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INSIDE

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Disclosing another doctor's error creates dilemma: Stay silent or speak the truth?

It's necessary to (carefully) disclose malpractice suspicions

It's not uncommon for a physician to find evidence suggesting that a patient received poor care from a previous doctor, sometimes indicating gross malpractice.

But if the patient has no idea of the problem, what does the second physician do?

Does he or she tell the patient?

The answer is sometimes yes, according to risk management and ethics professionals who frequently encounter this dilemma. But the real question is *how* you disclose the information, they say. Risk managers must become directly involved in the process and ensure that only factual information is conveyed, and in the best manner possible.

John Banja, PhD, director of the Center for Ethics in Public Policy and the Professions at Emory University in Atlanta, says he sees this scenario played out often on the Emory campus. As a large, prestigious teaching facility, the Emory University health facilities treat a number of patients referred from throughout the Southeast because their cases are especially

Stay on top of EMTALA with audio conference

Keep abreast of all the latest changes with *EMTALA Update 2002,* an audio conference sponsored by American Health Consultants. The conference, scheduled for Tuesday, June 4, 2002, from 2:30 to 3:30 p.m. Eastern time, will be presented by Charlotte S. Yeh, MD, FACEP, and Nancy J. Brent, RN, MS, JD. Yeh is medical director for Medicare policy at National Heritage Insurance Company. Brent is a Chicago-based attorney, with extensive experience as a speaker on EMTALA and related health care issues.

(See EMTALA audio conference, page 67)

difficult. Sometimes the doctors discover that the patient's problem is the care he or she received before coming to Emory.

"This is one of the most difficult situations that a provider can come across," he says. "Physicians have a difficult enough time disclosing our own errors, much less someone else's."

Health care providers have focused on disclosure in recent years, with many risk managers urging clinicians to tell patients about medical errors and other information that might be difficult to convey. Banja is a strong advocate of full disclosure, but says the real-world demands of a medical practice can make it difficult for physicians to report each other's shortcomings. For some, there is a great reluctance to rat on another doctor.

"Physicians realize that an awful lot of their reputation in the health care marketplace rests on how other doctors regard them. A physician is horrified at the prospect of other physicians thinking he or she is incompetent," he says. "I think that's one reason they defend each other as much as they do. If I don't defend my colleagues, they won't defend me when I get in trouble."

And too often, Banja says, money can be a deciding factor in whether to tell a patient about another doctor's error.

"A doctor may get a patient where there is not much question that the patient is there because of a botched job at another hospital. But the problem is that if they reveal that to the patient, that would be the last time they get a referral from Podunk Hospital," he says. "There's an unfortunate, dark financial dimension to a lot of this."

Culture can determine how scenario plays out

The ethics of the situation often are quite clear, says **Monica Berry**, BSN, JD, LLM, DFASHRM, CPHRM, vice president of risk management and loss control for the Rockford (IL) Health System in Rockford. Berry also is president of the American Society for Healthcare Risk Management (ASHRM). If the information appears to be important to patient's health, or if it appears to be a significant health care fact that the patient does not know for some reason, it is the duty of the health care provider to disclose that information, she says. The risk of liability and a lawsuit against the other physician cannot get in the way of that goal, she adds.

But how do you reach that goal?

"What we've seen so far is that physicians overall are very uncomfortable with this, and it's related to an admission of liability. No one wants to get involved with anything connected to malpractice, even if it's another doctor that will be sued," Berry says. "All of this is very understandable, but it's important to educate the physician on how to say what needs to be said."

Getting physicians to do the right thing, and in the right way, will be easier if you already have promoted a culture of safety and disclosure, says **Jane Bryant**, MHSA, FASHRM, director of risk management at Oconee Memorial Hospital in Seneca, SC. Bryant is president-elect of ASHRM. All physician education regarding disclosure should emphasize that providers must do whatever is right for the patient — even when it is difficult.

Banja, Berry, and Bryant all agree on the main point for education physicians about this dilemma: Caution them not to jump the gun and to proceed very cautiously when they suspect a previous doctor's medical error is unknown to the patient. Even if there truly was an error and the patient should know, you don't want the second physician blurting out the news to the patient before other steps have been taken.

The best approach, they say, is to have the second physician contact the first physician with his suspicions. And the physician should realize that, unless he found a pair of scissors in the patient's belly, they are *only* suspicions until more information is obtained.

"The second doctor should call the first and say that he's looking at this information and that information, and it looks like there was a problem and the patient isn't aware," Berry says. "Let the first doctor have a chance at explaining it. It's never a good idea to assume you have all the information and you know exactly what happened with the first doctor. You can be surprised."

COMING IN FUTURE MONTHS

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If, after talking to the first physician, it appears that there was indeed an error that should be brought to the patient's attention the first doctor should be given the opportunity to deliver the news.

"If you still think an error occurred, the doctor can tell the first guy, 'I'll give you a week to call the patient and tell her about this. If you don't, I will,'" Banja says. "That's what I'd like to see, but unfortunately that call doesn't happen. You usually have doctors either tell the patient, 'That other doctor made a mistake, and you should see a lawyer,' or they just don't do anything."

When both physicians are working within the same health care organization, the risk manager can facilitate the conversation, encourage them both to do the right thing, and provide guidance on how to disclose the information. When the doctors are not allied in any way, the second doctor's risk manager can help by calling the risk manager at the other organization to keep everyone informed and assure that the motive is only to do the right thing for the patient. In any case, physicians should be encouraged to contact the risk manager first for guidance.

The pecking order

Risk managers endorse the idea of letting the first doctor disclose the error. But if that does not happen, the burden still is on the second physician. In that case, Berry and Bryant recommend having the doctor provide as much factual information as possible to the patient, but nothing more. Avoid emotions, opinions, and recommendations for actions. Particularly if the first physician denies the suspected error, the second doctor should be careful to avoid any accusations of outright error or liability.

"Provide the patient with what you do know. You can say that we see these clinical findings, they usually stem from this type of care, and we think it affected your health in this way," Berry says. "You can state that we contacted your first physician on this date and asked that he speak with you, and our goal here is to just let you know everything we know."

Advise physicians to keep their emotions out of the conversation. What the patient does with the information is then up to him or her. Risk managers caution that the doctor — and the risk manager, if you're sitting in on this meeting — should absolutely avoid any mention of liability or lawsuits. Do not volunteer that the patient should talk to a lawyer.

"But if it comes up from the patient, you have to address it," Berry says. "This can be very difficult. If the patient asks whether the other doctor committed malpractice, you can say that is always a difficult question decided in the courts and that you can't give legal advice. Don't deny the patient any information, but don't encourage a lawsuit, either. It's a fine line."

Most of the liability risk lies with the first physician, the one suspected of the error, but risk managers caution that there is plenty of liability risk to go around if the situation is not handled well. If the second physician acts rashly and accuses the first of malpractice, a slander suit could result. Slander suits can be costly and ugly.

But also, there is some liability risk if the second physician does not act on the information. Research has shown very clearly that patients sue more for how they were treated after an error than for the error itself, and Bryant says the second physician becomes part of the problem if he or she does not disclose an apparent error. Banja agrees, saying that he has seen cases in which patients were infuriated that the people who knew of an error did not tell them. Particularly with surgery, he questions whether a patient can truly give informed consent if he does not know the actual, underlying cause of the surgery is a previous medical error.

"I heard of one case in which a surgical team left something in the patient's belly, leading to lots of complications; and four or five doctors down the line all saw the error in the chart. The patient was never told," he says. "I wonder whether an imaginative attorney could sue those doctors for somehow being complicitous in a fraud. I don't think that's a big stretch." ■

A new approach to M&M means learning from errors

Morbidity and mortality conferences are familiar to every risk manager and physician, but not everyone looks upon them fondly. Though they are intended as an open analysis of complications and an opportunity to improve care, too many physicians see them as humiliating, stressful ordeals that seldom lead to meaningful changes in care.

