients may unnecessarily suffer when health care providers are skittish about using opioid pain medications, and underprescribing can bring on the wrath of Joint Commission on Accreditation of Healthcare Organizations regulators and plaintiffs' attorneys now that the standard of care is clear.

Joranson says criminal prosecutions or investigations by drug enforcement authorities affect a small number of health care providers, but the risk is still significant. State medical boards have improved their education about pain management, he says, and many states that have new and progressive regulations or guidelines that specifically recognize the use of opiates in the treatment of pain. Many pain management-related investigations and prosecutions of physicians from past years would not be likely to happen today, he says.

Risk managers must watch out for physicians who respond with so much caution that they underprescribe pain medications, Joranson says. Aside from the tragedy of patients needlessly suffering, there now is substantial precedent for civil cases against the provider. A California doctor recently was ordered to pay a former patient's family $1.5 million because he failed to adequately treat the dying man's pain. Hospital records proved that the man was in terrible pain and that the doctor failed to provide adequate medication.

Wing Chin, MD, treated the 85-year-old man at Eden Medical Center in Northern California as he was dying of lung cancer. The hospital staff assessed and charted the man's pain level as required by the Joint Commission, and those records showed that he always reported that the pain was 7 to 10 on a 1-10 scale, with 10 being the "worst imaginable" pain. Chin did not provide adequate pain relief, and the family sued both the hospital and the physician. The hospital settled out of court for an undisclosed sum of money. The jury awarded $1.5 million, but the judge was expected to reduce the sum to $250,000 in compliance with state caps on jury awards. ■

## Patient's records show pain, need for opiates

The medical record of 91-year-old Ellen Anderson, a patient who died while under the care of Robert Weitzel, MD, shows that she was in considerable pain despite contrary arguments from law enforcement officials.

When Weitzel was charged with murder, prosecutors argued that the patient had no conditions that would cause substantial pain, and therefore the morphine prescription was unnecessary and administered for the purpose of hastening her death.

**Special Report: Criminal Charges in Health Care**

According to a synopsis of the patient's records provided by Weitzel's defense team, Anderson had appeared extremely anxious and was constantly screaming for the months preceding her death. She had severe osteoporosis, with a hip fracture six months prior to admission, and history of ankle and wrist fractures, as well as spinal compression

fractures. At the nursing home, she received an occasional Lortab, but mostly Tylenol for pain.

On admission, the patient was continued on her usual medications, and trazodone was ordered for sleep. However, she took no oral medications during the hospitalization, refusing all those given. Here is an excerpt from the patient's chart:

At 7:30 p.m., three hours after her admission, the charge nurse called and got a telephone order for morphine 10 mg intramuscularly (IM), citing what appeared to her to be the patient's "severe pain [patient becomes rigid and screams when touched] related to profound osteoporosis." The patient did well for the next four hours — "was calmer . . . after morphine . . . very needy," indicating normal pharmacodynamics for her age. At 3:30 a.m., about 11 hours after admission, a different nurse called the physician to report the patient was "moaning and screaming"; the nurse said the patient was in severe pain, and another morphine 10 mg IM was given; the patient then "appeared to sleep."

At 8:55 a.m., she was found with no respirations and no heart rate. Death was ascribed to probable myocardial infarction, and acute pneumonia was seen as contributory, with the benefit of the later autopsy results. ■

## Criminal cases undermine efforts to improve safety

Every time a health care provider hears about another one being dragged off to jail for making a medical error, the risk management community's efforts to improve the culture of safety loses ground, says **Grena Porto**, RN, ARM, DFASHRM, senior director of clinical operations at VHA Inc. in Berwyn, PA, and past president of the American Society for Healthcare Risk Management.

**Special Report: Criminal Charges in Health Care**

"I go around preaching full disclosure and admitting your mistakes in a nonpunitive environment, but people tell me we've got all these bureaucrats out there trying to throw people in prison for making mistakes," she says. "You know, it's a great point and not one for which I have an answer. Clearly, the prosecutors are not on the same page as the rest of us."

Porto notes that risk managers have tried for years to improve patient safety by instituting systems in which health care providers can report their own mistakes without fear of heavy-handed retribution. That message has always been a hard sell, and to a large extent, people have to just trust you and see over time that people are not punished unfairly for reporting their mistakes. Slowly but surely, the message has been getting across.

