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Root-cause analysis: Court steps in to affirm confidentiality in malpractice case

Ruling makes them not subject to discovery

Risk managers have feared that a root-cause analysis (RCA) could fall into the wrong hands ever since the Joint Commission on Accreditation of Healthcare Organizations began requiring them in response to sentinel events.

An ongoing malpractice case in West Virginia should provide some reassurance that courts may snatch the RCA away from an eager plaintiff's attorney and that the Joint Commission will provide backup when you're in trouble.

The court's ruling means that the RCA is privileged and not subject to discovery by a plaintiff, says **Thomas J. Hurney Jr.**, JD, attorney with Jackson and Kelly in Charleston, WV. Though the malpractice case still is in litigation, Hurney says the protection of the RCA was a major victory for the defendant. The case involves a claim of wrongful death against a surgeon with the Herbert J. Thomas Memorial Hospital Association, in the Circuit Court of Kanawha County *(Hess, et al. v. Surface,* Civil Action No. 01-C-2910). A 20-year-old patient was being prepared for a shoulder arthroscopy and soon after the joint insufflation, she crashed and died. Hurney says the hospital cannot divulge details of the incident during litigation, but the hospital immediately treated the incident as a sentinel event and conducted a thorough RCA.

When the patient's family filed suit, the plaintiffs' attorney soon targeted the RCA, Hurney says.

"The plaintiffs never sent subpoenas for the interrogatories, and they never asked for the root-cause analysis in so many words, but they kept asking witnesses to bring information that would have been encompassed by the root-cause analysis," he says. "It was clear they wanted that information. We filed a motion for a protective order."

West Virginia has a confidentiality statute for peer review, but Hurney says the plaintiff's attorneys tried different strategies to get around it. For instance, they argued that since the peer review committee isn't made up

solely of health care providers, it is not a "committee" whose work is privileged under the statute. And in the nightmare scenario imagined by most risk managers, the plaintiff's attorneys argued that the hospital waived its confidentiality by disclosing the RCA to the hospital board and to the Joint Commission.

"They also said that the root-cause analysis is more in the nature of risk management than peer review, partly because of the type of incidents that trigger a sentinel event and a root-cause analysis," Hurney says.

The calvary arrives

Hurney fought those allegations, along with associate Gretchen Callas, JD, explaining to the court that the RCA is intended as a quality improvement effort rather than simply as a post-incident report. Hurney says he already was making headway with his argument when the cavalry showed up in the form of the Joint Commission. The response of the Joint Commission will be reassuring to risk managers who wonder how they could fight such a claim on a local level. When word reached Oakbrook Terrace, IL, that a West Virginia court might let a plaintiff's attorney thumb through the RCA, Joint Commission legal counsel **Hal Bressler**, JD, took off at full gallop.

Bressler attended the hearing in which the court heard arguments regarding the RCA. He says the Joint Commission acted quickly because it realizes that the sentinel event system will become worthless if accredited hospitals fear that an RCA will be used against them in a malpractice case. The Joint Commission has spent years trying to convince providers that they must do a very candid, brutally honest RCA after a sentinel event to improve patient safety; just one bad outcome in a court could unravel much of that work, he says.

"We support the peer-review privilege strongly because we believe that for there to be successful error prevention, the root-cause analysis should be privileged and confidential," Bressler says. "Otherwise, they won't be done or they won't be done as effectively as they could be."

Along with the American Hospital Association, the Joint Commission filed *amicus* briefs with the court urging that the RCA be kept confidential. In the brief, the Joint Commission's Bressler argued that "Any decision allowing individuals access to peer review records, including root-cause analyses and action plans, would significantly and negatively effect the and safety of health care provided to all patients. Simply put, such an invasion of the confidentiality of the peer-review process would have a debilitating effect on the ability of health care organizations to improve the quality and safety of health care as well as on the ability of the Joint Commission to enhance the achievement of that goal through the accreditation process." **(See p. 87 for more from the Joint Commission brief.)**

Judge James C. Stucky ultimately dismissed the amicus briefs, saying they were not appropriate in the case, but he still ruled in favor of the hospital and declared that the RCA was a peer review proceeding under West Virginia law. He reviewed the RCA documents privately and determined that they were privileged and therefore not discoverable.

Risk managers: Take heart

The ruling was a big victory for the hospital, but Hurney and Bressler say it was a victory for hospitals all over the country. A ruling in circuit court in West Virginia has no legal authority elsewhere in the country, but both lawyers say risk managers can take heart in the outcome of this case because it provides encouragement that other courts would follow the same reasoning.

"Until there is an appropriate federal statute, determining what is privileged and discoverable from these peer-review actions is determined by each individual state law," Bressler says. "Nearly all states have peer review statutes, and you have to determine whether these statutes apply or not. We're pleased to see that the West Virginia court agreed with our interpretation."

Hurney also says the case illustrates the Joint

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Commission's determination and willingness to help hospitals who find their RCAs threatened by plaintiffs' attorneys. Though the favorable ruling came through the work of himself and Callas, he says he was impressed with how the Joint Commission rushed in to the fight.