But a new approach to the morbidity and mortality conference, known as the M&M at most hospitals, could change all that. At Cedars-Sinai Medical Center in Los Angeles, the surgery department has transformed its weekly M&M into an innovative educational study curriculum it calls the M&M Matrix. This progressive approach for reviewing surgical errors provides a forum where complications are discussed, analyzed, summarized into teaching points, and disseminated via e-mail to residents and participating attending staff, who are subsequently tested on the material.

According to Cedars-Sinai's associate director of surgical education **Leo A. Gordon**, MD, FACS, Cedars-Sinai's M&M Matrix is a significant departure from the old conferences that were characterized by heated oral discourse.

"In hospitals across the country, morbidity and mortality conferences often result in tempers flaring and fingers pointing — and the lessons are often left at the door," he says. "In Cedars-Sinai's conferences, we take a systematic look at three different surgical complications, summarize the points, set them in print, and distribute them to residents and participating attending staff as study guides on which they will be tested."

The typical M&M works much better in theory than in practice, Gordon says, and that's why Cedars-Sinai developed a different style. In the traditional M&M, the meeting is supposed to be entirely democratic, with the lowliest intern empowered to challenge the chief of surgery. And the participants are supposed to discuss errors openly to promote improvements in patient care.

"It can be a very sobering experience," Gordon says. "You can get some tremendous debate and exchange, but at the end of this conference, what happens to all this passion, debate, and educational juice that has been extracted? Nothing. There is an untapped mine of surgical education regarding error prevention that is developed in these meetings, and then nothing happens to it."

And this, Gordon says, was the impetus for implementing the M&M Matrix educational model about a year ago. The program also dovetails nicely with the goals of the Institute of Medicine's *To Err Is Human: Building a Safer Health System* report from 1999.

Matrix ensures information is put to use

The Cedars-Sinai program is focused on taking the M&M information beyond the highly restricted meeting to the hospital's continuing education program. Gordon acts as the moderator of the weekly M&M conference, and then compiles the information gleaned from the discussion into educational points. Not all of the specific tips, suggestions, and concerns are outlined in the matrix, but the memo is intended to summarize the major concepts discussed and to keep the topics fresh in everyone's mind after the meeting.

Gordon first distributes the information by e-mail to all residents and attending physicians. The M&M meetings are on Thursdays. He offers a hypothetical example of a 19-year-old male who develops a pulmonary embolism after undergoing surgery for multiple gunshot wounds to his pelvis.

"The M&M Matrix on this case would be called 'Pulmonary Embolism Following Surgical Procedures for Trauma,'" he says. "At the conference, the moderator would lead a methodical discussion on how and why this complication occurred. The subsequent study matrix would include a summary of the discussion along with current medical references specific to the complication."

Then on Monday, Gordon sends out another M&M memo to the staff — nurses and other clinicians. This memo also outlines the salient points of the M&M discussion, but it sometimes takes a different tack than the memo sent to physicians,

addressing the topic in terms of more interest to staff. The memos refer to specific patients and physicians only in a blinded manner, with no identifiers, to preserve the legal safeguards built into the M&M conference. **(See article, below right, and p. 66 for examples of both of the M&M Matrix memos.)**

E-mail important tool for promoting change

The two e-mails keep the discussion alive after the M&M meeting is history. Gordon emphasizes that e-mail is a tremendously useful way to make sure the M&M conference results are actually put into practice. The two M&M Matrix memos often spark more debate or discussion among recipients, leading to further refinements in the standard of care.

"I have found that people will send an e-mail [who] otherwise will say nothing at the conference," he says. "Some of the most insightful, and sometimes the most vitriolic e-mails come from people who never speak at the conference. It's a marvelous outlet for extending the educational benefits of the conference."

Physicians and staff have reacted enthusiastically to the Matrix, Gordon says. **Achilles A. Demetriou**, MD, PhD, chairman of Cedars-Sinai's department of surgery, says the M&M Matrix is "the perfect mechanism for transforming the valuable lessons of the morbidity and mortality conference into an active and ongoing program of medical education."

The emphasis on clinical improvements and changes in policy or standards or care helps reassure physicians that the M&M is more than just a day to put them in the hot seat and challenge their decisions, Demetriou says. Gordon's memos always focus on the findings of the conference, he says, never referring to any physician's error or mistake in judgment.

The memos make sure the ideas survive beyond the meeting, but the Cedars-Sinai Matrix doesn't stop there. Every four months, a written examination is given to the residents and staff, solely based on the points made at the surgical M&M conference. The examination is voluntary for attending physicians, but mandatory for residents. Then at the end of the year, everyone in the surgery department receives an in-depth analysis of the past year's complications, along with current references from the medical literature on how to avoid them.

According to Gordon, the complication-focused curriculum is a much more effective way to teach than the older normal-recovery model.

"The M&M Matrix is an evolving concept in resident education, in which the first exposure to a surgical procedure is a complication, rather than a normal recovery," he says. "This tracing backward from a surgical complication to normal physiology and surgical recovery makes a profound impression on young surgeons. It has been shown that surgeons who are exposed to errors early in their careers are less likely to make them later."

Gordon suggests that the M&M Matrix could be applied far beyond the surgical M&M, to any clinical department's review of complications and even to administration.

"The interest in this is amazing, and the reason is that it's so simple," he says. "It doesn't take a focus group or a task force. It doesn't take a revamping of a hospital system." ■

M&M outline detail complications, questions

Below is a typical M&M Matrix from Cedars Sinai Medical Center in Los Angeles. The outline is complication-oriented, each topic beginning with an analysis of the complication.

The subheadings are particular areas discussed at the conference, such as points made and questions raised. This outline is the basis of the year-long complication-oriented curriculum:

The M&M Matrix for April 18, 2002
Surgical Morbidity and Mortality Conference
Cedars-Sinai Medical Center

Six matrices were developed at the Surgical Morbidity and Mortality Conference of April 18, 2002:

1. Peritracheal bleeding
- A. Surgical anatomy of the peritracheal area
- B. Operative causes of bleeding
- C. Immediate postoperative causes of bleeding
- D. Delayed bleeding; the Herald bleed
- E. Preoperative workup for peritracheal bleeding

2. Tracheostomy techniques
- A. Percutaneous methods
- B. Open tracheostomy
- C. Relative morbidity and mortality of each technique; bleeding

D. Long-term complications of tracheostomy; stenosis

3. Tracheo-innominate fistulae
A. Incidence
B. Presentation
C. Causes
D. Operative management; approaches

4. Colocutaneous fistulae
A. Management
B. Etiologies; ischemia, enterotomy, drain erosion
C. Likely causes during mobilization for a colostomy

5. Drains
A. Types
B. Management of the sump drain
C. The global view, or "What am I draining, and what is the risk of manipulating this drain?"
D. Histological findings resulting from 40 cm Hg wall suction; pathology-surgical correlation

6. Exigent stomal bleeding
A. Workup
B. Role of colonoscopy
C. Risks of colonoscopy
D. Pseudo-aneurysms of colonic vasculature
E. Role of the red cell-labeled scan or "The Parallel Universe of Gastrointestinal Bleeding."
F. Surgical complications of stomal creation
G. Role of angiography; diagnosis, embolization ■

Staff memo gets M&M message to wider audience

Below is a typical M&M Monday Memo from Cedars Sinai Medical Center in Los Angeles. It serves two purposes. It is the moderator's summary about the previous week's conference. It is narrative and addresses issues raised at the conference.

It also is used as a vehicle for extending the discussions at the conference through the use of Q/A e-mails:

M&M Monday Memo for Dec. 3, 2001
Comments, Observations and Insights from the Surgical Morbidity and Mortality Conference at the Cedars-Sinai Medical Center

After Thursday's conference, my mail covered the spectrum of the surgical literature from the bound, hallowed pages of *The Journal of the American College of Surgeons* to the folded tabloid pages of *General Surgery News.*

Both publications had central articles on many issues surrounding our weekly conference. One, by Dr. William Silen writing in the *Journal of the American College of Surgeons,* is a scathing assessment of current surgical education, leading to the conclusion that "current trainees are the recipients of an extremely bad educational experience."

