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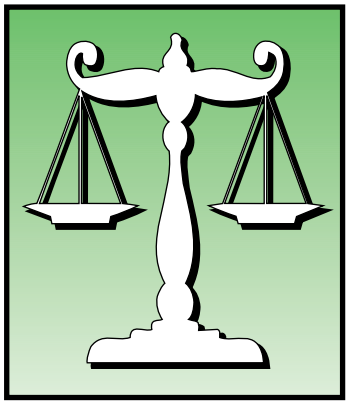

Healthcare Risk Management™

INSIDE

- Feds offer advice on EMTALA compliance . . . 19
- Dual staffing could be EMTALA problem 20
- Real-world advice offered for EMTALA 20
- Hospital awarded millions in brokerage dispute 21
- Columbia/HCA accused of plan to bribe auditor 22
- **Reader question:** How to respond to angry patient. . . 23
- Harassment claims pose major risk to health care . . . 24
- How to investigate harassment claims 26
- Lawsuit settled after test leads to boys death 28

Legal Review & Commentary

- **Botched defibrillation:** $600,000 1
- **Patient suicide:** $3 million. 2
- **Misdiagnosed infant:** $3 million. 4

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EMTALA warning means risk is greater for any emergency delays

Feds make it clear they will adhere to strict interpretation for payment

The federal law requiring emergency treatment for anyone who shows up in your emergency department has long represented a significant liability and regulatory risk for hospitals, but a recent warning from the federal government ups the ante even more. The feds are clamping down on any delay in treatment caused by efforts to seek third-party approval and payment, and that means you have to make sure the violation doesn't happen on your watch.

Since it first was enacted in 1986, the Emergency Medical Treatment and Labor Act (EMTALA) has required hospitals to provide "an appropriate medical screening examination" and treatment "as may be required to stabilize the medical condition" before discharging, transferring, or referring the patient to another provider. Generally known as the "anti-dumping law," EMTALA is intended to prevent hospitals from turning away patients who cannot pay if they are genuinely in need of emergency care. With its most recent statements, the government is letting providers know administrative delays while checking a patient's insurance can be considered a violation of EMTALA.

> **"If we haven't already learned the lesson, we're going to get our knuckles rapped."**

Inspector General **June Gibbs Brown** of the U.S. Department of Health and Human Services (HHS) issued a special advisory bulletin on EMTALA, explaining that the Clinton administration will be taking a hard line on the issue. She stresses that a managed care organization (MCO) contract cannot "excuse a hospital from providing needed emergency medical screening and stabilizing care." Contractual requirements for pre-authorization cannot get in the way of EMTALA requirements, she says.

That has always been the case, but the rise in managed care in recent years has led to more complaints against hospitals, according to the HHS, which enforces EMTALA along with the Justice Department. They have

obtained settlements in 67 dumping cases in the past two years, resulting in $2.3 million in penalties. That is more than 10 times the amount of penalties collected in the previous 10 years combined, partly because Congress allocated more money to EMTALA enforcement in 1996.

"Investigations of patient-dumping allegations have persuaded us that managed care patients may more likely be victims of dumping than other patients," Brown says.

Brown reports receiving 200 complaints a year regarding delays in emergency treatment due to attempts at getting MCO approval. EMTALA violations carry a penalty of up to $50,000, and flagrant or repeat violations can result in expulsion from all federal health care programs.

The American College of Emergency Physicians supported the strong position on EMTALA with a statement saying it could help avoid some of the dilemmas doctors face. MCOs often want providers to contact them before providing any screening or stabilization, but the government's statement makes it clear that such delays are not acceptable, says **Charlotte Yeh**, MD, chairwoman of the college's government affairs committee.

Warning could be used in your favor

For risk managers, this is one more way government regulators have set their sights on you. The government warning means that you must take steps to ensure patient admissions and billing processes do not get in the way of emergency treatment, even unintentionally, says **Mark Cohen,** ARM, RPLU, a risk management consultant with Sutter Health in Sacramento, CA. "Now more than ever, the message is that you must comply with this law completely and don't try to avoid it in any way," he says. "If we haven't already learned the lesson, we're going to get our knuckles rapped. We're going on 13 years since this law was written, so what's the mystery?"

