Specialized Information Publishers Association Winner

# Healthcare Risk Management™

AHC Media LLC

## IN THIS ISSUE



**Financial Disclosure:** Author Greg Freeman, Editorial Group Head Russ Underwood, Managing Editor Karen Young, Nurse Planner Maureen Archambault, and *Legal Review & Commentary's* authors Blake Delaney and Jon T. Gatto report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

**DECEMBER 2008**
**VOL. 30, NO. 12 • (pages 133-144)**

# Sex offenders pose liability risk when admitted for health care

*Provider may be responsible if offender abuses others in facility*

Health care facilities see a wide array of different types of people admitted for care, and not all of them will be the type you want to take home for dinner. Convicted sex offenders get sick and need long-term care just like everyone else, and that means you must be ready to respond when they are admitted to your facility. Failing to take appropriate precautions could result in the sex offender abusing someone on your property, and that would almost certainly result in a lawsuit.

The presence of sex offenders in health care facilities is gaining more attention across the country as risk managers and lawmakers realize that the aging population means more of those people now need long-term care. A 2006 report from the U.S. Government Accountability Office (GAO) stated that at least 700 registered sex offenders were living in long-term care facilities. Federal law requires all states to register sex offenders and to release information about their whereabouts when it is deemed necessary to protect others. Some states require that schools, churches, and neighbors be notified when a sex offender lives nearby, but the GAO investigation found that few require notification of long-term care operators or residents. **(See the story**

### EXECUTIVE SUMMARY

Sex offenders can pose a risk to other patients, visitors, and staff when admitted to a long-term care facility or other health care setting. The provider can be held responsible for the harm done if it did not take all necessary steps to protect others from the sex offender.

- Assess each patient individually, because not all sex offenders are alike.
- It may be necessary to warn staff about the patient's status.
- The liability from a sex offender's actions can be mitigated by showing you made a good-faith effort to protect others.

**on p. 136 for more on how communities are responding to the risk.)**

As more communities mandate notification, the burden then shifts to the facility. What response is allowed under the law, and what actions are necessary to protect other patients? The answer is not simple, but it is clear that health care providers have a responsibility to protect others when they are aware of the sex offender's status, says **Robin Sax**, JD, deputy district attorney for Los Angeles, who handles many sex crime cases. She points out that while the risk may be greatest in long-term care facilities, sex offenders can threaten patients in practically any health care setting.

**Healthcare Risk Management**® (ISSN 1081-6534), including **HRM Legal Review & Commentary**™, is published monthly by AHC Media, LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304.

**POSTMASTER**: Send address changes to *Healthcare Risk Management*®, P.O. Box 740059, Atlanta, GA 30374.

**Subscriber Information**

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

**Subscription rates:** U.S.A., one year (12 issues), $495. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. For approximately 15 CE nursing contact hours, $545. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $87 each. (GST registration number R128870672.)


AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is valid 24 months from the date of publication.

**Healthcare Risk Management**® is intended for risk managers, health system administrators, and health care legal counsel.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Greg Freeman** (770) 998-8455.
Editorial Group Head **Russ Underwood** (404) 262-5521 (russ.underwood@ahcmedia.com).
Managing Editor: **Karen Young** (404) 262-5423 (karen.young@ahcmedia.com).
Senior Production Editor: **Nancy McCreary**.




**Editorial Questions**

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

Also, she says, risk managers can expect to see more sex offenders in their patient populations in the coming years. Mandated sex offender registration has become common across the country only in the last eight years or so, Sax points out, so many of those registered still are younger than the typical long-term care resident. As that population ages, more sex offenders are likely to be admitted for care, she says.

"This raises the question of what kind of liability you are going to have when they are admitted. We know that the rate of recidivism with these people is high, much greater than with other types of crime," she says. "So you have to worry about the other people in the home being potential victims, not just of the proximity, but because they often are a vulnerable population."

## Train staff to minimize risks

Some states may allow a health care facility to deny admission to a known sex offender, sometimes on the basis that the facility is close to a school or other location that sex offenders must not live near. It also may be possible to have a policy prohibiting admission of sex offenders, Sax says.