"And then the local prosecutor comes in and arrests somebody in the hospital," Porto says. "That just paralyzes people. When you're talking about actually charging someone with murder with putting them in prison, you're talking about people's very survival. That terrifies them and they decide they're better off hoping nobody ever discovers the mistake." ■

## Compliance, peer review are your best defense

It is true that some professionals who monitor criminal charges are extremely discouraged to the point of sounding like they've lost all hope. When asked what risk managers can do to help physicians avoid criminal charges, **Jane M. Orient**, MD, an internist and executive director of the Association of American Physicians and Surgeons, says, "Advise the doctor to open a pet store, or learn carpentry. It's very difficult when they think they're following all the rules, and it just takes one overzealous prosecutor who's willing to distort the truth."

**Special Report: Criminal Charges in Health Care**

But others insist that risk managers can make a real difference. **Harvey Tettlebaum**, JD, is an attorney with Husch & Eppenberger in Jefferson City, MO, and has represented health care clients fighting criminal charges. He says risk managers can significantly influence whether criminal charges are brought and the outcome of any criminal investigation. One of the best strategies is something you probably already have working: a corporate compliance program.

Some medical malpractice cases lead to criminal charges of false claims because the government takes the position that a certain standard of care is expected before a Medicare payment is rendered. By submitting a request for payment,

the provider is certifying that it met those minimum standards of care. A corporate compliance program can show a good-faith effort to meet those standards and to avoid false claims.

Tettlebaum points another way the compliance program can help. Most criminal charges require proof that you intended to harm the victim or were recklessly negligent. That's a difficult burden of proof for criminal prosecutors in a health care case, so they often will try to show a pattern of gross negligence or reckless disregard for the quality of care provided.

"If certain operations in your hospital end up killing a patient several times in a row, or if you have a particular doctor whose care should raise some red flags when you look at the outcomes, the prosecutor may feel that rises to reckless disregard and prosecute," Tettlebaum says. "But a good corporate compliance program can demonstrate a culture of good faith, and that goes far to negate the charge of intent. If the prosecutor doesn't think he can show the intent, he won't bring the case."

The compliance program doesn't even have to prevent every act of negligence or medical error; it only needs to be sufficiently diligent to show that the organization cared and was trying to spot any problems or negative trends as soon as possible. Quality improvement and peer review programs can yield the same evidence.

"The worst thing is if the prosecutor can come in as a stranger to the medical world, and point out a trend or a series of errors that you should have found on your own," he says.

Tettlebaum cautions that hospital risk managers carry a particularly heavy burden because they work with so many other provider groups, such as physician groups, clinics, and long-term care facilities. Your association with each of them means you could be drawn into a criminal investigation if the accused person provided the care on your property or somehow under your management. That means you should check with each one to make sure he or she has good corporate compliance and peer review programs in place. ■

## Six strategies to reduce your risk of charges

Criminal charges and the effect they have on risk management efforts can be extremely discouraging for the risk manager. But all is not lost. There are some strategies you can employ to reduce the chance of such charges being brought, and to lessen their impact if they are. Here are some recommendations from the trenches:

**1. Confront the fears in your organization.**

While the risk of criminal prosecution is real, the actual number of charges filed against health care workers is not huge. The fear engendered by the cases that make the news is sometimes the worst result because it makes health care providers scared to admit mistakes and scared to administer legitimate, necessary pain relief.

**Special Report: Criminal Charges in Health Care**

One strategy can be particularly helpful in addressing the fears of your health care providers about prosecution or investigation. Risk managers can put together an inservice to address the fears head on. Explicitly tell them that few doctors and nurses are charged with criminal violations and that most charges result from unusual circumstances. Don't deny the risk, but try to put it in perspective.

And the inservices should not be just for doctors; they must be multidisciplinary, says **David E. Joranson**, MSSW, senior scientist and director of the Pain & Policy Studies Group and the Comprehensive Cancer Center at the University of Wisconsin in Madison. Doctors often get the attention when it comes to criminalization of medical errors, but Joranson says nurses are equally susceptible to the fears and misconceptions.

"In some cases, we see situations where nurses may not fully implement the prescriptions written by a physician, or they will withhold medication because they don't think the patient needs it," he says. "The doctor may write the prescription, but the nurse often controls what actually happens to the patient."

Joranson says you also should include pharmacists, because his research shows that they sometimes refuse to fill prescriptions, and some refuse to stock certain medications that might draw the attention of prosecutors or drug enforcement agencies.

**2. Make friends with your local district attorney.**

The local district attorney will be the person who ultimately decides whether to bring criminal charges in a questionable situation. Now is the time to get to know him or her, suggests **Grena Porto**, RN, ARM, DFASHRM, senior director of

clinical operations at VHA Inc. in Berwyn, PA, and past president of the American Society for Healthcare Risk Management.