Cohen says that the federal crackdown was prompted by hospitals and MCOs trying to fudge the rules in emergency departments, a practice that Cohen says most risk managers would admit is a reality in their hospitals. That fudging is not always the choice of the hospital, he notes. Rather, it often is a response to the demands of the MCO that the hospital play by its rules in seeking preauthorization, even if the MCO rules conflict with EMTALA. A good result of the government crackdown could be that hospitals have more support for saying no to MCOs, Cohen says.

That point is supported by **Lynn Tenerowicz**, RN, JD, risk manager at Baystate Medical Center in Springfield, MA. If the MCO tries to enforce a contract requiring some sort of preauthorization for emergency care, the recent statements from the HHS remove all doubt that such rules are illegal, she says. "I suspect some organizations where managed care contracts have required prior authorization will have to renegotiate those contracts and revise practices to ensure compliance. Some financial people who negotiate with managed care organizations would always hear that the requirements were not clearly stated before. I think there was some support for that argument previously, but now that's not the case. The requirement is very clear now."

What does this mean in terms of your emergency department's daily operation? Cohen and Tenerowicz say the EMTALA clarification means the treatment process and the payment authorization process must proceed on completely separate tracks. They may proceed concurrently, but they must be identified clearly as separate tasks and not interdependent ones. **(See pp. 19-21 for the government's recommendations and other tips on how to comply with EMTALA.)**

"Our emergency department will have the patient triaged by a nurse, and a determination is made as to where the patient is in the order of treatment. All the treatment process flows from that triage," Tenerowicz explains. "The staff also may begin the registration process in the interim, but they won't say to the patient that 'You can't have the screening exam until we check with the insurer.' You can have registration and treatment going on at the same time, but they're not contingent on each other."

(The feds say they are not sure about the legality of "dual-staffing" arrangements in which an MCO's own physician works in the emergency

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department to screen an MCO's patients. **For more on that issue, see story, p. 20.**)

Compliance with EMTALA inevitably will result in some patients abusing the emergency department for non-emergency care that will not be reimbursed. Cohen and Tenerowicz both are unhappy about that result, but Cohen says there is no need to fret over the unfairness of EMTALA. The actual cost of unreimbursed exams is probably lower than most financial officers would estimate, Cohen says, and besides, there apparently is no wiggle room left in the law.

"EMTALA is patently unfair to hospitals because you have to do the initial exam, and you won't get paid for some of them," he says. "Get over the fact that it's unfair and comply with the law. You have to live with it." ■

Feds offer advice for EMTALA compliance

In announcing its crackdown on the Emergency Medical Treatment and Labor Act (EMTALA) violations, the federal government offered a set of "best practices" that it suggests can help hospitals comply. Here is a summary of that advice:

• **No prior authorization may be required before screening or stabilization.**

It is not appropriate for a hospital to request or a health plan to require authorization before a patient has received a medical screening examination to determine the presence or absence of an emergency medical condition or before a patient's emergency medical condition is stabilized.

• **No financial responsibility or advanced beneficiary notification forms are allowed.**

Before performing an appropriate medical screening exam, the hospital should not ask a patient to complete a financial responsibility or advanced beneficiary notification form, nor should it ask the patient to provide a co-payment for any services rendered. Such a practice could deter patients from remaining at the hospital to receive care to which they are entitled and which the hospital is obligated to provide regardless of ability to pay, and it could cause unneeded delay.

• **Qualified medical personnel must perform the medical screening exam.**

A hospital should ensure that a physician or other qualified medical personnel (hospital staff approved by the hospital's governing body to perform certain medical functions) provides an appropriate medical screening exam to all individuals seeking emergency services. Depending upon the individual's presenting symptoms, this screening exam may range from a relatively simple one to a complex one that requires substantial use of on-call physicians and ancillary services available at the hospital.

• **Respond appropriately when a patient inquires about financial liability for emergency services.**

If a patient inquires about his or her obligation to pay for emergency services, such an inquiry should be answered by a staff member who is well-trained to provide information regarding potential financial liability. This staff member also should be knowledgeable about the hospital's anti-dumping statute obligations and must clearly inform the patient that, notwithstanding the patient's ability to pay, the hospital stands ready and willing to provide a medical screening exam and stabilizing treatment, if necessary.

Hospital staff should encourage all patients who believe they may have an emergency medical condition to remain for the medical screening exam and defer further discussions of the financial responsibility until after the medical screening has been performed.