"The Joint Commission absolutely made the point of protecting the sentinel event process. In fact, they said they don't even care what happens to the hospital in the liability case. They don't have a dog in that fight," he says. "But they came in and made a fight for the peer-review issue. There was an importance to this case beyond the dispute among these two parties." ■

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JCAHO defends hospital's right to keep it confidential

Healthcare Risk Management obtained a copy of the *amicus* brief filed by the Joint Commission on Accreditation of Healthcare Organizations in a West Virginia malpractice case, arguing that the defendant hospital's root-cause analysis qualifies for protection under the state's peer-review statute. Here are excerpts:

• "Health care organizations are reluctant to report or even fully review certain incidents because of the litigious atmosphere under which health care organizations operate which constrains their willingness to share peer review records for fear of self-indictment. This fear with respect to the Joint Commission has been alleviated in part by judicial holdings and statutory provisions specifically providing that records disclosed to, and of, the Joint Commission will remain confidential. If this confidentiality is threatened, as it would be by disclosure of peer-review records to Plaintiffs, it would chill the candor of those participating in the peer review process and might cause health care organizations to limit drastically their use of peer review committees. . . . Moreover, any [West Virginia] decision invading the confidentiality of a root-cause analysis and, by extension, the peer review process, will become known to health care organizations in other jurisdictions and would chill the candor of those participating in the peer review process, thus adversely impacting upon the health and safety of patients in the remainder of the country as well.

• The levels of [root-cause] analysis described above, when performed in response to the occurrence of a sentinel event, constitute peer review. A root-cause analysis committee or other hospital committee does not perform peer review when it monitors the performance of processes that involve risks or *may* result in sentinel events. This type of ongoing review is recommended by the Joint Commission, but it does not require submission of such information by health care organizations. Only the former constitutes the activities of a review organization engaging in peer review and the information generated by such organizations is confidential under West Virginia law.

• The [West Virginia] Peer Review Act, §30-3C-1 *et seq.*, provides, in relevant part: "Peer review organization" means any committee or organization engaging in peer review . . . 'Peer review' means the procedure for evaluation by health care professionals of the quality and efficiency of services ordered or performed by other health care professionals. . . .

There can be no question the hospital committee that performed the root-cause analysis in the instant case was: 1) a committee; and 2) evaluated the quality and efficiency of the services provided to Heather Allen [the plaintiff].

The first part of this analysis is simple. The Act broadly defines "review organization" to include *any* committee or organization. The hospital root-cause analysis committee certainly qualifies. The

next part of the analysis is whether the committee engaged in peer review. The answer to that question, under the definition set forth in the act, the definition provided by the West Virginia courts, the definitions adopted by the legislatures and courts of other states and the commonly accepted definition of peer review, is indisputably in the affirmative.

Analysis of root-cause analysis

A breakdown of the Act's statutory language reveals that the performance of a root-cause analysis constitutes peer review. First, a root-cause analysis is a "procedure for evaluation" of "services ordered or performed by . . . health care professionals." A sentinel event, even in the cases of patient rape or infant abduction, involves the actions of a health care professional with respect to the safety and welfare of his or her patient. The root-cause analysis evaluates: 1) what happened; 2) why did it happen; and 3) what were the most proximate factors. See Exhibit B. The "quality" of the services is at issue because the outcome was necessarily adverse. The "efficiency" of such services is an important point of the root-cause analysis. The analysis seeks to identify "changes which could be made in systems and processes — either through redesign or redevelopment of new systems or processes — that would reduce the risk of such events occurring in the future."

• Plaintiffs' assertion that the purpose of a root-cause analysis is general risk management and not peer review is misguided. Risk management contemplates a general review of procedures. A root-cause analysis, however, is performed only following a sentinel event and is, at its core, a review of a specific adverse occurrence. It looks first and foremost at the event itself and the actions or inactions of the attending health care professionals. It also examines the actions of related health care professionals and the health-care organization as a whole. A root-cause analysis committee may conclude that an individual health care professional was strictly at fault for a sentinel event or that a more systemic cause played a role. The purpose of peer review need not always be to assign blame for an occurrence, but can and should be directed towards preventing future adverse occurrences. This is the *sine qua non* of a root-cause analysis.

There should be no question that the actions of the hospital in performing a root-cause analysis pursuant to Joint Commission standards were "peer review" and thus protected under the Peer Review Act.

• *In State ex rel. Charles Town Hosp. v. Sanders,* 210 W.Va. 118, 556 S.E.2d 85, 93 (2001), the court expanded the information protected by the act to include documents not originated by a review organization but created for such organizations. The court held that the act clearly evinced a "public policy encouraging health care professionals to monitor the competency and professional conduct of their peers in order to safeguard and improve the quality of patient care." *(Sanders,* 556 S.E.2d at 93.)

• Plaintiffs argue that the hospital committee is not a review organization because it is allegedly not composed entirely of health care professionals. Although the hospital ably responds to this contention, the holding in *Sanders* provides additional evidence that such an assertion is untenable. The *Sanders* court held that a document created by a noncommittee member is protected by the act (556 S.E.2d at 93). In light of this holding, it is not likely that the existence of nonhealth care professionals on a root-cause analysis committee would be sufficient to eliminate the otherwise valid protection provided by the act.

• Plaintiffs also allege that because information associated with the root-cause analysis was to be disseminated to other, possibly nonpeer review, committees, including the Joint Commission, the information is not privileged. This proposition was specifically rejected by the *Shroades* court. The court held that "[m]aterial that originates in a review organization remains privileged even if held by a nonreview organization." (*Shroades,* 421 S.E.2d at 269.) Clearly, the court foresaw that peer-review information might be disseminated to other committees in the hospital. In fact, the whole purpose of peer review would be lost if a peer review committee could not communicate its findings and conclusions to others in the hospital in an attempt to implement corrective actions.

• In their response, plaintiffs assert that the policies of the Joint Commission with respect to the submission of a root-cause analysis by health care organizations rebut the hospital's claim that the root-cause analysis is protected by the Peer Review Act. This is simply not true. First, as noted above, the Joint Commission considers the confidentiality of the root-cause analysis process to be vital to the Joint Commission's mission to improve the quality and safety of health care. Any erosion of the confidentiality protections afforded to a root-cause analysis would undoubtedly chill the candor of the participants in the process and have severe

consequences to health care throughout the country.