The other was by Dr. Barry McKernan writing *in General Surgery News.* Dr. McKernan calls for a "new" educational model that would allow questioning, develop independent thinking, develop an ethic of cooperation, remain flexible, welcome change and focus on relevancy to practice.

Our conference allows questioning, develops independent thinking among our residents, develops a spirit of attending/resident cooperation, is flexible and focuses on issues relevant to practice. I will invite both Dr. Silen and Dr. McKernan to one of our meetings, because I think we have this "new" educational model of Dr. McKernan that can reverse the disheartening trends outlined by Dr. Silen.

Now to the e-mails. I am sorry that I cannot answer each e-mail received. An attending surgeon writes: "The presentation on myocardial dysfunction was a bit peripheral to the case. Do we have to discuss myocardial depression after a GSW as a surgical complication?"

The M&M moderator responds: The discussion of this case was among the most enlightening we have had at our conference. Keep in mind that our profession is grounded in basic physiology. Although I questioned the categorization of this case, there was no question that the issue was worth discussing. The resident had spent quite a bit of time in preparing what most attendees thought was a good review of this emerging concept.

An attending surgeon wrote: "I did not understand the point made about approaching the duodenum laterally in the fistula case."

The M&M moderator responds: The surgeon who made this comment is an "anatomic strategist." If the anterior approach to the abdomen was difficult, the speaker recommended a retroperitoneal approach, much like the retroperitoneal approach to an abdominal aortic aneurysm.

An attending surgeon wrote: "Are the residents aware of the department of medical photography? The description of the abdomen in the fistula case, while I am sure it was accurate, was

tough to envision."

The M&M moderator responds: Photodocumentation would have made the case presentation more understandable. The resident staff will be reminded of the availability of this service.

Reminder: The second M&M Matrix examination will be given on Thursday, Dec. 13 at 0715 hrs. All M&M attendees are invited. ■

Private security firms go undercover in your hospital

A patient with a drug problem slouches in an armchair in the emergency department waiting room. He has $500 in his pocket and needs serious attention. When the nurse finally calls his name, he empties his pockets and changes into a hospital gown. The employee logs in his possessions on a personal belongings sheet: tennis shoes, jeans, sweatshirt, but only $165. The other $335 went right into the hospital clerk's pocket.

Little did she know, her patient wasn't a patient. He was an investigator from Pinkerton Consulting & Investigations, performing a security performance evaluation. That type of undercover operation is performed at many hospitals, says **Catherine Curtis**, supervisor of investigations at Pinkerton.

"This was an ongoing, 2½-year problem for this hospital," she says. "It only took us 2½ hours to resolve."

Modeled after the mystery shopper used by many retailers, this program is used to improve staff performance and customer service. It also can serve as a practice test to prepare health care institutions for their triennial surveys by the Joint Commission on Accreditation of Healthcare Organizations, says **Walter J. Pry**, CPP, senior consultant for Chicago-based Pinkerton.

"Our program is tailored to meet the needs of each specific health care facility," Pry says. "State-licensed Pinkerton investigators go into a facility and evaluate the effectiveness of their security procedures, customer service and personnel performances. Their findings give the management a clear picture of the facility from a visitor's viewpoint."

Pinkerton is not the only private security firm providing these services; other companies provide similar undercover work. Many security companies provide security performance evaluations, and some, like Pinkerton, also work with hospitals on specific projects such as baby abduction drills. Pinkerton assists with baby abduction drills through a four-phase system, which include attempting to enter the secured area, entering the secured area, entering the secured area and causing diversionary action, and finally participating in the drill. After each phase, reports are submitted to security and nursing directors.

Criminal acts are only one focus

Undercover investigations are excellent for discovering the source of criminal activity in the health care organization, Pry says, but most of Pinkerton's health care work involves testing security procedures and staff's compliance with policy and procedures. Many hospitals hire a security firm to test access points, for instance.

"Can you enter the emergency department easily?" he asks. "We'll see what happens when a person walks in and tries to go places he shouldn't. And it's more than just whether the attempt was successful. We want to see how the staff treated this person when they approached him. What did the officer say? What was the security

EMTALA audio conference

(Continued from cover)

The conference will outline a new report that puts a national spotlight on inadequate emergency department (ED) on-call coverage. There is a growing trend of specialists refusing to take call for the ED, partly due to increased liability risks for medical malpractice and violations of EMTALA. If you don't take steps to ensure appropriate on-call coverage for your ED, you're at risk for violations and adverse outcomes. This program also will update you on any legislative efforts to compel managed care plans to reimburse hospitals for EMTALA-related services.

Each participant can earn FREE CE or CME for one low facility fee. Invite as many participants as you wish to listen to the EMTALA Update 2002 audio conference for just $249 for AHC subscribers and $299 for nonsubscribers, and each participant will have the opportunity to earn 1 nursing contact hour or 1 AMA Category 1 CME credit. For more information, or to register, call American Health Consultants' customer service department at (800) 688-2421 or (404) 262-5476, go on-line at www.ahcpub.com, or e-mail customerservice@ahcpub.com. ■

officer doing when you approached?"

The same kind of questions applies during the first phase of a baby abduction test. It's good if security officers or other staff challenge visitors, but undercover officers also focus on customer service. In other words, can the staff say no and be nice about it?

"Customer service is key because health care is so competitive these days," Pry says.

Pry and **Ron Long**, managing director of Pinkerton, initiated the program in 2000 when Pry was director of security at Sinai Hospital of Baltimore. Pry says he became concerned when staff members commented on the security performance of his department.

"I didn't feel that random visits to the department by myself were productive. I was searching for an additional tool that could be used as a performance improvement program with the Joint Commission," Pry says. "The risk manager and the director of security are there for 40 hours a week, and when they're gone, everything changes. For the most part, our investigators go in on weekends and at night when employees don't think they're being watched as closely."

Long says access vulnerability is more of a concern since the terrorist attacks of 2001, and security firms can be hired to investigate any kind of compliance with hospital policy. Most investigations, however, combine patient safety and customer service concerns.

"One example is an investigator will go out in a parking lot and call security to say he or she can't find their car," Pry says. "Everything is noted: how long it takes security to get out there, what they do, what they don't do."

At one hospital, undercover investigators reported that a guard in the emergency department was lax, so his superiors warned him to improve his performance. Soon after, the guard noticed a suspicious person who said he was waiting for a shooting victim. The guard thought the man was another undercover investigator and didn't want to be reprimanded again.

"So he asked the man more questions until he figured out that the man actually was the shooter and came to finish off the patient," Pry says. "The guard's questioning caused the man to flee, and he was able to help identify him for the police. The first experience had put the guard on his toes."

Long points out that the undercover investigations are not used strictly to punish poor performers. Pinkerton encourages clients to reward those employees who are found doing admirable jobs. All the positive findings show in the final report by the company, just like the problems.

"If you have a security guard who acts responsibly and says, 'Wait a minute. We don't have a Dr. Smith. Who are you really looking for?" then that we write that up as a very proactive intervention," Long says. "The employer might praise the guard for his good work and give him a night out at the movies as a reward."

The investigators usually do not reveal themselves to staff, even if they find misconduct. That way, the same investigators can be used again, with the benefit that they are familiar with the facility and employees. But in some cases, such as criminal conduct, the investigators may have to act immediately to apprehend the offender and preserve evidence. In the case involving the thieving emergency department clerk, the investigator summoned security and identified himself so the evidence could be collected.

Drills can spot problems, test improvements

Pinkerton recommends doing an undercover investigation quarterly, though some facilities will do them as often as monthly. The investigations can target any area or problem known to the risk manager, or the company can randomly test various access points and similar areas known to be at risk for problems.

Normally, only the risk manager and director of security know of the undercover investigation at first. But after the first time, the staff usually knows that the technique is being used because the findings are presented as a teaching tool. And Pry says that can be good for the staff to know that undercover investigators might be present somewhere, some time.