• **Follow the proper steps for voluntary withdrawal.**

If patients choose to withdraw their request for examination or treatment, the hospital must follow these steps:

1. Offer patients further medical evaluation and treatment that may be required to identify and stabilize an emergency medical condition.
2. Inform them of the risks and benefits of the examination and treatment and of the risks and benefits of leaving before the exam and treatment are provided.
3. Take "all reasonable steps" to secure patients' written informed consent to refuse the exam and

treatment. The medical record should contain a description of the examination and/or treatment that was refused.

• **Report violations of the anti-dumping statute.**

If a nurse, doctor, other staff member or patient thinks a hospital has violated the anti-dumping statute, the incident should be reported to the Health Care Financing Administration office in the region in which the hospital is located. ■

Feds unsure how to handle dual-staffing concerns

"Dual-staffing" arrangements raise serious questions about compliance with the anti-dumping statute, but the federal government says it is not clear whether such arrangements should be discouraged. In the advice offered for complying with the statute, the government says it still is investigating the issue and will issue a decision on dual staffing's legitimacy soon.

The issue arises from the practice of some managed care organizations (MCOs) and hospitals to enter into an arrangement in which the hospital permits the MCO to station its own physicians in the hospital's emergency department, separate from the hospital's own emergency physician staff, for the purpose of screening and treating MCO patients.

The result is that there are two separate groups of physicians providing emergency care, possibly with different policies, protocols, referral practices, formularies, and relying on different on-call physicians.

Some proponents argue that dual staffing can facilitate the provision of care to MCO patients, especially when they present in stable condition. But some hospitals and physicians have raised questions about how dual staffing affects compliance with the anti-dumping statute because the MCO patient is separated from the normal track in the emergency department.

For now, it seems risk managers should be wary of dual staffing. The Health Care Financing Administration (HFCA) and the Health and Human Services Office of the Inspector General (OIG) say the practice is suspicious, and they are soliciting comments on how dual staffing fits in with the anti-dumping statute.

"Theoretically, one could construct two equally good emergency service tracks, each adequately staffed and each with equally good access to all of the medical capabilities of the hospital, such that both MCO and non-MCO patients received equal access to screening and stabilizing medical treatment," HCFA and OIG write in the advisory document. "This arrangement would seem to satisfy the requirements of the anti-dumping statute."

If the two tracks are not equivalent, plenty of problems could arise. What if either the MCO or non-MCO track is understaffed or overcrowded, and a patient in a particular track is subjected to a significant delay in screening and stabilizing treatment, even though a physician was available in the other track? What if the different protocols and other issues result in different standards of care for the two tracks? How can the hospital ensure a patient receives appropriate emergency services if the MCO track operates independently?

HCFA and OIG say in the advisory document those are "difficult questions and we have not yet determined how to treat issues related to dual staffing under the patient anti-dumping act." ■

EMTALA compliance means strict rules

Complying with the Emergency Medical Treatment and Labor Act (EMTALA) is difficult for a hospital that's uneasy with handing out free treatment to all comers in the emergency department, but the recent warning from the federal government leaves little doubt as to the need for strict compliance.

Some real-world advice for EMTALA compliance comes from **Lynn Tenerowicz**, RN, JD, risk manager at Baystate Medical Center in Springfield, MA:

1. **Make sure everyone understands the idea of "parallel services."** This topic is easy to understand when administrators sit around talking about it, but the practical application in the emergency department may be quite difficult. It is possible that the emergency department will have to restructure a number of administrative processes to create truly parallel and separate systems for admission and examination.

Be prepared for some grumbling that it is not realistic to keep the two tasks completely separate. Insist that it can be done but listen to the concerns about the difficulty of making it happen in a busy emergency department.

2. **Keep the clinician ignorant about payment.** The doctors and nurses should be unaware of any reimbursement issues, insurance coverage, or contract requirements for a patient — at least until EMTALA has been satisfied by the examination and stabilization of any emergency condition.

3. **Get down to the emergency department and see for yourself.** To understand the difficulties of complying with EMTALA and to formulate realistic solutions, you have to see what the staff encounter when trying to comply. You can't do that from your office.

4. **Look for red flags that could mean you are at risk for violations.** Check for any registration process that still requires any form of prior authorization. Watch for informal habits that could violate the statute, such as a registration clerk handing a phone to the patient and suggesting he or she call the insurer to find out about coverage.

Another red flag would be statistics showing that a high number of people leaving the emergency department before receiving an examination or treatment. That occurrence could indicate some kind of experience is discouraging them from staying if they are not able to pay or if they fear their insurer will not pay without prior authorization.