• However, the Joint Commission recognizes the variety in the peer review statutes of the states and the need for certainty on the part of a health care organization. It is impossible for the Joint Commission to affirmatively state that a root-cause analysis will never be held to be discoverable in every court in the country. Even in states that appear to have a broad peer review statute (such as West Virginia), plaintiffs (such as those in the instant case) will attempt to obtain discovery of confidential documents. Because of the need for certainty in this area, the Joint Commission is currently seeking a federal statute that explicitly guarantees the confidentiality of a root-cause analysis and other peer review materials. The enactment of such a statute will eliminate the types of actions such as the one before this court.

• The Joint Commission has never received a request from a health care organization in West Virginia for utilization of Alternative 4 [the reporting option that hospitals may use if they fear reporting the RCA to the Joint Commission would constitute waiving the peer review privilege under state laws]. The hospital did not seek this alternative method of submission and thus clearly believed that the information was privileged even prior to the inception of this litigation. Moreover, of health care organizations across the country, only a very small percentage chooses to use Alternative 4. ■

Houston Medical: Of cameras and criticism

Hospitals continue to open their doors to television producers, and some risk managers say the latest reality show is exploiting patients' most private moments with the hospital's blessing.

Cameras have become much more common in health care facilities in recent years, with many allowing producers access to emergency departments and other areas as they make reality television programming for entertainment purposes. The practice came to a head in 2000 when Johns Hopkins Hospital in Baltimore allowed camera crews unprecedented access to create a six-hour, prime-time, ABC News miniseries that garnered substantial publicity. The miniseries was widely hailed for its in-depth look at the inner workings of a hospital, but some risk managers criticized

the hospital for jeopardizing patient confidentiality and privacy.

The latest entrant in the hospital-as-entertainment category is Memorial Hermann Hospital in Houston. A respected teaching hospital, Memorial Hermann allowed ABC access to patients and staff in a wide range of situations, including a number of intimate moments of grief.

The general media characterized the program as great entertainment, with TV critic Monica Collins writing in the June 18 *Boston Herald* that "'Houston Medical' shows us how it is inside a real hospital, where a tiny, fragile baby dies while a mother weeps and wails. This is not happy stuff. We wonder why the subjects have allowed their most private moments to be shown on TV. But they have, and it's unrelievedly dramatic."

Officials at Memorial Hermann declined numerous requests from *Healthcare Risk Management* for interviews or information about how the hospital protected the rights of its patients and staff. With the previous program, Johns Hopkins officials told *HRM* that all patients shown on camera gave consent, though some patients were taped in emergency situations and then consent was obtained afterward. That raised questions among some risk managers, who questioned whether distraught patients and family members could truly give informed consent. Critics also questioned whether the hospitals participating in these programs are sending the wrong signal to staff, after years of trying to ensure confidentiality and the privacy rights of patients.

The Memorial Hermann program is another example of "turning health care into entertainment," says **Sandy Mahon**, vice president for risk management and quality assessment with Program Beta, the risk pool for hospital districts in California, based in Alamo. Mahon coordinates risk management activities for 77 hospitals, and says she would discourage any of her hospitals from allowing media access for entertainment purposes. She didn't think much of the Johns Hopkins program and didn't like what she saw in the new Memorial Hermann show either. "I don't know what's in it for them. We're not in the entertainment business. We're in health care."

In the first episode of "Houston Medical," a young couple was shown with their premature twins. The episode followed them through the stress of watching one child die, at one point focusing on the mother as she wailed at the baby's bedside, "Why is this happening to me and my baby? It's something I did! Please take me instead!" In the week leading up to the show, that clip of the mother screaming also was shown over and over again in prime time as a promotion.

As with the Johns Hopkins program, Mahon questions whether patients and family members understand that their most private moments of grief will be used that way, and whether they feel compelled to consent.

"These people are in very vulnerable situations, and then they have people come up and say how much they'd like it if you would cooperate with the film crew," she says. "We have to ask if they feel the need to cooperate so that the level of care is appropriate, whether there will be any retaliation if they don't cooperate and be the good patient, the good parent. People's minds are reeling in these situations, and they don't want to do anything that might upset the people responsible for saving their baby."

Like other critics, Mahon points out there is a major difference between programs intended as entertainment and programs that serve a legitimate educational purpose, such as those that educate people about diabetes care or spinal injury rehabilitation. But she says "Houston Medical" and similar shows provide only a minimal amount of useful information, and the main purpose of the program is entertainment.

"Memorial Hermann is a respected hospital, and I truly don't have a clue why they would want to go down that road," she says. "It's a *People* magazine version of health care, with profiles of the beautiful blonde doctor and the buff microsurgeon out jogging with no shirt." ■

A Back-to-Basics Primer

Slip-and-fall cases may be routine, but still are a risk

By **Trey Henegar**, JD
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Slip-and-fall accidents can happen at any time of year and for a wide range of reasons. Bad weather, and the resulting wet, slippery floors,

can greatly increase the likelihood of people slipping on your facility's floors, but these accidents can happen when you least suspect them. Health care facilities can be particularly susceptible to slip-and-fall accidents because of frequent mopping and spills.

Managing a slip-and-fall hazard doesn't rank among the more interesting risk-management activities, but it actually should be a major priority for risk managers. The potential payout for such a claim makes it worth your time. Hopefully, you have policies and procedures in place to make sure your facility is well maintained, and that any incidents are reported and properly documented. If not, this would be a good time to contact your insurer to discuss any concerns you may have.

The following review of a recent case shows how a risk manager, using good documentation, can assist in providing quality information for defending a lawsuit. It was mid-February, and a 25-year-old woman and her girlfriend came to the hospital to visit a friend who was recovering from surgery. She parked her vehicle in the parking lot and made her way toward the entrance. As she walked, she slipped and fell on the ground. The incident was reported and the risk manager took the visitor to the emergency room. An incident report was filled out that stated, "Visitor slipped and fell in our parking lot."