In too many cases, criminal charges are filed just because the prosecutor doesn't understand what actually happened in the hospital or how some medical systems work. He or she sometimes doesn't know that the health care organization will thoroughly investigate problems and take corrective action, so he or she thinks a criminal case is the only way to make sure the mistake is not repeated.

"You can contact your district attorney and invite him or her to visit your organization and become familiar with your risk management program," Porto says. "Make it a very cooperative thing, with both of you offering and learning. They can learn more about what happens in your organization, so it's not a mystery if they start hearing allegations; and you can learn more about how their office operates and what their concerns are. You'll both feel better the next day."

Porto advises making the encounter friendly and cooperative. It's probably best not to say you're scared of criminal charges, but you can admit that with a big, complicated institution like your health care system, there will be situations that sometimes need the district attorney's attention. And as one of the hospital's liaisons with the legal community, you'd like to get to know the local prosecutor.

As part of the give-and-take, you can explain how your department oversees error investigations and the various systems you have in place to improve quality. And remember that the district attorney will warm up to you more if you can offer something to show you're not an adversary. Ask if there is any way that you or your hospital might help with some of his or her pet projects. The answer might be no, but you scored points just by asking.

The key, Porto says, is to do this *now*, before any problems arise. Any previous personal experience with the district attorney, even just a lunch, might make him or her look at an allegation differently when it arises. You want the district attorney to pick up the phone and ask you, "What's this I hear about a morphine overdose?" so you can explain the situation, instead of having him or her launch a criminal investigation.

**3. Get cozy with the local media, too.**

For many of the same reasons, you should woo the local newspaper, television, and radio reporters, Porto says. Help them understand how medical errors or other problems are handled within the health care system, all the while putting a positive spin on how much your organization is working to improve the quality of care.

"Invite them in, either in a group or one at a time, to see more of how your department operates," she says. "Acknowledge that your department is the one that handles a lot of the stories they'll be interested in, so you want to get to know them up front. Help them understand before the allegations start flying and people start making assumptions about what happened and what people's motivations were."

As with the district attorney, you have to get to know the media before anything happens.

"By then, it's very hard to get their attention and explain things to them rationally," she says. "In the midst of a crisis, everything you say sounds defensive, and they're skeptical about your motivations."

## *Changing attitudes*

**4. Consider offering a symposium on criminal charges in health care.**

The law enforcement community and the general public often are way out of step with the latest thinking in risk management, Porto says. They often respond to a medical tragedy, or a perceived tragedy, by demanding punishment, while risk managers want to look at the bigger picture and improve the system that allowed the error to happen.

If you're feeling ambitious, a local symposium on the topic may go a long way toward changing the attitude in the community. Porto suggests contacting a local college or university for help and inviting local prosecutors and law enforcement agencies. The public discussion should reveal some of the discrepancies in the way people respond to criminal allegations, and you should be able to create a better atmosphere, one in which authorities aren't eager to file criminal charges.

And at the very least, the symposium should allow you to meet law enforcement authorities and the media.

**5. Once a criminal investigation is considered, immediately offer your aid.**

You probably will hear that the district attorney is considering criminal charges before they actually are filed. This is your chance, Porto says.

"Go to the prosecutor, in the most cooperative tone possible, and offer to help the situation to help them understand what happened at your

hospital that night and how you're already responding to it internally," she suggests. "Remember that charges are filed sometimes just because they don't truly understand what happened, or what you're going to do about it."

In some cases, this conversation can lay to rest the prosecutor's concerns before they mushroom into something more serious. And of course, this conversation will be much more productive if you already know the prosecutor personally.

There is a limit to how much you can use this technique, of course. You can't divulge critical information, particularly if you think the criminal charges might be warranted. But in cases where you're sure criminal charges are not justified and a simple explanation might put the whole matter to rest, go to the phone immediately. It's a good idea to consult your legal counsel before making this call.

**6. If criminal charges are filed, make sure the defendants are portrayed in the media as real people.**

In a high-profile case involving a medical error or allegations of criminal conduct in a health care facility, the media often describes the victim in great detail and gives only a cursory identification of the health care professionals. That often is because the plaintiff's attorney encourages access to the victim and the defense attorney denies access to the accused.

"Don't let that happen," Porto cautions. "You end up with everyone sympathetic to the victim and seeing the health care workers as just faceless, uncaring employees. That makes it a lot easier to believe that they did these terrible things they're charged with and that they had some evil intent."