5. **Don't let compliance efforts stall at a supervisory level.** Make sure the word about EMTALA compliance gets all the way down to the staff who actually talk to the emergency patients. There's no benefit if supervisors are well-intentioned but other staff continue with the old way of doing things.

Staff should be taught to avoid any comments suggesting that the insurer might not pay for the emergency visit. It is particularly important to teach staff that EMTALA can be violated by such comments because they inadvertently can discourage patients from seeking treatment. That is a difficult point for staff to understand sometimes because the comments are meant to be helpful, not discouraging. ■

Hospital receives $21.5 million in brokerage case

A not-for-profit hospital in Springfield, OH, is due $21.5 million in damages and penalties from the huge brokerage house of Kidder, Peabody & Co. in Chicago after an arbitration panel ruled that the hospital was misled when seeking investment advice. The award sets a new record for the highest amount ever levied against a brokerage house in a customer dispute.

The award should send a signal to health care risk managers and financial officers that they do not have to sit idly by as their organizations lose a ton of money on ill-advised investment programs. If it appears the investment was so inappropriate as to constitute misconduct by the broker, it may be worth your while to pursue a legal remedy, says **Jerry Santangelo**, JD, an attorney with the law firm of Neal, Gerber & Eisenberg in Chicago. Santangelo represented the hospital.

"It's not uncommon for hospitals to have a need for investment of surplus cash funds for various needs and uses, so they're natural targets for the sales investment vehicles and products," he says. "When those vehicles and products turn out to be very bad choices, the hospital usually just takes the loss. For a not-for-profit hospital, that can be an especially bad outcome."

Big losses worth pursuing

Most hospitals never pursue any legal remedy with the broker, Santangelo says. This case should indicate that the legal remedy is worth pursuing when the loss is big enough and the apparent misconduct severe enough, he says.

After six months of evidentiary hearings, an arbitration panel of the National Association of Securities Dealers ruled recently that Community Hospital of Springfield and Clark County and its retirement plan are entitled to damages totaling $21.5 million from the brokerage house Kidder, Peabody & Co. The award was made up of $17 million in compensatory and $4.5 million in punitive damages. Santangelo says the award was more than he initially had hoped for.

The arbitration panel held that Kidder sold the hospital high-risk, derivative securities in 1993 knowing that the hospital was an unsophisticated investor interested in maintaining a conservative investment portfolio of government-backed

bonds. According to the panel, Kidder fraudulently induced the hospital to invest in highly volatile collateralized mortgage obligations (CMOs) by misleading the hospital as to the liquidity and risk of these derivative securities. The panel determined that Kidder had "full knowledge that this investment was inconsistent with the hospital's needs," Santangelo says.

"The hospital had traditionally purchased certificates of deposit, Treasury bonds, and then they were introduced to these government-backed bonds called CMOs," he says. "They never really understood or appreciated what they were buying or the risks of what they were buying. They had been advised that with these bonds they could participate with the big banks because they had a million dollars or more to invest."

In fact, the hospital ended up buying some of the riskiest fixed-income assets around. The market for collateralized mortgage obligations collapsed in 1994 and the hospital lost about $17 million on its investment. As part of the evidentiary hearings, the hospital showed it had relied on Kidder to provide advice for its investments.

"Like many investors in today's market, the hospital was under the false impression that because CMOs are backed by the government, it is a safe investment," Santangelo explains. "Kidder did nothing to correct this impression, even after a strong warning by the National Association of Securities Dealers reminding brokerage houses not to place unsophisticated investors in the market."

Kidder is now defunct, having been sold by General Electric to Paine Webber in late 1994. General Electric retains the liability for the litigation involving Kidder. *Healthcare Risk Management* sought comments from General Electric, but the calls were not returned.

The brokerage firm's main defense was that the hospital should have known what it was buying. The hospital had a sophisticated board of directors, a chief financial officer with years of experience, and written investment policies that outlined what items were acceptable for investing. CMOs were not listed specifically, but the hospital found a way to make them fit within the policy.

Hospital leaders had to admit publicly they had bungled the investment and then plead ignorance to the extent that they could blame the decision on the brokerage house. That would not be an easy admission for some hospital leaders to make, but in this case, many millions of dollars had been lost.