"They know that the next patient might be an investigator and it keeps people aware of the need to act properly at all times," Pry says. "It's always in the back of their heads."

One hospital leader in charge of security says undercover work can make a big difference in how staff perceives it job. Security guards, in particular, change their attitude when they know they might encounter an undercover investigator at any time, says **Lionel Weeks**, vice president for facilities at Lifebridge Health in Baltimore, which operates three hospitals and other facilities in the area. Lifebridge has used undercover investigators for several years.

"The first time we had them come in, we got reports that some of the guards were not

customer-friendly, no eye contact, and sometimes the investigators should have been challenged more and they weren't," he says. "We sat down with the guards and supervisors and showed them exactly what we had found when they thought no one was looking. Next time the investigators came in, what a difference."

Weeks says his organization continues to use the undercover investigators at least twice a year. The first time, Weeks took no disciplinary action based on the findings. But after that, staff were on notice that they could be punished for poor performance uncovered by the agents. And Weeks points out that many of the reports highlight exemplary performance by security guards and others, which always results in the employee being praised.

The cost of an investigation depends on the size of the campus and exactly what is being investigated, but Pinkerton charges an hourly rate of $100 to $200 that covers all the necessary personnel and other expenses. A single visit might take about eight hours, so Pry says $1,000 is a typical fee for an investigation. For quarterly investigations, a hospital might spend a total of $5,000 a year.

Clients often have the company come back and investigate the same issue after improvements have been made.

"It can even be used as a quality improvement project for the Joint Commission," Pry says. "They will ask what you've done to improve security and ensure the safety of patients and visitors. You can show that you were at this level the first time we came in, then you improved this much each time the investigators came back."

Undercover security programs have been implemented in 10 Baltimore metropolitan hospitals with a high degree of success, Pry reports. ■

Patient safety group works to reduce medical errors

With mounting evidence that the vast majority of medical errors in this country are systems-related and not attributable to individual negligence or misconduct, the nonprofit National Patient Safety Foundation (NPSF) has launched the first nationwide initiative to achieve measurable systems change in hospitals.

Under the banner of "Stand Up for Patient Safety," 17 leading hospitals from across the country are joining forces with NPSF to mobilize a groundswell of activity and support among all hospital leaders to reduce errors and improve patient safety. This movement calls for replacing traditional barriers to patient safety with a new culture of accountability, trust, system improvement, and continuous learning.

Founding hospitals will help chart the course for the future by taking a strong and public stand for patient safety and raising the bar for others to follow as the Stand Up for Patient Safety campaign is rolled out nationally. As hospital leaders engage in the campaign, NPSF will provide their hospitals with new tools to implement systems change, including training modules, monitoring and reporting program activities and breakthrough strategies, and new educational materials for patients, says **Timothy Flaherty**, MD, founding NPSF board member and current chairman of the Board of the American Medical Association.

"We are confident that a national call to action such as Stand Up for Patient Safety will go a long way in keeping patient safety at the forefront of health care," Flaherty says. "By focusing on continuous, positive determination and action in an open and transparent manner, we will demonstrate that it doesn't take a tragic incidence of error to mobilize true leaders for change."

Behind this new campaign are disturbing estimates about the number of deaths and injuries each year that are caused by medical errors. New data just released from The Commonwealth Fund find that an estimated 22.8 million people have experienced a medical error of some kind, personally or through at least one family member. This data reinforces a 1999 Institute of Medicine report that revealed that from 44,000-98,000 deaths each year occur due to medical errors at an annual price tag of $17 billion to $29 billion.

Often the exact magnitude of these statistics is debated, and the public's attention is drawn away from real issue. NPSF leaders have taken the stand that whether everyone agrees with these conclusions, one preventable error is one error too many. The Stand Up for Patient Safety campaign is also the outgrowth of a new consensus among government agencies, medical societies and the business community that hospitals are ground zero when it comes to patient safety. While medical errors occur in all health care settings, the thinking goes, how they are addressed in the hospital has wide-ranging implications for the rest of the health care industry. This is because the risks associated with

hospitalization are significant, the strategies for system improvement are crucial and can be better documented, and the importance of patient trust is paramount, says **David Page**, CEO of Fairview Health Services in Minneapolis.

"If the nation is going to address the problem of reducing medical errors, we must start where we can have the greatest impact; and this is in the hospital setting," Page says. "Not only are hospitals the nexus of health care delivery at the community level, they bring together all the diverse forces that play a role in patient safety. Unless hospitals take the lead, it is likely that real change will be slow and preventable medical errors will persist."

While most hospitals are committing at least some level of resources to patient safety, one area of great concern to NPSF is how little is known generally about the engagement of hospital boards of trustees in preventing medical errors by supporting full disclosure when errors do occur and by allocating adequate resources to prevention. Page says this could be one of the most significant barriers to effective action and change throughout the institution and the community. Through the engagement of hospital leaders in the Stand Up for Patient Safety campaign, Page says he hopes the call to reduce errors from the top-down will not be ignored. NPSF will provide hospitals with new educational tools that can be used to elevate patient safety at the community level. These materials will include pamphlets, posters, videos, and web-based information. ■

RNs file suit against Tenet for understaffing

Registered nurses represented by United Nurses Associations of California/Union of Health Care Professionals (UNAC/UHCP) filed a lawsuit against Tenet Healthcare claiming that Tenet has engaged in systematic understaffing of RNs throughout Southern California and failed to pay them for legally protected work breaks.

Sonia Moseley, executive vice president of UNAC/UHCP, says Tenet Healthcare has RN staffing shortages throughout Southern California. As a result, she says, many RNs are forced to work through their breaks without getting paid.

"The plaintiffs believe it's wrong for Tenet Healthcare to steal from frontline nurses and harm patient care," Moseley says.

In the lawsuit filed in Superior Court of the state of California, Los Angeles County, the nurses allege that Tenet Healthcare is violating California's Unfair Competition Law and California Labor Code's wage and hours regulations. The nurses are seeking class-action status for their wage and hour claims on behalf of all Tenet Healthcare RNs in Southern California. In an unusual request of the court, the RNs are asking for injunctive relief that would, if granted, force Tenet Healthcare to provide adequate nursing staff for RNs to take lunches and breaks. The RNs believe the lawsuit will force Tenet Healthcare to operate its hospitals in accordance with California law and will help protect patients. The RNs are also seeking back wages and damages for a class of potentially up to 7,000 Tenet Healthcare RNs who may have not been paid for work at 36 Southern California hospitals.

Under the California Unfair Competition Law, the nurses are requesting that Tenet Healthcare disgorge its profits from this practice if it is found to be illegal. Based in Santa Barbara, Tenet Healthcare Corp. is a nationwide provider of health care services, which owns or operates 116 acute-care hospitals. Twenty-eight percent of Tenet Healthcare's acute-care hospitals are in Southern California. ■

Assisted-living facility pays $1.5 million for hiring felon

A Virginia jury has found Summerville Assisted Living facility in Woodbridge negligent for not properly caring for a former patient and awarded the patient $1.5 million.

The jury deliberated fewer than 90 minutes. Barbara Crowe, daughter of the patient, 83-year-old Margaret Noel, filed suit last year on behalf of her mother. Noel was the facility's first patient in 1998 and was living in the facility's Alzheimer's wing when she fell and broke her hip in 1999. **Jeffrey J. Downey**, JD, Crowe's attorney, says Summerville's negligence was exemplified by "an utter disregard for the safety of their residents, especially their vulnerable Alzheimer's residents who were placed in the hands of a convicted felon, who received a few hours of video training and was placed on the floor caring for some 15-20 residents."

Evidence also showed that staffing levels were not based on the needs of the residents, but on the corporate budget, which did not take into account the acuity of the residents. In his closing argument, Downey, an attorney with Robins Kaplan's Washington, DC, office, urged the jury to "show by your verdict that elderly people with Alzheimer's disease still have a quality of life that is worth something."