Instead, make sure the media get information that allows them to portray the accused as real people, perhaps even allowing the press to do a personal profile. The more the public knows about them personally — that the nurse is the mother of three, struggled through nursing school at night, and cares for her aging mother — the harder it is to believe that she killed a patient on purpose. ■

## Hospital sued by gay man denied access to partner

In what could signal a need for hospitals to revise their longstanding rules about who constitutes "family," a Baltimore hospital is under fire for its refusal to allow a gay man access to his partner during treatment.

Bill Flanigan recently filed suit against the University of Maryland Medical System for "negligence and intentional infliction of emotional distress." The suit arose from a situation in which Flanigan says he was temporarily denied access to his partner of five years, Robert Daniel, during treatment at the medical system's shock trauma center in Baltimore. Daniel was taken to the center on Oct. 16, 2000, for treatment of an AIDS-related complication.

The Lambda Legal Defense and Education Fund is representing Flanigan pro bono and issued a statement explaining the lawsuit. According to the group, Flanigan asked hospital staff if he could see the patient and confer with his doctors soon after his admission to the Shock Trauma Center. The hospital reportedly told him that only family members were allowed to do so, and that "'partners' did not qualify," according to Lambda.

Flanigan explained he had a Durable Power of Attorney for Health Care Decisions and that he and Daniel were registered as domestic partners in California. Still, Flanigan was refused access to Daniel or his doctors and was provided no information on his partner's condition, according to the lawsuit. When Daniel's sister and mother arrived four hours later, they interceded, and Flanigan was allowed access to the patient. But by then Daniel had lapsed into unconsciousness and never awakened.

The University of Maryland Medical Center released a statement explaining that it had not yet been served with a lawsuit, but that it had followed proper procedures in the case. The hospital said: "According to (Maryland) state law, someone who says he is a guardian or has power of attorney for health care must present documentation of those wishes. Otherwise, we rely on family members." ■

## Feds: Almost all nursing homes are understaffed

How's this for a risk management red flag? A recent federal study alleges that nearly every nursing home in the country is understaffed to the point that it cannot provide basic care to patients.

The study was mandated by Congress and presented by the Department of Health and Human Services (HHS). It found that 97% of nursing homes in the country did not provide minimal staffing, which it defined as allowing an average of 2.8 hours a day of care from nurse aides and 1.3 hours a day from licensed staff members. The findings are "strong and compelling evidence" in support of minimum staffing levels at nursing homes, according to the report.

Those minimum-staffing levels may not materialize anytime soon, however. The HHS report suggests that making such levels a federal requirement may cost too much. Instead, the HHS recommended a market-based solution.

In other findings, the report says that 91% of nursing homes do not have enough staff to provide routine care in these areas: dressing/grooming, independence enhancement, exercise, feeding assistance, changing wet clothes and repositioning residents, and providing toileting assistance and repositioning residents.

The solution would not be easy, the HHS says. Implementing minimum thresholds of care would require increasing wages by as much as 7% because the demand for nurses would increase, the study says. Increased staffing levels were not the only suggested solution, however. The report also suggests that non-nursing staff could be put to work during peak hours, such as mealtimes, and better policies on absenteeism might lead to having more nurses on the job on any given day.

As an alternative to mandating staffing levels, the HHS report suggests that the government might make public the staffing levels of nursing homes in hopes that public demand would spur the facilities to improve care.

The nursing home industry acknowledges the staffing problem, though it doesn't necessarily agree with the government's recomendations. **Charles H. Roadman II**, MD, president and CEO of the American Health Care Association, a leader in the nursing home industry, says the HHS study "corroborates the sentiment expressed by America's long-term care community that the nation's Medicare and Medicaid programs for patient care are woefully underfinanced, and the staffing crisis is largely a symptom of the larger problem of chronic underfunding."

The federal concludes that the shortage of nursing personnel is "likely to become worse," and Roadman agrees.

"Yet it should come as no surprise to policy-makers that in order to increase wages and to make front line nursing jobs more competitive, Medicaid can no longer pay just slightly more than $4 per hour, per patient, for shelter, meals, labor costs, special care, certain therapies, and other items," he says. "Costs far outweigh governmental reimbursements for care, chronic underfunding of Medicaid directly impacts staffing, and this fact can no longer be denied." ■

## $10 million in funding for efforts to reduce errors

Health and Human Services (HHS) Secretary Tommy G. Thompson recently announced that President Bush will propose $10 million in funding for an initiative to improve patient safety and reduce medical errors. The increased funding will bring the total HHS budget for improving patient safety to $84 million in fiscal year 2003.

The funds will support efforts to put known safety technologies into wider use, develop new approaches, and support a stronger system for rapid reporting of adverse medical events. Medical errors have been estimated by the Institute of Medicine to cause between 44,000 and 98,000 hospital deaths and cost between $17 billion and $29 billion in excess health care costs in the United States each year.