Santangelo says the extent of the mismanagement was extreme in this case, but he points out that many other hospitals fall prey to the same sort of bad investment advice on a smaller scale. This case shows you do not necessarily have to just accept the loss, he says. "If it really reaches the level of being misled by a brokerage house that knew better, you can seek a remedy through litigation and arbitration. And you have to remember that dealing with a big, respected brokerage house is no guarantee against being led astray. Kidder was a big Wall Street firm, and that offered no protection in this case." ■

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Justice joins 2nd Columbia whistle-blower lawsuit

What could be more sensational than charges that Columbia/HCA kept a second set of books to defraud the government? How about charges that the health care giant planned to bribe an auditor who raised questions about a cost report?

The allegation of bribery is at the heart of the most recent whistle-blower lawsuit against Columbia/HCA. The U.S. Justice Department has joined the lawsuit against Columbia/HCA in Tampa, FL, in which a whistle-blower claims there was a plan to bribe an auditor and that the health care giant tricked the government into financing its acquisition of home health care agencies.

The case is related to the whistle-blower lawsuit the federal government joined in October, filed by James Alderson. Both of the lawsuits allege a systematic scheme to defraud the Medicare program through the cost reports Columbia submitted annually for Medicare reimbursement. The other lawsuit alleges that Columbia/HCA kept a second set of books in order to defraud the government.

In a similar vein, the lawsuit unsealed in December alleges that Columbia misrepresented its costs so the federal government would unwittingly finance its acquisition of home health care agencies. **Stephen Meagher**, JD, an attorney with the law firm of Phillips & Cohen in Washington, DC, says the second lawsuit indicates that

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Columbia/HCA's deception was widespread. The law firm represents both whistle-blowers.

"Taken together, these lawsuits reveal that the heart of the case against Columbia is pervasive cost-reporting fraud," Meager says.

Both fraud cases are qui tam cases that allow the whistle-blower to recover some of the damages themselves. The latest case was filed by John Schilling, a former reimbursement manager for Columbia in Florida. He filed the case in federal district court in Tampa in 1996 under seal, as required by the False Claims Act, to give the government time to investigate the fraud allegations.

Schilling's lawsuit reveals that he was the source of the information leading to the criminal case pending against four Columbia executives currently awaiting trial in Florida. Meager calls Schilling's cooperation with federal authorities "extraordinary," noting that he provided documents and evidence crucial to the government's criminal case. Schilling is unavailable for comment because he will be a witness in the criminal trial, set for May 1999. Calls seeking comment from Columbia/HCA were not returned.

Schilling worked for Columbia in its Southwest Florida division from 1993 to 1995, left the company, and returned after filing his lawsuit. He first worked as a consultant and later accepted a job as a financial manager at a Columbia facility in 1997. He no longer works for Columbia.

Meager says Schilling became aware of what he alleges were Columbia's fraudulent practices when he was instructed by his superiors to try to divert the attention of a Medicare auditor who raised questions about one issue in a cost report filed by Columbia. Meager says Schilling claims his superiors wanted him to offer the auditor a better-paying job with Columbia if she pressed to investigate the cost report further. Schilling says he did not make the offer to the auditor.

After Schilling left Columbia and returned, he says he uncovered more evidence of cost reporting fraud involving Columbia's home health operations. When Columbia acquired Olsten Corp.'s home health operations in 1994, it paid Olsten "wildly inflated management fees" instead of a realistic purchase price, according to Meagher. The cost of the management fees can be passed on to Medicare through cost reports, so Columbia/HCA recouped those allegedly inflated fees. Schilling alleges the fraud continued after the purchase, with Columbia shifting marketing and other hospital expenses into the home health agencies so they could be reimbursed at a higher rate than if the expenses were reported by the hospitals.

Both lawsuits were filed under the False Claims Act, which allows private individuals to sue companies that are defrauding the government and recover money on the government's behalf. The whistle-blowers, also known in the legal system as "relators," are entitled to a percentage of the recovery as inducement for those with knowledge of fraud to report it. Companies found to have defrauded the government can be required to pay up to three times the government's losses, plus penalties of $5,000 to $10,000 per false claim. ■

Reader Question

Use caution in responding to patient's angry letter

Question: I am the risk manager for a large acute care hospital and several affiliated clinics. With the number of patients we see, it is not uncommon to receive a letter of complaint regarding the way a patient was treated. If the patient alleges actual malpractice, I know how to proceed. But what if the patient is only alleging that our staff was rude or insensitive?

Answer: This issue was addressed recently by **Debra McBride**, RN, JD, assistant vice president for risk management at Midwest Medical Insurance Company in Edina, MN. She spoke at the recent meeting of the American Society for Healthcare Risk Management in San Diego, addressing several topics regarding dissatisfied patients. The following is her advice concerning angry letters.