The risk manager had the patient examined and told her, "Don't worry about it; we'll take of everything." The patient's initial assessment did not reveal any injury, but it was later discovered that she had suffered a fractured ankle. It required an open reduction and internal fixation. The hospital took care of the bills, and everything appeared fine until a couple of months later when the lawsuit arrived in the mail.

Room for improvement

In reviewing the actions taken in this instance, we can see some areas that need improvement and questions that we need to ask ourselves when slip-and-fall cases such as this occur in and around our facility. First, make sure the person who fell is evaluated and treated in your emergency room at no cost. While the initial assessment may be free of charge, instruct your staff not to promise payment for subsequent visits or treatment. Second, always have a camera loaded with film in your office. This will allow you to record an event on a moment's notice and photograph the scene in its current state. Include the date and time on your developed photos. When taking pictures, always take a couple of photos showing the entire landscape (or overview) of the area in question. Also take photos of the specific area where the incident occurred. A good rule of thumb is to have the person who fell show you the exact spot. If someone refers to a crack or a dip in the pavement, have him or her show you where it is located. Take a picture of it and if possible; use a ruler in the photo to show its width or depth. In one case, a risk manager took a picture of a person's shoes. In this instance, it was winter as well, and this photo helped to establish that the visitor was wearing shoes that were inappropriate for the conditions.

Gather information as soon as possible

Third, it is suggested that the person alleging to have fallen complete a detailed statement, and then sign and date it. While you will fill out your own incident report, this statement, along with any witness statements, can also be beneficial. Remember to include the names and addresses of your witnesses. If the injured person's version is recorded immediately, it makes it difficult for him or her to change his or her story at a later date (after speaking with a local personal injury attorney).

Fourth, determine who is in charge of maintenance and what information is available concerning the area in question. Is your maintenance department responsible for the grounds, or do you subcontract with another company for certain services such as snow removal? This information also should be included in your report. (Snow can greatly escalate your risk for slip-and-fall accidents. It is a good idea to maintain a log of dates and times of snow removals.)

We were able to settle the above case before it went to trial. The area had been hit with quite a bit of snow and while the parking lot had been plowed, it was still covered with packed snow. Interestingly, a witness to the fall was related to a hospital employee and knew the visitor. She reported that the two women were horseplaying in the parking lot when one of them fell. This information helped bring the suit to a quick conclusion.

In retrospect, it would have helped end the case sooner if the risk manager had asked a few more questions and probably taken a few photos to better record what happened in that particular instance. Whether it is a case of professional or general liability, documentation always is the key. The sooner you can record the information from

all known parties involved, the better chance you have of reducing your loss. ■

Justice Department hits hospitals hard for fraud

One hundred thirty-nine hospitals currently or formerly operated by Tenet Healthcare Corp. will pay the United States and 22 states $17 million to settle allegations that the facilities overcharged federal health care programs in connection with laboratory services.

The U.S. Justice Department announced the settlement recently. Under the settlement, the United States would receive $16.18 million. The remaining $820,000 of the settlement amount would be put in an escrow account for the benefit of the participating states — Alabama, Arizona, Arkansas, California, Florida, Georgia, Indiana, Iowa, Louisiana, Massachusetts, Mississippi, Missouri, Nebraska, Nevada, North Carolina, Oregon, South Carolina, Tennessee, Texas, Washington, West Virginia, and Wyoming.

The settlement with the Santa Barbara, CA-based corporation resolves allegations by the United States that the hospitals submitted claims to the government to pay for laboratory tests without regard as to whether the tests were medically necessary, had been properly ordered by physicians, or were otherwise reimbursable under certain federal health care programs. These programs include Medicare, Medicaid, TRICARE — the military's health care program — and the Federal Employees Health Benefits Program.

Another Tenet facility, Brotman Medical Center in Culver City, CA, will pay the United States $9.75 million to settle allegations that it overcharged Medicare in connection with the provision of rehabilitation services to hospital patients. The settlement resolves allegations that Brotman improperly charged Medicare at rates reflecting that certain services were made available to patients in beds licensed specifically for the purpose of providing rehabilitation services. The government alleges that, in fact, the services were provided in beds that were not licensed for rehabilitation purposes and that are reimbursable by Medicare at lower rates. Further, the settlement resolves allegations by the government that Brotman misrepresented the square footage of the rehabilitation unit and other units in the hospital on annual cost reports that the health care provider submitted to the Medicare program.

The civil settlement includes a full resolution of claims brought against Brotman and its parent corporation, Tenet Healthcare Corp., by a former controller of Brotman, William Noll, under the *qui tam* or whistle-blower provisions of the False Claims Act. Noll, who filed his suit against Brotman in September 1998, will receive approximately $1.93 million of the total recovery as his statutory award. Under the *qui tam* provisions of the False Claims Act, a private party can file an action on behalf of the United States and receive a portion of the settlement if the government takes over the case and reaches a monetary agreement with the defendants.

Another seven U.S. hospitals will pay more than $6.3 million to settle charges that they illegally billed the government for surgical procedures that were not reimbursable. The Justice Department alleged that between 1987 and 1994, the hospitals charged federal health care programs for procedures involving experimen+tal cardiac devices that were not, in fact, reimbursable.

Scripps Health, which owns hospitals in La Jolla and San Diego, CA, will pay the United States $3.8 million. UPMC Health System, owner of two hospitals in Pittsburgh, will pay $1.5 million, according to the Justice Department. Oklahoma City's Integris Baptist Medical Center will pay $629,000, Hoag Hospital in Newport Beach, CA, will pay $305,000, and St. Joseph's Regional Medical Center in South Bend, IN, will pay $107,000.