Under the initiative, HHS' Agency for Healthcare Research and Quality will receive $60 million, an increase of $5 million, for patient safety. A portion of the increased funds will provide "challenge grants" to states to encourage the adoption of proven but underused technologies by health care organizations to reduce medical errors. The new funding also will be used to train on-site patient safety experts to provide technical assistance and support to states to encourage a culture of patient safety. The Food and Drug Administration (FDA) also will receive $5 million in funding for patient safety, bringing their total funding for this issue to $22 million.

The new funds will allow the agency to improve its ability to assess and follow up on reports of adverse events that occur after using FDA-regulated products. Specific initiatives include partnering with the private sector to develop technologies, such as bar coding medications so electronic prescription programs can be widely introduced and diminish the number of medication errors. ■

# Improper payment rates decline in 2001

The Department of Health and Human Services (HHS) recently reported that the rate of improper Medicare payments continued to decline last year. The improper payment rate, which estimates the portion of Medicare fee-for-service payments that do not comply with Medicare laws and regulations, was 6.3% in fiscal year 2001, compared with 6.8% in fiscal year 2000.

This is less than half the 13.8% estimated in 1996, the first year HHS' Office of Inspector General (OIG) calculated the rate. For fiscal year 2001, medical reviewers examined the medical records behind 6,594 claims filed on behalf of 600 beneficiaries nationwide. These were randomly selected by OIG from the total 34 million beneficiaries enrolled in fee-for-service Medicare. About 931 million fee-for-service Medicare claims were filed in 2001. The improper payments fall into these categories:

- **"Medically unnecessary" services** — Usually cases in which medical reviewers determined that the beneficiary's condition did not warrant inpatient hospital care, but did warrant a lower level of care (43.2% of improper payments in 2001);
- **Documentation deficiencies** — Instances where medical records were insufficient to support the claims, or nonexistent (42.9%);
- **Miscoding** — Services found to be coded for a higher level of care than was supported by the medical records (17%).

The claims involve fee-for-service payments to physicians, hospitals, and other health care




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

**Subscriber Information**

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

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




Editor: **Greg Freeman**, (770) 998-8455.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@ahcpub.com).
Production Editor: **Nancy McCreary**.





THOMSON
AMERICAN HEALTH CONSULTANTS

**Editorial Questions**

For questions or comments, call **Greg Freeman**, (770) 998-8455.

providers. The Centers for Medicare & Medicaid Services, which administers the Medicare program, takes steps to recover all improper payments identified by the OIG review — many have already been recovered, the OIG report said.

The improper payment rate does not measure fraud, although some overpayments could be the result of fraud. The audit process does not attempt to determine the exact cause of the error. ■

# Suit: Mandated translation services never offered

Two New York hospitals are facing lawsuits that accuse them of failing to offer non-English-speaking patients translation and interpretation services mandated by federal, state, and city law.

The legal action was recently filed by the New York Lawyers for the Public Interest Inc. on behalf of Make the Road by Walking (MRW), a local non-profit organization advocating for the rights of low-income Latinos and African-Americans.

The suit was filed against Wyckoff Heights Hospital and Woodhull Hospital, both located in Bushwick, a mostly Hispanic section of northern Brooklyn. The plaintiffs claim that the hospitals have effectively denied equal access residents of the surrounding area by not providing health services in Spanish.

**Andrew Friedman**, co-director of MRW, says the lack of translation services at the hospitals are symptomatic of a national problem. He notes that Title VI of the 1964 Civil Rights Act and the New York City Human Rights Law both prohibit discrimination based on race, national origin, or color. Failing to provide adequate translation services is a violation of those laws, according to the lawsuit.

Woodhull Hospital spokesman **Stephen Bohlen** says the hospital provides extensive translation services and other aid to non-English-speaking patients and family members. The hospital has 450,000 clinic visits and 18,000 inpatient visits per year with a very diverse patient population, so Bohlen says it is inevitable that some problems will occur. But the hospital works hard to provide sufficient translation services, he adds.

The hospital has a volunteer translation pool of 625 staff members who collectively speak 50 languages. The staff also has 24-7 access to a telephone service that provides translations for more than 130 languages. ■



# Sign up now to continue receiving bioterrorism news

We hope you have enjoyed receiving complimentary issues of *Bioterrorism Watch* with your subscription to *Healthcare Risk Management*. Your last free issue will be in June.

Beginning in July, *Bioterrorism Watch* will become an eight-page bimonthly subscription newsletter that will offer both CE and CME credits. The six yearly issues combined will offer six hours of CE and CME.