First, she cautions you not to be quick to rule out the likelihood of a malpractice lawsuit. In fact, the way you handle the letter may determine whether the patient follows with a malpractice claim. McBride points out that whenever a

patient is angry enough to write a letter to you voicing those complaints, some response is necessary. Failing to respond quickly and adequately can spur a lawsuit.

Plaintiffs often report that "filing a lawsuit was the only way to get their attention," so you need to make sure the patient feels that you heard the complaint and are taking it seriously. A personal response is necessary, not anything resembling a form letter or a generic acknowledgment that the letter was received. McBride suggests keeping these things in mind when composing the response letter:

- Avoid any admission of liability.
- Do not blame others for the problem.
- Keep your answer fairly simple. An overly complicated answer can inflame the patient's anger because, regardless of the content, it may suggest you are denying the problem.
- If the patient asked any questions in the complaint letter, answer them as clearly and simply as you can.
- If the patient's questions cannot be answered, be honest in saying the answer is beyond your knowledge.
- Avoid medical jargon.
- If it seems the letter was intended solely to vent frustration and anger, say you understand the patient's frustration and anger. Offer to discuss the patient's concerns at a convenient time. ■

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Harassment can be legal land mine in health care

Lawsuits claiming harassment are flourishing in the health care industry and should be a major area of concern for risk managers, warns **John Lyncheski**, JD, attorney with the firm of Cohen & Grigsby in Pittsburgh. In addition to the liability posed by actual cases of harassment, health care institutions face the risk of unwarranted jury verdicts and increased awards from juries that perceive you as insensitive in responding to a claim.

Health care provider companies can be a real minefield for harassment claims because of the preponderance of female employees and male physicians in superior positions, he says. The traditional styles of encounter between nurses and physicians, for instance, easily can lead to claims of harassment, especially with younger employees who are not used to, and don't accept, the traditional style.

Lyncheski is a labor law specialist who has represented a number of health care facilities defending themselves against claims of workplace harassment. He spoke recently to attendees at the annual meeting of the American Society for Healthcare Risk Management (ASHRM) in San Diego, cautioning them that many juries are sympathetic to the plaintiff and believe that a case must have merit if it makes it to trial. Jury verdicts often reach seven or eight figures, making the issue a serious risk.

Also, the financial cost is not the only liability you could face from a harassment case.

"The effects of harassment can not only be financially devastating but will significantly impact employee morale," Lyncheski says. "If you don't deal with these cases properly and promptly, harassment can have far-reaching and harmful effects on the workplace and negatively influence employee morale and employee relations, even for those not directly involved."

Sexual harassment is not the only risk

Sexual harassment has dominated the headlines in recent years, but health care providers also face liability risks from age harassment, racial harassment, and same sex harassment. Lyncheski points out that the current trend toward fierce government intervention in the health care industry can make matters worse for any facility accused of harassment, with the aggrieved party seeing government regulators as an attractive outlet for their frustration.

Risk managers should have a thorough understanding of the types of harassment that can occur in the workplace and take the appropriate steps to minimize the risks, Lyncheski says. Recent case law has helped clarify some previously murky issues in harassment law, such as when the employer is liable for a case

of harassment. He says recently issued opinions indicate the employer is "absolutely liable and has no defense" if harassment based on the employee's sex results in the supervisor taking a tangible employment action against the subordinate, such as hiring, firing, failing to promote, reducing pay, or reassigning or causing a significant change in benefits.

Other situations can be less clear in terms of the employer's liability. If a supervisor attempts to extract sexual favors through threats (but doesn't actually carry through), or if the supervisor engages in other offensive verbal or physical conduct, the employer is not automatically liable. In that case, the employee must prove that the threats or conduct created a hostile work environment. To counter the claim, the employer must prove that it acted reasonably to prevent and promptly correct the harassment, and that the victim of the harassment unreasonably failed to take advantage of the employer's preventive or corrective measures or otherwise avoid the harm. **(See story at right for more on defining a hostile work environment.)**

That is a change from previous interpretations of sexual harassment law, Lyncheski says. In recent Supreme Court rulings, the harassment victim has to prove management-level people had reason to know about the supervisor's harassment and failed to take prompt and immediate action.