All of the hospitals denied wrongdoing in regard to the cardiac devices. Scripps Health president and CEO **Chris Van Gorder** said in a statement that the cardiac devices were allowed for use in clinical research. They were considered the best available technology at the time, he said, and the U.S. Food and Drug Administration later approved them.

"We believe we billed in compliance with all Medicare rules and regulations," he said, and settled the case "to avoid the delay, uncertainty, inconvenience, and expense of fighting these claims."

The hospitals were among more than 100 that had been named in a lawsuit filed by a whistle-blower who is a former medical device salesperson. The Justice Department says the whistle-blower will receive more than $1 million of the settlements, and other hospitals still are under investigation. ■

AMA: States are in crisis of liability and of costs

A report from the Chicago-based American Medical Association (AMA) says at least a dozen states are in a medical liability insurance crisis that has forced physicians to limit services, close practices, or move to other states.

Annual costs for medical liability insurance could reach as much as $200,000 or more for some physicians, especially surgeons and obstetricians. The AMA says 30 more states have the same problems to lesser degrees. The physicians' group surveyed physicians in all 50 states and determined that the states in crisis are Florida, Georgia, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington, and West Virginia. The only states that have escaped the malpractice crisis are those that have enacted laws protecting providers, usually during similar crises in the 1970s and 1980s. California, Colorado, Indiana, Louisiana, New Mexico, and Wisconsin, for instance, have laws that establish caps for pain and suffering and limit the amount lawyers can charge for contingency fees.

In response to the nationwide crisis, the AMA and other physicians' groups recently called on Congress to take action. Testifying before the House Judiciary Subcommittee on Commercial and Administrative Law recently, AMA secretary-treasurer **Donald Palmisano**, MD, says the situation has become so critical in some states that physicians are forced to limit services, retire early, or move to another state where liability premiums are more stable.

"Many OB/GYNs and family physicians have stopped delivering babies, and some advanced and high-risk procedures, such as neurosurgery, are being postponed because surgeons cannot find or afford insurance," Palmisano says. "The AMA always has held that patients who have been injured through negligence should be compensated fairly. Unfortunately, the current liability system has failed patients. The United States has created a liability lottery, where select patients receive astronomical awards, and many others suffer access to care problems because of it."

Lawrence Smarr, president of the Physician Insurers Association of America, told the subcommittee that rising damage awards in malpractice cases and lowered returns from investments available to malpractice insurers have combined to create "the perfect storm" of a malpractice crisis.

"During the period 1991-2001, the percentage of million-dollar-plus claims increased from 2.06% to 7.9%," he reported.

Help may come in the form of H.R. 4600, the HEALTH Act, a bipartisan bill introduced recently that would make a series of changes in malpractice laws, most notably imposing a $250,000 cap on noneconomic damage awards. Subcommittee Chairman Bob Barr (R-GA) said the bill is necessary because "a national liability insurance crisis is ravaging the nation's health care system."

Barr said California's landmark 1975 Medical Injury Compensation Reform Act is a model for national reform. That law includes a $250,000 noneconomic damage cap. Barr noted that California has not been affected as seriously as other states by the current malpractice crisis.

The vast majority of Americans also support liability reform, according to a recent survey by the Health Care Liability Alliance (HCLA). 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.

"The spiraling costs generated by our nation's dysfunctional liability system are borne by everyone," Palmisano says. "We need a system that ensures fair compensation and puts an end to the liability lottery. The HEALTH Act will go a long way toward bringing common sense back to our liability system."

Furthermore, they agree that litigation is one of the primary factors behind rising medical costs and reduced access to care. By overwhelming margins, the HCLA poll shows, Americans favor legislative reforms such as limiting trial lawyers fees and guaranteeing patients full payment for medical expenses and lost wages while placing reasonable controls on awards for noneconomic damages, such as pain and suffering.

The poll resulted in these other findings:

- **Lawsuits hinder access to medical care:** Nearly four out of five Americans (78%) express concern that skyrocketing medical liability costs could limit their access to care, as doctors in many parts of the country, particularly those providing specialized care, scale back services or abandon their practices.
- **Too many lawsuits:** Nearly half of Americans (48%) believe the number of malpractice lawsuits against health care providers is "higher than is justified" compared to just 17% who said the number of claims is "lower than is justified."

To bring more attention to the problem, the AMA has considered a march on Washington, DC. The group has decided against a march this year, but it is forming a task force to organize a "major national event" calling for tort reform, Palmisano says.

Delegates at the annual AMA House of Delegates meeting debated an action plan to fight rising malpractice premium costs, which they say are driving physicians out of practice. The delegates called the problem a "highest priority" and voted to launch a broad-based coalition — including trade and professional associations, medical groups, farmers, and patient advocacy groups — to "promulgate a public information campaign on the issues of civil liability reform."

The delegates decided against a march on Washington for this year but the "major national event" task force might reconsider that option for a later date, says AMA trustee **D. Ted Lewers**, MD, of Easton, MD. He says the delegates also directed the AMA board of trustees to take a series of steps that would thwart what they called "circuit-riding expert witnesses." Some AMA delegates contend that traveling expert witnesses will say whatever suits a plaintiff's cases. So the delegates directed the AMA to "go on record condemning any physician who would harm a colleague with false testimony" and to explore the possibility of all specialty societies establishing registries of testimony. The AMA also will encourage specialty societies to sanction or expel members who give false testimony.

The American College of Obstetrics and Gynecology already maintains such a registry and expels members when it discovers evidence of false testimony. ■

Road to proportional malpractice reform

Pennsylvania governor Mark Schweiker has indicated that he will sign into law a bill hailed by many as the first step in reforming the state's out-of-control malpractice liability system.