Medical experts testified throughout the four-day jury trial that Noel's quality of life had greatly diminished because of the fall and because she was not able to seek treatment right away. Doctors testified that Noel is still unable to walk because of the fall, which fractured her hip in four places. Downey says the jury's quick turnaround time "reflected that fact that this jury rejected outright the defendants denial of liability and believed that defendants in fact tried to cover up their serious neglect."

Downey also says the verdict reflects a complete rejection of the notion that Alzheimer's patients can't experience pain and suffering, a defense he says is often articulated in settlement discussions if not in court. ■

Most consumers support caps on pain and suffering

The vast majority of Americans support medical liability reform, including a cap on pain and suffering, according to a survey recently released by the Health Care Liability Alliance (HCLA).

Donald J. Palmisano, MD, JD, secretary-treasurer of the Chicago-based American Medical Association (AMA), says the survey results show that the American people support the health care community's drive for liability reform. Palmisano is a founding member of HCLA and a member of its board.

"Liability reform is one of the AMA's top legislative priorities, and these survey results show the vast majority of Americans support liability reform as well," he explains. "An overwhelming 78% of Americans say they are concerned about the impact rising liability costs have on access to care, and 73% support a law that caps pain and suffering awards."

Palmisano says that the AMA has always held that patients who have been injured through negligence should be compensated fairly, but unfortunately, the current liability system has failed patients. The United States has created a liability lottery, he says, where select patients receive astronomical awards and many others suffer access-to-care problems because of it.

"We will never have true access to care for all unless the hemorrhaging costs of the current medical liability system are addressed," he says.

"The new survey shows that 71% of Americans agree that one of the primary reasons health care costs are rising is because of medical malpractice lawsuits. The spiraling costs generated by our nation's dysfunctional liability system are borne by everyone. We need a system that ensures fair compensation and puts an end to the liability lottery," Palmisano says. ■

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Malpractice at heart of new proposal

Newly introduced legislation by Reps. Jim Greenwood (R-PA) and Christopher Cox (R-CA) to fix the medical malpractice crisis is a major step forward in placing the interests of patients before those of personal injury lawyers, according to the American Association of Health Plans (AAHP).

AAHP calls frivolous litigation the greatest threat to high-quality, affordable health care. **Karen Ignagni**, AAHP president and CEO, says the legislation could directly improve health care in the country.

"Personal injury lawyer attacks on doctors and other members of the health care community have driven up health care costs, decreased the quality of care patients receive, and prevented millions of Americans from accessing the health care system," she says. "Personal injury lawyers have benefited at the expense of consumers for far too long. The HEALTH Act will protect patients by implementing many of the same provisions that have been successful in California for decades."

The cost of litigation

According to an AAHP study conducted by PricewaterhouseCoopers, litigation is responsible for 7%, or $5 billion, of new health care costs — equivalent to the price of health insurance for 2 million Americans.

"The culture of blame and litigation is destroying our health care system," Ignagni says. "Too often, fear of litigation takes precedence over what is best for patients. We need a new accountability paradigm where today's rampant liability is replaced with fair and efficient solutions for patients." ■

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

Plastic surgery procedure ends in brain damage: $5.75 million settlement

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

News: A part-time exotic dancer and graphic artist underwent plastic surgery procedures as an outpatient at her physician's office. The physician's certified registered nurse anesthetist (CRNA) overmedicated the patient, who went into respiratory arrest. The hallway and doorways were too narrow for EMS to get a stretcher into the physician's operating room. The patient was eventually taken to a hospital, but not before she suffered severe brain damage from long-term deprivation of oxygen.

The patient and her mother brought suit against the physicians and nurse anesthetist. Prior to jury selection, the defendants settled for $5.75 million.

Background: The plaintiff, a 39-year-old part-time exotic dancer and graphic artist presented to her plastic surgeon's New York City office for the replacement of cheekbone implants, a brow lift, laser freshening around her eyes, and the injection of Isologen into her lips. The general plastic surgeon consulted with and was joined by an ophthalmologic plastic surgeon. Assisting the surgeons was the plastic surgeon's CNRA, who was responsible for sedating and monitoring the patient. A third physician, who was licensed in Brazil but not in the United States, accompanied them.

During the pendency of the case, the defendant physicians claimed that the third physician was only there to observe. That claim was later contradicted by the CRNA.

The surgery was initiated by the CNRA's administration of an IV sedation mixture, which included a narcotic and a barbiturate. The sedation drugs caused the plaintiff's oxygen-saturation level to drop to below 85%. When it rose to 92%, the CRNA administered an additional dose of barbiturate. The first procedure was the injection of Isologen. When the plastic surgeon began the injection, the patient went into respiratory arrest. Resuscitation efforts began, and a 911 call was made.

EMT responders could not get their stretcher into the operating room because the hallway leading to the room had an opening that was only 32 inches wide. The doorway into the operating room also was too narrow. By the time the patient was transported to a nearby hospital she had suffered irreparable brain damage from the lack of oxygen.

Following her discharge from the hospital, the patient and her mother sued the providers, claiming the plastic surgeon failed to properly ascertain the qualifications of the defendant CRNA. The CRNA had been certified nine years prior to this case. But under the law of the jurisdiction, re-certification is required every two years.

Had the CRNA been employed by a hospital or an ambulatory surgery center, failure to have an up-to-date CRNA certificate would have been an absolute bar to practice; but was unclear whether the lack of certification was an absolute bar to

practice in a physician's outpatient office.

The plaintiffs also contended the plastic surgeon failed to properly supervise the CRNA, as the physician could identify neither the source nor amount of sedation medications that were administered. The plaintiffs also claimed all the defendants failed to properly monitor the patient, misused dangerous drugs during her initial sedation intake, and failed to properly resuscitate her by foregoing the use of supplemental oxygen and using an Ambu bag that was too small.

Initially, the City of New York also was named in the suit as the EMTs provided a portion of the care to the plaintiff, but the City was dismissed on summary judgment. The EMTs testified that the defendants' resuscitative efforts were grossly inadequate as the Ambu bag employed by the physicians and CNRA was too small and that the operating team had failed to administer supplemental oxygen. The EMTs said the application of one-handed chest compressions as opposed to full-blown cardiopulmonary resuscitation was of little or no use to a patient who had stopped breathing. In addition to claiming that the plastic surgeon failed to ensure that his office allowed proper emergency access and egress for a patient accompanied by emergency medical personnel, the plaintiffs maintained that the plastic surgeon failed to have appropriate emergency care equipment on site and failed to have staff trained to handle patient emergencies.

"One wonders that had any of the physicians recognized their own shortcomings or those of their CRNA or at least those of the physical setting, perhaps this patient's misfortune would not have been so great."

At his deposition, the CRNA pled his Fifth Amendment rights against self-incrimination and refused to answer questions regarding the drugs he had administered to the plaintiff or where he had obtained them.

The CRNA testified that a third physician had scrubbed in and was injecting the patient with Isologen when she stopped breathing.

The case was confidentially settled for $5.75 million.

What this means to you: Many of the outstanding risk management issues could have been avoided or minimized had the procedures been performed in a hospital or a more heavily regulated outpatient facility. The physician's office also could have been better designed, equipped, and staffed.

"For instance, in most jurisdictions licensure requirements and building codes require hospitals and ambulatory surgery center operating suites and rooms to be built and maintained with ample doorways and adjacent hallways," say **Lisa Winton**, RN, BSN, LHRM, CPHQ, and **Gaby Morley**, RN, BSN, LHRM, of Tampa (FL) General Hospital. "It is unlikely that in such regulated facilities, EMTs or other first-responders would have been delayed in accessing and treating the patient as was case in this scenario. In addition, more regulated facilities would have been equipped with a code cart, and inclusive in the cart would have been appropriately sized Ambu bags. Aside from the architectural limitations that impacted the emergency stretcher's ingress and egress, one would have presumed that an appropriately stocked code cart should have been readily available in a physician's office where surgeries were regularly performed. At a minimum, if the physician's office was not equipped to handle patient emergencies themselves, they may have been well advised to have a standing relationship with the closest hospital.