"Under the old standard, if the harassment was stopped, the employer was pretty much off the hook," Lyncheski says. "That's not so any more. The opinions encourage employers to be proactive and would-be victims to avoid harm when possible." **(See p. 26 for tips on investigating a harassment claim.)**

Risk managers should see the harassment policy as the first line of defense, Lyncheski says. Health care providers should have policies that include "stiff warnings to those who would engage in any form of harassment that the employer means business and will promptly and appropriately discipline offenders, no matter how high their position in the organization."

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But remember that an unread policy is worthless, he says. He offers this advice on writing a harassment policy:

- Maintain evidence that all employees have received the policy. All new hires should sign a form indicating they have received the policy, read it, and understand it.
- Update the policy and reissue it, completely circulating it to all employees, at least once a year.
- Post the policy in areas accessible to all employees, such as break areas.
- Don't forget employees in remote or satellite locations, temporary employees, and part-time employees.
- The policy should make clear that harassment is against the law, not merely something frowned upon.
- Include instructions for dealing with harassment by supervisors and by fellow employees and anyone else staff come in contact with as part of their employment. That may include patients, vendors, clients, and customers. ■

Defining harassment: Know the standards

Some forms of harassment can be easy to identify, but others require a close look at how the courts will define harassment, cautions **John Lyncheski**, JD, an attorney with the firm of Cohen & Grigsby in Pittsburgh.

The two terms most often used to describe sexual harassment claims are "quid pro quo" and "hostile work environment." A quid pro quo claim alleges the supervisor tried to extract sexual favors from a subordinate through threats or promises regarding the subordinate's job terms or benefits — the blatant sort of harassment that comes to mind easily. The only defense is to claim that the harassment never occurred, Lyncheski says.

A hostile work environment claim is more nebulous, but it can be just as legitimate as a quid pro quo claim. Lyncheski explains that a hostile work environment refers to unwelcome and offensive verbal or physical conduct severe or pervasive enough to alter the conditions of employment by creating a work environment that a reasonable person would find to be hostile or abusive.

Those standards have been defined by the court in regard to sexual harassment, but

Lyncheski says the same standards probably would apply to claims alleging age or race harassment.

Age discrimination is prohibited by the Age Discrimination in Employment Act (ADEA), which protects workers from outright employment discrimination based on age, such as refusing to hire someone because he or she is too old for a workplace that prefers younger employees. But the ADEA also protects employees already on the job from disparaging comments or actions regarding their age, Lyncheski says.

As with sexual harassment, employers must be careful to let all employees know that disparaging comments about a person's age are not acceptable. What may be considered joking around by one employee may be considered offensive and unwelcome by another, he says.

Four criteria must be satisfied

Recent court rulings indicate that age harassment claimants will be required to satisfy these four criteria if they want to prove a hostile work environment:

- The employee must be 40 years or older.
- The employee must have been subjected to harassment based on age.
- The harassment must have reasonably interfered with the employee's work performance and created an objectively intimidating, hostile, or offensive work environment.
- There must be some basis for liability of the employer for the harassment.

Lyncheski also cautions that racial slurs or "code words" are considered to contribute to a hostile work environment.

Common sense needed when responding

Some claims may pose a challenge to the risk manager trying to determine their legitimacy, but Lyncheski warns that you should not go overboard in declaring some situations to be harassment. He suggests that you look at the big picture, including the nature of the conduct, its severity, its frequency, whether it involves physical threats or humiliation, and whether it interferes with the employee's work.

"The standard requires extreme conduct and is not meant to include simple or occasional teasing, offhand comments, sporadic use of abusive language or gender-related jokes, or isolated incidents that are not extremely serious, though a single severe incident may suffice," he says. "Horseplay, teasing, and off-hand comments should not be considered sexual harassment unless they are serious or extreme."

Overreacting to a harassment claim can have its own drawbacks. If you punish an employee for activity that should not be considered harassment, or if you punish an employee out of proportion with the nature of the offense, the accused employee could have a legitimate claim. As an example, he cites the recent lawsuit known as "the Seinfeld case," in which a man sued his former employer for firing him for harassment.

A subordinate had alleged sexual harassment on the basis of the man's joking in the workplace about a "Seinfeld" episode in which the Seinfeld character forgot a girlfriend's name but knew that it rhymed with a part of a woman's genitalia. The company supported the subordinate's claim of sexual harassment and fired the man, but he sued and won a $26.6 million award.