The law will address the issue of joint and several liability. Under joint and several liability, a company found even 1%, 5%, or 10% liable in a civil suit can be held 100% financially responsible, the legislators said. Liability is "joint" because all of the defendants are liable together, and "several" in that any defendant may be pursued for the entire verdict. Thus, a plaintiff may recover the full amount of the award from any of the defendants. The result is that litigants often go after companies with deep pockets, putting Pennsylvania at an economic disadvantage with regard to attracting, creating, and retaining jobs. If the provisions in the bill are enacted, defendants found to be at fault would only be held liable for their proportionate share of damages. Under the reform measure, defendants who are found by a judge or jury to be less than 60% liable would only pay their fair share of the overall liability.

The effort to amend the reform provisions into Senate Bill 1089 was led by Sen. **Jeffrey Piccola** (R-Dauphin), Sen. **Hal Mowery** (R-Cumberland County), and House Majority Leader John Perzel (R-Philadelphia).

Senate Bill 1089 will begin to return fairness to our civil justice system," Piccola says. "It offers hope to Pennsylvania's business community that reform of joint and several liability and other critical tort reform measures which have been adopted in most states are finally under way in the commonwealth."

Among the hardest hit by joint and several liability are health care facilities because they must obtain insurance above the mandated limits, the legislators noted. "In fact, hospitals may be named in a suit simply because they have insurance coverage," says Piccola. "In the current climate, their insurance premiums continue to escalate while the number of insurance underwriters decreases."

Five commercial carriers that insured more than half of the hospitals and health systems in Pennsylvania have left the market or are not renewing policies during this current annual insurance renewal cycle, Mowery says. Mowery and Piccola cite several cases in which Pennsylvania hospitals have had to reduce services and lay off employees as a result of joint and several liability's affect on insurance coverage.

Among them is Methodist Hospital in Philadelphia, which cited the rising costs of malpractice insurance for its decision to cease delivering babies, a service it has been providing for more than a century. As a result, 91 full-time and part-time Methodist employees will lose their jobs. Albert Einstein Healthcare Network was forced to lay off 127 employees, the direct result of rising medical malpractice premiums. Havertown's Mercy Community Hospital closed its emergency department and all inpatient services earlier this

year. Summit Health in Chambersburg has closed its Healthy Beginnings Maternity Clinic after 15 years of serving 200 Medicaid patients annually. Memorial Hospital in York County had to go as far as London in search of affordable excess insurance coverage.

The potential of assuming 100% of a verdict has forced several Pennsylvania hospitals to reduce services and lay off employees so that they could afford the necessary insurance coverage. This has come at a time when five commercial carriers that insured more than half of the hospitals and health systems in the state have left the market or are not renewing policies during the current insurance renewal cycle. The legislation retains four additional circumstances where a defendant could be liable for full payment of an award: intentional misrepresentation, intentional tort, violations of the Hazardous Sites Cleanup Act, and cases where alcoholic beverages are served to a visibly intoxicated patron. ■

A new path to prevent deadly MRI accidents

Following a horrific accident last year in which a young patient was killed, the American College of Radiology has issued new safety recommendations for the use of magnetic resonance imaging (MRI) machines.

Many of the new recommendations include restricting access to MRI rooms. Others include appointing a special director of hospital MRI facilities and educating emergency personnel and others who might work near or in an MRI department about safety (*American Journal of Roentgenology* 2002; 178:1,335-1,347).

Why new guidelines?

The guidelines were issued partly in response to an accident in July 2001 in which a metal oxygen canister that was mistakenly taken into an MRI examination room by a non-MRI staff member killed a 6-year-old boy. The MRI's powerful magnet drew the canister to the boy's head. The accident happened at the Westchester Medical Center in Valhalla, NY.

Emanuel Kanal, MD, of the University of Pittsburgh, was the lead author of the guidelines. His team recommends restructuring the MRI department environment so that MRI departments be divided into four zones. The zones would include a patient waiting room (Zone 1), a patient changing / holding area (Zone 2), a control room (Zone 3), and the MRI room (Zone 4). Access to Zone 3 and 4 would be restricted to trained MRI personnel.

Also, the team says that each facility should appoint an MRI director to oversee all aspects of safety and write reports about accidents, or near-accidents. The report also suggests that hospitals

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implement a comprehensive MRI safety education campaign for emergency personnel such as firefighters and police, as well as hospital maintenance and janitorial workers. ■

Legislation may give legal protection to patient safety

Legislation making its way through Congress could represent a major improvement in the protections afforded information that is reported for the purposes of improving quality and patient safety.

The legislation has been lauded by representatives from many areas in health care, such as American Association of Health Plans president and CEO **Karen Ignagni**. She says the tripartisan legislation introduced by Sens. Jim Jeffords (I-VT), John Breaux (D-LA), and Bill Frist (R-TN) that would give legal protection to information that is the voluntarily reported for purposes of quality improvement and patient safety.

"But a major obstacle stands in the way . . . Currently, information that is shared among providers is not considered confidential."

Legal protection for the information could make it possible to fulfill some goals outlined in the 1999, Institute of Medicine (IOM) report on medical errors, she says. The IOM report says the best way to reduce medical errors is to expand the use of voluntary reporting systems — which currently are underutilized — so that providers and other health care participants can learn from past incidents.

"The IOM recognized, however, that in our current environment, with malpractice lawsuits increasingly out of control, providers have a strong incentive not to report this information," Ignagni says. "The sad result is that we have virtually no information about why medical errors happen, and lives continue to be lost as a result. We need to replace this culture of blame with a culture of safety, that puts the lives of patients over the interests of trial lawyers."

Dick Davidson, president of the American Hospital Association, also praised the legislation. "The bill lays out a common-sense approach to improving patient safety," he says.