"From a medical standpoint, it is not clear why the CRNA administered another dose of barbiturate following an episode of decreased oxygen saturation. Instead, one might have expected the administration of oxygen, which seems not to have occurred. Furthermore, as to the actions of the CRNA, within hospitals [as well as in some outpatient ambulatory surgery centers], personnel are generally required to document all medications that are administered. Procedurally, this would have virtually eliminated the ability of the physicians CRNA from pleading the Fifth with regard to what medications the patient was given and where those medications came from," Winton and Morley say.

"As for the presence of the third physician, if the physician had merely been observing and was not licensed to practice in the jurisdiction, this opens the question as to why the other physicians would have allowed her to even touch the patient, which also raises questions as to the credentials of the other two plastic surgeons. Obviously, one does not have to

credential oneself in one's own office, but at least the specialist surgeon was practicing in the other's office, and there is no indication that his competency was questioned prior to the incident. One wonders that had any of the physicians recognized their own shortcomings or those of their CRNA or at least those of the physical setting, perhaps this patient's misfortune would not have been so great," Winton and Morley add.

Hospitals and ambulatory surgery center comparisons aside, physician's office health practitioner personnel should be qualified to perform some minimal levels of emergency health care services and be qualified to perform the duties for which they are hired.

"In this case, one wonders what the CNRA's qualifications were. One of the basic requirements of hiring and continuing the employment of licensed personnel is to ensure that they are appropriately licensed at the time hired and that such licenses are maintained. In addition, in physicians offices where surgeries are being performed which require the use of anesthetics, at least one person in the office be qualified in basic life support [BLS] or even better advanced cardiac life support- [ACLS] certified, just in case something untoward occurs. These are basic skills for most health care practitioners, but may mean the difference between the life and death of a patient. The fact that only one-handed compressions were being attempted on the patient indicates that it is likely no one had current BLS of ACLS certification," conclude Winton and Morley.

Reference

• *Angela Bourodimos, a mentally incompetent person, by her mother and court-appointed guardian, Eleni Bourodimos, v. Doctors #1-2 and Frank Halcomd, RN,* New York County (NY) Supreme Court, Index No. 100089/98. ■

Stay on top of EMTALA with audio conference

Keep abreast of all the latest changes with *EMTALA Update 2002,* an audio conference sponsored by American Health Consultants. The conference, scheduled for Tuesday, June 4, 2002, from 2:30 to 3:30 p.m. Eastern time, will be presented by Charlotte S. Yeh, MD, FACEP, and Nancy J. Brent, RN, MS, JD. Yeh is medical director for Medicare policy at National Heritage Insurance Company. Brent is a Chicago-based attorney, with extensive experience as a speaker on EMTALA and related health care issues.

The conference will outline a new report that puts a national spotlight on inadequate emergency department (ED) on-call coverage. There is a growing trend of specialists refusing to take call for the ED, partly due to increased liability risks for medical malpractice and violations of EMTALA. If you don't take steps to ensure appropriate on-call coverage for your ED, you're at risk for violations and adverse outcomes. This program also will update you on any legislative efforts to compel managed care plans to reimburse hospitals for EMTALA-related services.

Each participant can earn FREE CE or CME for one low facility fee. Invite as many participants as you wish to listen to the EMTALA Update 2002 audio conference for just $249 for AHC subscribers and $299 for nonsubscribers, and each participant will have the opportunity to earn 1 nursing contact hour or 1 AMA Category 1 CME credit. For more information, or to register, call American Health Consultants' customer service department at (800) 688-2421 or (404) 262-5476, go on-line at www.ahcpub.com, or e-mail customerservice@ahcpub.com. ■

No time for a wheelchair; an $85,000 verdict made

News: A 72-year-old woman was admitted to the hospital to rule out the occurrence of a stroke. After being discharged, she went unescorted to the hospital lobby where she tripped, fell, and fractured her left arm. She brought suit against the hospital for not providing her with wheelchair transportation from her room to the hospital exit. The jury awarded her $85,000.

Background: The woman was admitted to the hospital for dementia and to rule out the possibility of her having experienced a stroke. After being hospitalized for several days, she was discharged. At the time of discharge, the patient was attended to by her children. The floor nurse went to find a wheelchair, but the patient and her family did not wish to wait. They escorted themselves to the hospital lobby, where the patient tripped and fell over a stanchion — a ceiling

support post — in the hospital lobby. She fractured her left, nondominant humerus in the fall. Her pre-existing left shoulder prosthesis did not require replacement from the incident.

The plaintiff sued the hospital for negligence by failing to provide her with a wheelchair, even though she admitted that a nurse had gone for one and that she and her family did not wait for it. The patient also claimed that there should not have been a stanchion in the lobby. She claimed the incident exacerbated her dementia.

The hospital maintained that the plaintiff left the floor against the nurse's discharge instructions with her children before the unit nurse was able to bring a wheelchair. The defendant also denied that there was any defect in the arrangement or design of the lobby.

A jury awarded the plaintiff $85,000.

What this means to you: Standard hospital policies generally provide that all patients should be escorted to the facility's exit.

"This case illustrates the classic example for the rationale for policies requiring all patients to be taken to the exit whether by wheelchair, stretcher, or simply accompanied by hospital personnel. And in light of the policy and attempt by the floor nurse to abide by the policy, but for the actions of the patient and her children, one wonders why the plaintiff in this case was awarded anything," says **Leilani Kicklighter**, RN, ARM, MBA, CPHRM, director, corporate risk management, Miami Jewish Home & Hospital for the Aged.

"By nature, patients are persons who have received or are waiting to receive medical care. They have experienced some illness or malady that requires some kind of medical treatment. Such an experience, generally leaves one in a weakened state of being or at a minimum not accustomed to being on one's feet. Therefore, unless a patient leaves the hospital against medical advice or runs out the door, as seems to have been the case in this scenario, patients are always escorted to the exit and more often than not such transportation is provided by a wheelchair. About the only defenses to such a claim of negligence for failing to provide exit transport are the hospital's policy against such unescorted exits and documentation of the facts surrounding the patient's exit tactics. Ideally, the documentation would need to be done prior to the incident, but that is virtually impossible under the facts of this case, given the time it takes to get from the unit to the door. And, regrettably for the facility, the plaintiff prevailed under such a fact pattern.

"Perhaps, in anticipation of discharges, wheel-chairs should be gathered prior to advising a patient they have been discharged. Another thought is to conduct a study to attempt to determine whether there are an adequate number of wheelchairs to handle all the types of transports on a daily basis. Trying to find a wheelchair or the length of time it might take to find a wheelchair can test the patience of patients and family members who are anxious to leave the hospital after they've been discharged," adds Kicklighter.

"As to the stanchion in the lobby, risk managers should evaluate the entrances and lobbies in their facilities with a critical eye to determine if there are potential areas that are risks for infirm visitors or patients to trip. Sometimes, a barrier to divert pedestrians from the hazardous area is all that is needed as a preventive measure," concludes Kicklighter.

Reference

- *Rose Friedman vs. Presbyterian Hospital*, Kings County (NY) Supreme Court, Index No. 13794/99. ■

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No matter what type of emergency faces your health care organization, how well you fare will largely depend how well your staff knows its individual roles. Careful planning, practice drills, and clear job descriptions can make the difference.

You can never practice enough. That was the primary lesson learned when personnel at Atlanta's Grady Memorial Hospital kicked into high gear with the aftermath of a bombing in Centennial Olympic Park downtown.

When tragedy hit during the 1996 Olympics, the admitting and registration staff — such as personnel throughout the hospital — already had been repeatedly drilled on what to do if an emergency occurred while the city was hosting thousands of visitors from all over the world, says **Linda Leatherman**, director of admitting and registration. Possibilities ranging from a large influx of heat-related cases to terrorist attacks were covered.

"We did hold a lot of drills, but we could have held more," she says. "If you're going to have an emergency preparedness process, you need to practice it and get staff comfortable with it."