"Basically, the employer overreacted, exercised poor judgment, and paid the price," Lyncheski says. ■

Investigate harassment quickly, consistently

When you get word that someone in your organization is charging workplace harassment, you must move quickly and consistently, says **John Lyncheski**, JD, an attorney with the firm of Cohen & Grigsby in Pittsburgh. A timely investigation will yield more truthful witness statements, partly because the employee and supervisor will not have time to tell their friends and co-workers what version of the story to believe.

A quick investigation also might keep the harassment claim from growing into serious litigation, Lyncheski says. A harassed employee might keep the matter in-house if he or she feels you have responded quickly and appropriately, with some display of concern. It also is important to be consistent with harassment investigations so any disciplinary steps can be shown to be in line with that from previous cases.

Confidentiality is important throughout the investigation, and you must treat both the

complainant and the accused harasser's stories as credible. Lyncheski suggests following these 11 steps:

1. Confirm the name and position of the complainant.

2. Determine who allegedly harassed the complainant.

3. Determine exactly what happened and get as many facts and details as possible. Be patient and sensitive to the complainant's discomfort in relating the incident.

4. Ask how the complainant felt and feels now.

5. Ask what action the complainant would like to see taken.

6. Have the complainant's account reduced to writing. Make sure the complainant signs and dates it.

7. Follow up with any appropriate interviews, obtaining all relevant facts and putting them in writing, signed and dated by the interviewee.

8. Interview the accused and obtain his or her response to the allegations. Be sure to note any admissions, denials, or claims of consensual conduct by the accused.

9. Analyze the evidence. Top levels of management should meet to complete this task. Legal counsel should be consulted.

10. If the evidence indicates that sexual harassment has occurred, take appropriate disciplinary action.

11. Carefully document the steps taken, the decision reached, and all supporting facts. Retain all written documentation in a confidential investigative file.

"If there are only three things that you remember to do, be sure they are document, document, document," Lyncheski says.

When devising a complaint procedure for harassment, be sure to provide multiple avenues for reporting the claim. The nature of sexual harassment, for instance, may make a female employee uncomfortable reporting the claim to a male supervisor.

"Additionally, if the person selected by the employer to receive complaints is the target of allegations or is insensitive, designating only one person is risky business," he says.

While it is crucial to take the accuser's claims seriously, you also must be careful not to abuse the rights of the accused. The accused cannot be treated as guilty until you have sufficient reason to reach that conclusion, and any hasty or careless action could lead to a lawsuit that would rival the original harassment claim. Here are the steps that Lyncheski suggests for avoiding a claim by the accused:

- Do not make any decisions until there is a good faith basis for doing so.
- Discuss the problem only with those who have a need to know.
- Do not include any derogatory or inflammatory language concerning either of the parties involved in any written statement.
- Avoid publicly reprimanding the accused harasser. Third-party knowledge can open the way to defamation actions. ■

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NEWS BRIEFS

Congress calls for safer needles

In the Omnibus Appropriations Act of 1999, Congress urges a requirement for the use of safe needle devices and more accurate needlestick reporting in U.S. health care institutions. Although the directive is not mandatory, the new law charges the Occupational Safety and Health Administration, Centers for Disease Control and Prevention, and U.S. Food and Drug Adminsitration with reponsibility for protecting health care workers from needlestick injuries that can transmit lethal viruses such as HIV, hepatitis B, and hepatitis C. ▼

Settlement shows labs liable

A recently settled negligence lawsuit reinforces the idea that hospitals may not have to take the blame for all patient injuries resulting from incorrect test results. A California laboratory agreed to pay $2.5 million after a faulty test failed to detect a boy's critical disease, leading to his death. The 2-year-old boy suffered from chronic granulomatous disease, a rare, inherited blood disorder that affects the immune system. Children with the disease must take measures to avoid certain bacteria and viruses, and they must be treated with interferon gamma. A doctor at the University of Florida treated the boy in 1994. The doctor suspected chronic granulomatous disease and sent a blood sample to Specialty Laboratories in Santa Monica, CA, for diagnosis.

The lab misdiagnosed the results, according to Miami attorney **Don Russo**, who represented the boy's family. Since the test results showed the boy did not have the disease, the doctor did not treat the boy with interferon gamma. As a result, the boy easily succumbed to a bout of pneumonia in 1996. The family sued the lab, claiming the nitro-blue tetrazolium dye test was faulty. In the discovery phase, it was revealed that the test may give inaccurate results when blood is sent across the country by air. Russo reports that the settlement is one of the first cases where an out-of-state lab was shown to have violated quality control regulations regarding the test in question. ■