We are offering *Healthcare Risk Management* subscribers a special introductory annual price of $99. Don't miss a single issue of *Bioterrorism Watch*. Call our customer service department today at (800) 688-2421 or visit us on-line at www.ahcpub.com to continue receiving *Bioterrorism Watch* for the low yearly price of $99. ■

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

# Adult meningitis goes undetected, resulting in death: $2.5 million Ohio settlement

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

**News:** After three trips to a hospital emergency department (ED), a 32-year-old woman's meningitis went undetected for days. The lack of timely treatment with antibiotics resulted in her death. The case was confidentially settled during the trial against the hospital for $2.5 million.

**Background:** The otherwise healthy patient was the activities director for the defendant hospital's skilled nursing facility. She initially presented to her employer's ED Sept. 29, complaining of an earache in her left ear and a moderate headache. After being triaged, she was directed to the hospital's ED, which also is a primary care clinic. She was then diagnosed by a family practitioner as having an infection in her left ear. The hospital-employed physician prescribed a customary dosage of the antibiotic Zithromax. She was discharged home and advised to seek further medical attention if her condition worsened.

The patient went home and took the antibiotic as directed. The next day, her condition significantly deteriorated, including a fever, unrelenting pain in her left ear, headache, and chills. She returned to the hospital's ED, was triaged again, then directed to the primary care clinic. While being examined, the patient cried profusely because her pain was so intense. However, despite her new symptoms and significant pain-induced distress, no neck exam was performed, no diagnostic studies were conducted, and her antibiotics were not changed. This time, the employee physician diagnosed her as having a perforated right eardrum in addition to the left ear infection. The patient was simply discharged home with some pain medication in addition to the Zithromax and, again, instructed to return if her pain persisted or condition worsened.

On Oct. 2, just three days after her initial visit, the woman's mother took her back to the hospital because her advanced symptoms precluded her from driving. The patient now complained of a throbbing headache, drowsiness, a very stiff neck, and photophobia, which is abnormal sensitivity to light. On this visit, she was not directed to the clinic but treated in the ED. The ED attending physician initially gave the patient Demerol and Compazine for her pain and mental state. After making a working diagnosis of meningitis, there was at least a two-hour delay in administering vancomycin. However, in addition to the delay in giving her the appropriate drug to treat the serious infection, she only was given 1 g, even though the recommended dose is double that amount. Further, despite the intensity of her headache, the physician did not order a CT scan, but instead performed a lumbar puncture. As a result of the procedure, the patient's brain herniated, and she expired.

The decedent's mother brought suit against the hospital. With regard to the first and second ED visits, the plaintiff contended that while the underlying cause of the ear problems went undetected,

the medications prescribed for the left ear infection and right ear perforation were inappropriate. Specifically, the mother claimed that instead of Zithromax, her daughter should have been given erythromycin.

The first and second ED visits aside, the plaintiff alleged that on the final visit to the hospital, the patient's deteriorating mental status should have been serially monitored, but instead the patient was inappropriately given a dose of Demerol and Compazine. The plaintiff claimed that these drugs masked the actual underlying cause of her daughter's condition because when the patient's mental status further deteriorated over time, it was erroneously attributed to the administration of these sedation-effect drugs and not to meningitis. Further, the plaintiff alleged that her daughter's drowsiness should have alerted the physician to the fact that she might have early signs of increased intracranial pressure, for which there is a significant risk of brain herniation with a lumbar puncture. The plaintiff contended that had the ED physician ordered a CT scan first, it would have been apparent that the decedent had increased intracranial pressure as a partial foundation for her prominent headache pain. However, the ED physician performed a lumbar puncture in the face of this increased intracranial pressure, her brain herniated, and the patient expired.

Finally, the plaintiff argued that the paramount concern for any patient suspected of having bacterial meningitis is the timely administration of an appropriate dose of antibiotics. The decedent was not given her first dose of antibiotics until nearly two hours after initial evaluation, and she was given a suboptimal dose — one that was insufficient to stem the development of further serious and, in this case, life-threatening infection. At trial, even the hospital's expert stated that as soon as the working diagnosis of meningitis was made, combative antibiotics should have been administered within 30 minutes of such diagnosis at appropriate levels to treat the aggressive infection.

The plaintiff averred that the patient had relied on her employer's ED personnel to properly diagnose and treat her; however, they fell below the standard of care in not recognizing the progression of meningitis. The plaintiff claimed that the array and severity of symptoms on the third ED visit should have been timely interpreted as meningitis and treated accordingly. After the plaintiff presented her case at trial, the hospital confidentially settled for $2.5 million.