About 100 people were injured by the blast that early morning in July, but most were treated at the scene. Thirty-four patients were taken to Grady for treatment; 13 were admitted, and 10 needed surgery. At one point, Leatherman notes, 257 reporters, camera crews, and other news media personnel were clustered on the street outside the emergency clinic.

Leatherman gives her employees and other hospital staff high marks for doing an outstanding job of everything from taking care of patients and family members to cleaning up the floors. However, a post-event analysis of the disaster plan did bring to mind some procedures that will be done differently the next time disaster strikes, she notes. These included:

• During pre-Olympics planning, each department was asked to draw a flowchart outlining who does what if disaster strikes.

But when staff began dealing with the real emergency, assumptions were made that were not included in those algorithms.

"On ours, for example, it says that [when a disaster occurs], admitting coordinators are to begin an emergency bed count — what's available, who could be moved out of [the intensive care unit]," Leatherman says.

"What actually happened is that the inpatient nursing staff started moving patients. In critiquing our emergency preparedness, we realized we didn't effectively communicate each algorithm to each department," she says.

Next time, Leatherman adds, admitting will perform the bed count and will do a better job of communicating with nursing.

• Since Grady's emergency clinic is approximately the size of a football field, it's quite a distance from the care area to registration.

When patients started arriving during the lowest-staffed shift, there were enough employees in each of the four care zones to obtain identifying information, but no one to run the information back to the registration desk.

"For the first 15 or 20 minutes, we were really hurting for staff," Leatherman recalls. "There were a lot of nurses ready to help, but they didn't

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think about helping with registration. In the future, they will take on those duties."

After the initial crunch, she adds, there was plenty of help as off-duty employees heard the news and began reporting for work.

• Patient data weren't entered into the computer system quickly enough.

Although the information was efficiently gathered , Leatherman says, it existed only on paper for too long. Information clerks and nursing floors didn't have up-to-date information to share, for example, with relatives of the injured.

"If you're taking in lots of patients, you have to have a way of knowing who you have in the house," she says. "For the benefit of family members who weren't allowed in the emergency department, this needs to be in the system and communicated. We ended up having to do a lot of cleanup after everyone caught their breath."

• Practice sessions focused on bringing the patients in for treatment quickly, but no one was assigned to handle discharges.

Patients who weren't badly hurt and were ready to go home waited to be told what to do next, Leatherman explains. "There was no one designated to say, 'Take this medication and go home,' to close the loop for those who weren't going to be admitted."

When the real thing happens, people tend to forget what's listed on the disaster plan, she says. Although it had been agreed that the shift supervisor in emergency registration would be in charge of the admission and registration process, that supervisor found this to be a difficult role to play when Leatherman showed up to help out.

"When I said, 'What's my assessment?' it was hard for her [to respond]," she recalls. "People came to me and asked what they should do."

Leatherman's admitting manager and emergency registration manager currently are working on clarifying and expanding their algorithms, and on adding more "job-action sheets" that describe specific duties that need to be performed in responding to a disaster. The action sheets are invaluable when personnel who don't normally perform a certain function are called upon to fill in, she explains.

Action sheets spell it out

For example, there is an action that describes exactly what needs to be done during an emergency bed count, Leatherman says. Rather than spending time explaining the procedure, the person in charge can simply hand the sheet to the employee assigned to that task.

Meanwhile, her department continues to be involved in meetings with nursing and other departments as Grady continues to evaluate its emergency plan, Leatherman adds. "Improving communication is always something to work on." ■

BIOTERRORISM WATCH
Preparing for and responding to biological, chemical and nuclear disasters

They don't call it bio*terror* for nothing: Fear is the foe when anthrax spores are found within hospital walls

'We feel we were able to ward off a panic . . .'

Clinicians nationwide were beset with hoax powder scares last year at the height of the anthrax attacks, but at one hospital, the threat turned out to be real. Positive cultures for *Bacillus anthracis* were found within hospital walls, setting off a wave of anxiety that threatened to descend into panic.

"There was a mounting level of anxiety among our health care workers," said **Maureen Schultz**, RN, infection control coordinator at Veterans Affairs (VA) Medical Center in Washington, DC. "It had to be dealt with before we could work out any other aspect of the situation."

The events began to unfold last October, when it was discovered that the anthrax letter sent to Sen. Tom Daschle (D-SD) might have contaminated other federal buildings through cross-contamination of mail processed at the Brentwood postal building in Washington, DC.

"It was several days before the contamination was discovered, and by that time, several downstream facilities, including our VA hospital, were contaminated," she said recently in Salt Lake City at the annual meeting of the Society for Healthcare Epidemiology of America (SHEA).[1] In light of the situation, it was recommended that mailrooms in federal buildings be cultured for anthrax.

"One of the things we found frustrating was that we were not given any guidance as to how we should screen the mail," Schultz said. "So we [took] cotton swabs and ran each swab over an approximately 10 to 50 square inch area."

Four of 34 environmental swabs taken in the hospital mailroom grew *B. anthracis*, with colony counts varying from one to 11. The anthrax was found on a canvas mail tote, a cardboard box that had been mailed, on the top of a mailroom speaker, and on a canvas mail cart.

The fear factor

"Even before the contamination was discovered, [we] decided to take some action because of the growing concern among our employees," she said. "So [we] convened a group from the emergency response team, infection control, safety, and public affairs."

The focus of the response was to determine risk level, provide prophylaxis as needed, decontaminate the environment, and get accurate information to all 1,700 health care workers, patients, and visitors, Schultz said. In order to reduce the high level of anxiety, a series of educational sessions were held, information was posted on the hospital web page, press releases were distributed, and printed materials were given to staff, patients, and families. In addition, a series of "town-hall" meetings was held to fully air the concerns of employees.

"These were informal sessions that we had in our auditorium where many health care workers could come and interact on an informal basis," Schultz said.

The risk to hospital workers was determined to

This supplement was written by Gary Evans, editor of *Hospital Infection Control.* Telephone: (706) 742-2515. E-mail: gary.evans@ahcpub.com.

be low, and only eight staff members were started on prophylactic antibiotics. Those included five mailroom employees who were encouraged to take full 60-day regimens. Another three workers, considered at lower risk, were given 10-day regimens due to possible contact with contaminated mail. The mailroom and surrounding area were decontaminated by an outside contractor.

Overall, some 500 health care workers attended the education sessions, and each town-hall meeting drew more than 200 staff members. With the colony counts low and the contamination limited, the decision was made to limit prophylaxis to only the eight aforementioned employees. That approach was not well received by other health care workers who feared they could have been unknowingly exposed.

"We refused treatment to all other employees, and initially, this created a lot of anxiety among the health care workers, particularly in these large town-hall meetings," Schultz said. "They were demanding ciprofloxacin or doxycycline in case they had come in contact with something contaminated. But we did hold firm on this, and we did not provide prophylaxis to any other employees."

Still, at the SHEA meeting, the Centers for Disease Control and Prevention (CDC) conceded that many of its initial assumptions about anthrax turned out to be false, including the perception that mail handlers were not at risk for inhalational anthrax. Given that acknowledgment, *Bioterrorism Watch* asked Schultz if she would now reconsider the decision to limit antibiotic prophylaxis to a few workers. "Based on the information we have now, no. I don't think we would change that decision." There really was no evidence that any widespread contamination had occurred, she added.

A total of 34 workers reported to the occupational health service for clinical evaluation, but there were no reports of staff refusing to work, and patient care was not interrupted. The initial level of fear and anxiety among many of the workers eased off under the continuous education and communication effort.

"We feel we were able to ward off a panic situation by the actions that we took," she said.

NYC hospital faces similar situation

A similar contamination incident was feared at Memorial Sloan Kettering Institute, a 431-bed cancer center in New York City. Some 1,200 health care workers at Sloan Kettering work in the same building as Gov. George Pataki's Manhattan office, which was reported to be the target of anthrax mailing. On Oct. 17, possible anthrax (positive by polymerase chain reaction test) was discovered in the governor's office. Pataki and staff vacated their part of the building, and infection control staff and hospital administration at Sloan Kettering developed a response plan to protect their workers.