"Creating a culture of safety within our organizations is key, where nurses and doctors share information when mistakes happen to help us learn from and prevent them," he says. "But a major obstacle stands in the way of doing just that. Currently, information that is shared among providers is not considered confidential. The Institute of Medicine has called on Congress to knock down this barrier by providing legal protection for information collected to advance patient safety research and education. This bill would accomplish this goal — a goal the nation's hospitals strongly support." ■

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Delay in transfer results in death: $5 million awarded

By **Jan J. Gorrie**, Esq., and **Seema Patel**
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News: Following a seemingly minor automobile accident, a passenger was taken to the emergency room and admitted for overnight observation. Her condition worsened, and the next morning, she was transferred to a trauma center for emergency surgery. She died 31 days later due to complications from the delay in treatment. The Ohio jury awarded $5 million.

Background: The Ohio State University professor was a passenger in the back seat of an automobile involved in an accident. She was wearing the only available restraint, a lap belt without the shoulder strap. At the scene of the accident, she had no visible signs of injury, but complained of stomach pains. She was transported by ground ambulance to the local community hospital, where the emergency room physician, who subsequently consulted with a surgeon, evaluated her.

She was admitted for observation, and her husband left the hospital thinking that he would take her home the next morning. The surgeon left no orders for further testing or for a serial physical examination. Because the facility did not have a CAT scan with contrasting capabilities, none was ordered. During the night, her condition worsened. The nurses called the surgeon several times. He said she would be fine until the morning and that he would be in to see her then.

When the surgeon arrived in the morning and examined her, he detected what he believed to be a tear in her mesentery, which is a double layer of peritoneum attached to the abdominal wall and enclosing in its fold a portion or all of one of the abdominal viscera conveying to its vessels and nerves. The surgeon recommended that she undergo emergency surgery. The patient's husband asked that she be transferred to one of the two nearby trauma centers so that the surgery could be performed there; these more sophisticated services were a 40-minute drive away. She was air-evacuated to one of the centers. However, severe sepsis already had developed, and the contents of her bowels had emptied into her stomach. Despite the surgery, she died at the trauma center hospital 31 days later.

The plaintiff alleged that the hospital held itself out as a place a person could receive adequate emergency care and treatment. The plaintiff also alleged that in order to assure the delivery of such emergency care, the hospital should have had protocols requiring more extensive testing, and that if the facility was unable to have the requested tests and follow-up performed, the protocols would have addressed the need to transfer. The plaintiff maintained that the community hospital surgeon was negligent in not performing sufficient tests and medical examination either prior to or after admission and for not responding more quickly to and acting upon the change in her condition.

The community hospital surgeon maintained that at the time of transfer, the patient was doing

well, and that if any negligence were involved it should be on the part of the trauma surgeon and the trauma center. The trauma surgeon testified as to the patient's poor condition upon arrival at the trauma center. The jury found the community surgeon negligent and the community hospital vicariously liable; it returned a verdict of $5 million.

What this means to you: This case focuses almost entirely on the practice of medicine and provides a serious caution for physicians treating cases in the emergency department setting.

"When the patient looks 'good,' the physician can more easily overlook the 'bad,'" observes **Ellen L. Barton**, JD, CPCU, a risk management consultant in Phoenix, MD. "The fact that the car accident was described as a relatively minor one unfortunately might have created a mindset in the physician so that he wasn't as thorough as he should have been, and the examination and testing were not as probing as they should have been. Clearly, some remedial continuing education would be helpful. The fact that the patient had been wearing only a lap belt and immediately complained of stomach pains should have signaled the need for careful and thorough examination of the abdomen and, if indicated, the need for a CAT scan. Since the facility did not have the appropriate equipment, a transfer should have been arranged in a timely fashion.

"The lack of appropriate equipment raises a corporate liability issue. Hospitals and other health care facilities should always be in a position to treat patients with necessary medical equipment or be able to arrange for their transfer to facilities that have such equipment, if they do not have what is necessary to treat or assess the patient," adds Barton.

"Finally, the fact that the physician's response to repeated calls from nursing staff was less than adequate and, in fact, appears callous. Protocols for medical response to nursing concerns need to be in writing and clearly understood. For example, if nursing staff felt that the physician was not responding appropriately, they could have used a chain-of-command policy to contact the medical director or chief of staff or some other resource that would have addressed the nurses' concerns and possibly saved the patient's life," she concludes.

Reference

• *Lyons v. Clarkson,* Franklin County (MO) Court of Common Pleas, Case No. 97808-7796. ■

Ambulance errors lead to $10.2 million settlement

News: While in route to a 911 call from the home of an infant experiencing febrile seizures, a dispatched ambulance became lost. Once it arrived on the scene and packed the infant for transport to the hospital, paramedics were instructed to administer a controlled substance. Then they discovered they did not have the key to their narcotics cabinet. The plaintiffs claimed that the series of delays resulted in permanent brain damage. The ambulance company settled for $10.2 million.

Background: An infant developed febrile seizures due to a high fever and her parents called 911. An ambulance was dispatched, but it got lost in route and was delayed by approximately 13 minutes. Upon arrival, the paramedics assessed the infant as being hypoxic with a 78% blood-oxygen level.

On the way to the hospital, paramedics were advised to give Valium to the infant to control her seizures. However, the paramedics were unable to comply with this instruction because the key to the narcotics cabinet had been forgotten. Another ambulance was dispatched to intercept the first ambulance so that the Valium could be accessed. This resulted in a delay in administering the Valium of approximately 10 minutes.

Once the infant arrived in the hospital, she was diagnosed with profound hypoxic ischemic brain injury. The plaintiff alleged that this delay in transporting her to the hospital and in administering the Valium resulted in oxygen deprivation for at least 40 minutes, which led to the permanent brain injury and spastic quadriplegia. These conditions require the use of a wheelchair and gastrostomy tube for feeding. The plaintiff is unable to walk or talk and is completely dependent upon others.