**What this means to you:** "From the facts provided, the patient's initial visit to the emergency room seems perfectly appropriate, as does the triage to the primary care clinic. However, things go downhill from there. The second visit made 24 hours after the first was the key visit to correctly diagnose and treat the patient," opines **Ellen Barton**, JD, CPCU, a Phoenix, MD-based risk management consultant.

"The second visit is problematic for several reasons and raises several questions. Was the triage to primary care appropriate? When an otherwise healthy 32-year-old returns to the emergency room within 24 hours and her condition is significantly worse, shouldn't a red flag go up? Further, to worsen after 24 hours on antibiotics means that the choice of antibiotics has to be questioned. Finally, when a patient has fever and chills, perhaps an infectious disease specialist should have been called in to explore potential signs of septicemia," she states.

"As for the third and final visit to the emergency room, it is unlikely that the patient could have been saved (without neurological impairment) even if the appropriate dosage of antibiotics had been given immediately upon her arrival at the emergency room. Intravenous antibiotics were needed stat! While the patient was actually seen in the emergency room on this visit as opposed to being directed to the primary care clinic, the medical judgment exercised was problematic and only made a bad situation worse," says Barton.

"While the basis of negligence in this case clearly appears to be poor medical judgment (not once, but twice — the second primary care physician and the emergency room attending physician), there are a couple of things the hospital could have done to create a setting where the likelihood of poor medical judgment being exercised may be decreased:

"1. The hospital's policies and procedures should provide for specific protocols when a patient returns to the emergency room once or multiple times: a) within 24 hours; b) within 48 hours; c) within 72 hours. The red flags should go up, and such patients should be regarded as high risk.

"2. The hospital's triage system should be thoroughly reviewed to be certain that the criteria used to triage are appropriate. In addition, the personnel exercising judgment regarding triage

decisions need to be appropriately qualified to make such judgments. Lastly, there should be very clear criteria regarding the referral to primary care.

"3. While this case is based on physician negligence (albeit hospital employees), a hospital may wish to contract for emergency room medical services and to require that the emergency medicine physicians not only provide their own insurance but also indemnify the hospital for any amounts the hospital might become liable to pay because of the physicians' negligence. (The primary care physician was clearly a hospital employee; however, it is unclear from the facts presented if the emergency room attending physician was also an employee). Although with the focus on the third visit, it appears that he was either a hospital employee or a contracted employee for whom the hospital had undertaken to provide liability coverage," concludes Barton.

### *Reference*


• *John Doe, Administratrix of the Estate of Jane Doe v. ABC Hospital,* Cuyahoga County (OH), Court of Common Pleas. Laurel Matthews of Cleveland for the plaintiff. ■


## Restrained victim dies: Confidential settlements

**News:** An automobile accident victim was taken to a community hospital emergency department (ED). Once it had been determined that the victim sustained a fracture to his neck, the patient was transferred to a trauma center hospital. In the midst of the transfer, information regarding the victim's blood alcohol level was mistakenly transcribed. Following the transfer, the patient became extremely agitated and was restrained. Several days after admission, the patient died, and his family brought suit against the health care providers. The family alleged that the providers' treatment was based on a misdiagnosis related to the blood alcohol test, which led to the patient having been overrestrained and subsequently led to the patient's death from aspiration pneumonia. Several providers, including the trauma center hospital, settled for confidential amounts prior to trial.

**Background:** A 69-year-old man was in an automobile accident. He was taken from the scene of the accident to a community hospital by ambulance. Multiple diagnostic tests were performed, and it was determined that his neck had been broken in the accident. In addition, a blood test revealed that his blood alcohol level was slightly elevated. The attending ED physician decided that it was in the patient's best interest for him to be transferred to a trauma center, where more sophisticated services were available to treat the patient's neck fracture. In the course of arranging for the transfer, the results of the blood test were transcribed into the trauma center's chart as "300" and/or "0.300" with no units attached seemingly due to a miscommunication between the transferring physician and one of the admitting residents at the trauma center.

Once the patient arrived at the trauma center facility, he was fitted with a halo support brace to protect his broken neck. He became extremely agitated and incoherent, attempting to pull the halo brace and IV lines. The attending resident sedated the patient with Ativan and recommended that the patient be restrained to prevent further injury. Then, based on the notation in the chart indicating an elevated blood alcohol level, one of the attending residents on call at the time suspected that the patient might have been suffering from acute alcohol withdrawal and he consulted with a neuropsychiatrist who specialized in the treatment of agitated patients and in particular patients suffering from acute alcohol withdrawal. Because of the severity of the patient's agitation, the neuropsychiatrist agreed with the resident's assessment and included acute alcohol withdrawal in the patient's differential diagnosis and continued with the previous orders for sedation and restraint.