The hospital employees worked on 10 floors of the 40-story building, including three floors that shared an air-ventilation system with the governor's offices. The response was honed to focus on mailroom staff and some 250 employees who worked on the three floors with shared air. With incomplete information on the scope of potential contamination of Pataki's offices, hospital clinicians decided to perform nasal cultures on the employees on the three floors, **Janet Eagan**, RN, an infection control professional at Sloan Kettering reported at the SHEA conference.[2] All of the 245 cultures taken were negative.

"I think the nasal swabs were more to allay fear," she said. "We wanted to do something that was proactive."

Public health investigators first used the nasal swab approach after the first anthrax case in Florida, but the CDC would later advise against routine use of the practice. The reliability of the swabs came into question, in part, because even those exposed may test negative as the nose clears of spores. At a Nov. 1, 2002, press briefing, the CDC advised against using nasal swabs "as a nonspecific probe to determine whether anthrax has ever been present in an environment."

Of course, clinicians at Sloan Kettering were dealing with a situation before that clarification was issued, but even then there were doubts about the wisdom of swabbing the workers.

"By the time we agreed to do the nasal swabs, I was kicking myself, thinking what on earth are we going to do with this information," **Ken Sepkowitz**, MD, epidemiologist at the hospital told SHEA attendees. "The nasal swabs was a screw-up, but with the information we had . . ."

With all the swabs negative, no antibiotics were administered. Additional efforts were needed to reassure the "worried well" that they were not at risk. Personnel from infection control, safety, security, and social work all met with the staff. Building management conducted an independent environmental survey of the building.

"E-mails went to all staff that all 245 employees tested had negative results," Eagan said.

"Communication is key. We believe that by having a hands-on approach — actually being there meeting with staff — prevented panic in employees that were very vulnerable."

Then word came that the original specimen from the governor's office had been found culture negative on retesting. The hospital had been through an intense false alarm drill, but overall had met the challenge, Eagan said.

"Decisions were made using incomplete information at a time-sensitive pace," she said. "Staff responded in a positive manner to the high visibility of administrative leadership, infectious disease, and infection control in numerous educational sessions and e-mail alerts."

References

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APIC: Smallpox plan uses outdated infection control

Designating patient facilities a mistake

The Centers for Disease Control and Prevention (CDC) has based its smallpox bioterrorism response plan on "outdated concepts," and entire sections need to be revised to reflect current epidemiologic strategies, the nation's leading group of infection control experts warned.

The Association for Professionals in Infection Control and Epidemiology (APIC) commented on the *CDC Interim Smallpox Response Plan and Guidelines*, which has been released as something of a work in progress.

"In general, we are concerned that the draft guidelines appear to be based on outdated strategies used to control this disease decades ago and do not appropriately integrate those infection control strategies and environmental controls utilized in our hospitals today," the APIC letter stated.

The CDC response plan calls for investigators to rapidly immunize a "ring" around the first cases. The ring concept uses isolation of confirmed and suspected smallpox cases followed by contact tracing, vaccination, and close surveillance of contacts. The ring approach was used to successfully eradicate smallpox from the world in 1980. But the ring concept was effective when the demographics of smallpox were very different, when few were infected, and the vast majority of people already were immune.

As part of the ring response, vaccine would be administered to people involved in the direct medical care, public health evaluation, or transportation of confirmed or suspected smallpox patients.

"Vaccination, like any preventive strategy, is more effective if given prior to exposure," APIC argued. "If health care workers are not immunized prior to case identification, these individuals [especially emergency department staff, direct caregivers, and laundry personnel] should be vaccinated immediately upon documentation of a case in their community. It is crucial that we not wait for a case to present in the facility before taking preventative action."

In addition, it may not be possible to distinguish between febrile response to vaccine or actual exposure in health care workers, APIC warned.

"Approximately 20% of vaccinated employees will develop fever and not be able to work if vaccine is given in response to a suspect or confirmed case," the association stated. "We need to develop strategies for dealing with staffing shortages whether they are due to febrile reaction to vaccination, true infection / disease, or refusal to care for patients in a smallpox emergency."

'Misuse of resources'

APIC also questioned the CDC concept of a "Type C isolation facility" for smallpox patients. As proposed, the sites would be facilities that are at least 100 yards from any other occupied building, or those that have nonshared air-ventilation systems with filtered exhaust.

"We believe it would be a misuse of resources to design, build / retrofit, and maintain a designated facility that is not integrated with the existing health care system," APIC stated. "Using alternative structures rather than enhancing the current infrastructure is not a wise use of our limited resources."

Instead, existing facilities could substantially

benefit from dedicating resources to ensuring appropriate air handling and ventilation systems for existing clinics, emergency departments, and isolation rooms. "This would provide the added benefit of controlling more likely exposures to infectious droplet nuclei [tuberculosis, disseminated zoster, chicken pox, measles, etc.] in addition to minimizing or eliminating the likelihood of intrafacility transmission of smallpox," APIC stated.

The association expressed concern that health care delivery might be compromised in separate Type C facilities, particularly if they are not designed to provide services such as intensive care, ventilator support, dialysis, and laboratory resources. Rather then designate facilities for smallpox patients, each hospital should be prepared in advance to activate its program when the first case is identified, APIC argued.

"There needs to be a predetermined area [building or wing, etc.] that meets the 'Type C' facility requirements for isolation," APIC noted. "Part of a facility's planning would include a determination regarding the number of patients that could be housed in the designated area."

Some of the cleaning and disinfection recommendations in the document are out of date with current sterilization principles and practices. That includes "fogging" rooms to disinfect environmental surfaces, the association charged.

"CDC has not recommended the fogging of rooms for many years," APIC stated. "We strongly suggest the deletion of any archaic references to fogging." ■

Stanford sets the standard for bioterrorism planning

A separate piece: Stand-alone plan advised

It's not enough merely to update the bioterrorism component of your current disaster preparedness plan, experts say; you must create a detailed bioterrorism response plan that stands on its own.

That's precisely the philosophy behind the Stanford (CA) Hospital and Clinics (SHC) & Lucile Packard Children's Hospital (LPCH) Bioterrorism Response Preparedness Plan, which is gaining widespread recognition as a model for such plans. In fact, several Kaiser Permanente facilities in California already have adopted the plan.

"You need a separate [bioterrorism] plan," asserts **Eric A. Weiss**, MD, assistant professor of emergency medicine at Stanford, associate director of trauma at Stanford Hospital, and chairman of the disaster committee and bioterrorism task force. "During most disasters, for instance, you don't rely on the microbiology lab to identify pathogens. Also, infectious disease and infection control staff take on a major, heightened role."

In disasters such as an earthquake, Weiss notes, you generally don't have to worry about the quarantine of patients or the spread of infectious agents. Similarly, you may not have to put on protective clothing or worry about cross-contamination of existing patients who may be immunosuppressed.

A bioterrorism plan had been in place prior to 2001, Weiss says, "but it was really just a skeleton plan — not very comprehensive. It was part of a larger disaster preparedness plan, but a plan to deal with mass casualties from bioterrorism is very different."

When you have a major disaster such as the collapse of the World Trade Center, Weiss notes, local health care providers are likely to come to the hospital and offer to chip in and help wherever they can.

"But what happens when the word goes out that patients are walking around with smallpox?" he asks. "Are providers going to want to stream down to the hospital and potentially infect themselves and their families? You need a response plan to address the safety of health care providers, so they will feel comfortable and want to show up for work."

To create such a plan, the Bioterrorism Planning Task Force was formed, incorporating personnel from 30 or more different departments at both facilities. Those departments include infectious diseases, infection control, emergency medicine, pediatrics, critical care, intensive care units, nursing and hospital administration, dermatology, psychology, social services, and environmental health and safety.

"We began putting the plan together when we identified the fact that the current plan was not adequate," notes Weiss. "We accelerated our activities after Sept. 11. After Sept. 11, *everybody* wanted to be part of it."

[Editor's note: The bioterrorism plan is available on the Stanford web site at www.stanfordhospital.com.] ■