The defendant ambulance company countered that any delay in administering medication did not effect the outcome and that the plaintiff's seizures could not have been controlled outside of the hospital setting. Further, the defendant rebutted the plaintiff's life expectancy and projected cost of care; however, the ambulance service provider ultimately settled prior to trial for $10.2 million.

What this means to you: While this scenario involved a pre-hospital provider, many health

facilities are in the business of providing ground and air ambulance services. As participants in the emergency medical services (EMS) arena, hospitals may find themselves faced with the errors addressed in this case. It is a difficult reality when the public EMS providers or the organizations they have contracted with are unable to find a patient when they are in need of immediate medical care. The public is counting on EMS not to get lost, but when they do and the directional error is compounded by additional errors in the delivery of health care, settlement is usually the chosen route.

"While this tragic case was settled prior to trial, one of the major issues could have been resolved [although expensive] to avoid this situation. Ambulances can now be equipped with a GPS system [the newer ambulances have this as a standard feature] to guide the driver to the exact location," notes **Lynda Nemeth**, RN, MS, JD, director of quality/risk management at Norwalk (CT) Hospital. "For many ambulance services, there are maps that have been divided into grids for each section of a city/town, and the second EMS staff person locates the address and directs the driver to the specific location. Furthermore, in many towns, either the fire department or the police department are designated as first responders and are trained as emergency medical technician [EMTs], when a 911 call comes into the dispatch office, they respond and are the first to arrive on the scene to administer initial resuscitation or care, prior to the arrival of EMS."

Unfortunately, the errors did not stop with a few wrong turns. Once the ambulance arrived, the missing key also created a delay.

"The issue related to access to the narcotic cabinet is more difficult to resolve. Dependent on state laws specific to securing of narcotics and controlled substances, alternative methods of locking these drugs, such as a combination lock or keypad lock might be utilized. This would allow the entry code to be available to all of the EMS crew that would drive that particular ambulance, and it could be changed periodically by the company director. Some states, however, would not allow this, as they feel that the security of the drugs would be diminished using this type of system. The entity that owns/controls the ambulance service, whether private- or hospital-owned, would have to develop policy and procedure which complied with their state laws," adds Nemeth.

"While the facts of this case do not show whether the EMTs did a pulse-oximetry reading or whether oxygen was administered on arrival at the scene, this should have been part of the initial treatment of the infant. And so, in addition to the errors in the delivery of care, there may have also been a regrettable deviation in the standard practice of health care," concludes Nemeth.

Reference

• *Anonymous Infant v. ABC Ambulance Co.,* Suffolk County (MA) Superior Court. M. Breakstone, Boston, for the plaintiff. ■

Failure to notify leads to a $425,000 verdict in NJ

News: After presenting to the emergency room, a young man died. Though his discharge papers identified him and contained the name and telephone number of his parents, his parents were not made aware of their son's death until they received the bill from the hospital 29 days after his death. The jury awarded the parents $425,000 for pain and suffering.

Background: The young man was found suffering from a drug overdose in the bathroom of a McDonald's restaurant. He was taken by ambulance to the nearest hospital and died in the emergency room. There were discharge papers in his shirt pocket from a neighboring hospital identifying him as a recent parolee and gave the name, address, and phone number of his parents with whom he resided. But his parents were not told that he had been hospitalized and died. His body was sent to the county morgue and an autopsy was performed.

In the meantime, his parents had reported their son missing to the police and to his parole officer. The decedent's parents had even contacted a psychic in the hope of learning of their son's whereabouts. It was not until 29 days later that the young man's parents learned of his fate. The news came with the hospital's bill for services.

The parents brought suit against the hospital for violating hospital policy by failing to inform them of their son's hospitalization and death when the hospital clearly had a record of the decedent's name, address, parents' names, and phone number. The case went to trial, and the jury awarded the parents with $425,000 in pain-and-suffering damages.

What this means to you: Even in the absence of clear medical professional liability, there may still be liability for the poor delivery of health care services.

"Although this is a case that has nothing to do with the practice of medicine, it has everything to do with the delivery of health care," notes **Ellen L. Barton**, JD, CPCU, a risk-management consultant, in Phoenix, MD. "All hospitals and health care facilities have a corporate responsibility to maintain a good system of communication not only between and among their independent medical staff and employed health care professionals and all other employees, including administrative staff, but also with patients and their families. In this case, the hospital failed miserably. While one might forgive a short delay in communication, the fact that there was never any communication is unacceptable and clearly below the applicable standard of care."

Hospital emergency rooms are busy places and are often the hub of life or death situations. While all efforts are made to save lives, the reality is it cannot always be done. And, in the cases of death, the facility should be prepared.

"Having policies and procedures in place not only regarding the procedure for contacting patients' families but specifically assigning responsibility for the various tasks is critically important. In all likelihood, staff members assumed that someone else had done it. When everyone is responsible, no one is responsible. It may have been that the specific task of notifying family members of a death was not clearly assigned to a defined staff member. In this case, perhaps the emergency room social worker, should have been accountable," adds Barton.

"This case also points up the lack of communication between the billing department and administration or risk management or social work or patient relations, or whatever department might be charged with the responsibility of handling sensitive cases or simply cases where the patient has not survived. Perhaps the development of a policy and procedure to identify and address the issues surrounding billing in sensitive cases would go a long way in delivering quality health care," states Barton.

Reference

• *Stephen and Janine Sante v. St. Mary's Hospital*, Essex County (NJ) Superior Court, Case No. L-9775-98. Michael Zerres, Esq., of Chatham, NJ, for the plaintiffs. ■