Approximately 24 hours later, the neuropsychiatrist was able to determine that, if alcohol ever played a part in causing this patient's agitation, it was no longer a factor because of the lapse of time and the fact that any alcohol in the patient's blood stream would have completely metabolized. The neuropsychiatrist signed off the patient's care and recommended that the attending physicians pursue a more definitive diagnosis for the patient's extreme agitation. The plaintiff argued that it was not clear from the medical record what the neuropsychiatrist's role was — whether the specialist had signed

off the chart and resigned from the patient's care or, as a consultant, if he had assumed the leading role as the attending physician.

Two days later, the patient died. The cause of death was disputed. The plaintiff claimed that the patient had died from aspiration pneumonia, and that his sedation and restraints had prevented him from being able to clear his throat. The plaintiff also alleged that all of the physicians had misdiagnosed and were, in fact, misguidedly treating the patient as an alcoholic, allowing his pneumonia to go untreated. They further alleged that the hospital nurses failed to monitor the patient closely enough and failed to loosen his restraints as necessary to allow him to breathe. In addition, the plaintiff claimed the nurses further failed to perform or recommend the respiratory therapy needed to allow the patient to clear his chest.

Prior to trial, the trauma center, the attending physician, and medical resident settled at mediation for confidential amounts. The trial proceeded against the only remaining defendant, the neuropsychiatrist, who contended that the inclusion of acute alcohol withdrawal in the patient's differential diagnosis was entirely appropriate, given the patient's severe agitation. Further, the neuropsychiatrist testified that he consciously ignored the "300" blood alcohol recorded level because without any units of measure associated with the number, it was clinically insignificant and indecipherable. Instead, the neuropsychiatrist maintained that the mild sedation and restraints were ordered and were procedurally necessary and mandated to prevent the patient from injuring himself.

Finally, the physician entered pathology slides into evidence that revealed that the patient had died from a heart attack, which was completely unrelated to the pneumonia alleged by the plaintiff. Whether the patient coughed at all during his hospital stay was hotly debated at trial, as coughing is a necessary symptom for the diagnosis of pneumonia. According to the verdict report, the jury found no negligence against any of the defendants except the hospital. However, all damages were predicated on the finding of liability against the neuropsychiatrist; therefore, the plaintiff was awarded nothing at trial.

**What this means to you:** "This case in large part is based on the inexperience and poor medical judgment of the attending resident physician. Although the facts do not indicate the time line from the accident to admission to Hospital No. 1 to admission to the trauma center, it is probable that the time line is anywhere from six to 12 hours. This amount of time is not sufficient for someone to suffer from acute alcohol withdrawal. The focus should have been appropriately working up the differential diagnosis of 'acute delirium,' regardless of the blood alcohol level instead of allowing the blood alcohol level to dictate treatment. Calling in the neuropsychiatrist was not inappropriate; however, when he signed off the case, the resident and attending physicians should have broadened their approach to diagnosis," notes **Ellen Barton**, JD, CPCU, a Phoenix, MD-based risk management consultant.

"In addition, it is important for all medical personnel — particularly those in training — to be sensitive to allowing their judgment to be inappropriately influenced by stereotyping patients as drunks, bums, or other equally negative categories. Formal or informal inservice educational sessions should be held for physicians and nursing personnel on how to deal with difficult, hard-to-handle patients. By providing the necessary emotional tools for dealing with these types of patients, health care providers will be able to refrain from acting on their automatic reactions before they have had a chance to thoroughly review and access the medical facts of the case," adds Barton.

"Finally, the hospital's policies and procedures on restraints, particularly the provisions on the monitoring of patients who are restrained, needs to be carefully reviewed. Such policies and procedures should provide criteria for respiratory therapy for restrained patients who may have compromised airways. Regardless of the errors of the medical staff, which may or may not have been covered under the liability provisions of the hospital, the trauma center hospital's need to contribute to the settlement was likely predicated on its failure to monitor a patient that had been clearly deemed as one who required additional attention," concluded Barton.

## Reference

• *Frank Millis, Individually and as Executor of the Estate of Robert Lee Mills Sr. vs. Geraldine Difford Hicklin, Memorial Hermann Healthcare System d/b/a Memorial Hermann Hospital, Christine Cocanour, MD, Billy Gill, MD, and Kenneth Reed, MD,* Montgomery County (TX) District Court, Case No. 99-0402070-CV. ■