"If you determine that this type of patient poses a risk that you are just not able to accommodate, then I would imagine you could deny admission to them," she says. "That would be by policy, not by law, and you're always going to be better off if it is a uniform policy across the board, not just denying admission to one particular person."

**Helenemarie Blake,** JD, a senior partner at the law firm of Fowler White in Miami, says resident-on-resident crime results in a number of lawsuits against long-term care facilities and other health care providers. Knowing that a person is a sex offender is the first hurdle, she says. She recommends conducting background checks on new patients, but Blake acknowledges that a background check usually takes too long when a patient needs admission.

"The one thing I always emphasize to my clients is personnel training," she says. "If you have staff that are trained to recognize dangerous situations, you can identify and prevent some crimes before they ever happen. That's going to be true whether you know the person is a sex offender or not."

Blake has seen lawsuits involving sexual predation in long-term care facilities, and her experience has shown her that the crimes do not always

involve a relatively well sex offender who preys on a weaker resident. In many cases, the sex offender is developmentally disabled, she says.

"Patient rights are important, and a lot of times state laws make it clear that the developmentally disabled are allowed the right of sexual expression," she says. "But there can be a fine line between sexual expression and a sexual offense. That's the type of lawsuit we see from time to time. The allegations always involve lack of training for the staff and lack of supervision."

### Defense verdicts are possible

The outcome of the case often involves how closely the facility followed its own policies and procedures, Blake says.

"There is a proliferation of these types of lawsuits because they have a great sympathy factor attached to them," Blake says. "They can involve scenarios that we all find tragic, and there can be a motivation to settle them, because the facility does not want more publicity for the event, regardless of whether they really could have done anything to prevent it."

Blake says, however, that some of the cases should not be settled. She has seen cases in which the facility did everything possible to protect patients by putting the sex offender near a nurse's station or security desk, trained the staff to watch that person carefully, and still the person managed to assault someone.

"If all the steps were taken appropriately, certainly we are comfortable taking these cases to trial," she says. "There are defense verdicts out there. You can win these cases as long as you can show that you did the right things and your residents' safety was your highest priority."

If the verdict goes the other way, however, the potential for liability is significant, Blake says. The sympathy factor with juries is huge, and so the cases tend to yield high verdicts, she says.

### Must respond to sex offender status

If you do admit a known sex offender, you are obligated to mitigate the risk to others, Sax says. Placing the sex offender near a nurse's station is good practice, Sax says. Watching the patient carefully is the most important part of any response plan, and having the patient near the nurses is key, she says. Sax also recommends providing counseling for the sex offender resident. The counseling can reduce the risk of repeat offenses, she says.

A key step for a risk manager is to find out exactly what kind of crime the sex offender committed. State laws differ on what crimes result in registration, so you cannot assume that every sex offender is a child molester or rapist. Some people must register as sex offenders after being convicted of other crimes such as statutory rape or indecent exposure — not a good history but not the same as the more serious crimes.

"You can assess the risk by looking at the crime for which they were convicted and make adjustments accordingly," Sax says. "If they were convicted of sex crimes against a child, then you know you want to be especially vigilant about children who may be on the premises. Or if the person was convicted of a crime against adults, you can consider the people who live in the facility to be at risk."

### You can notify staff of status

It is legal to notify staff and other patients about the resident's sex offender status, Sax says. A person's sex offender status is public information, available on a number of databases, so there is no privacy breach by letting others know that the person is a registered sex offender, she says. Whether you should notify patients may depend on the circumstances, but it is always a good idea to let your staff know, she says.

"Risk managers should develop a uniform policy about how to handle sex offenders, because health care facilities can get into trouble when it looks like you're singling someone out for harsher treatment," Sax says. "If you say sex offenders won't be admitted, then it should be all sex offenders and don't make individual exceptions. Or you can say you

### SOURCES

For more information on sex offenders in health care facilities, contact:

- **Robin Sax**, JD, Deputy District Attorney, Los Angeles. E-mail: robin@robinsax.com.
- **Helenemarie Blake**, JD, Senior Partner, Fowler White Burnett, Miami. Telephone: (305) 789-9200. E-mail: hblake@fowler-white.com.
- **Michael Fogel**, PsyD, Department Chair, Forensic Psychology, The Chicago School of Professional Psychology. Telephone: (312) 410-8959. E-mail: mfogel@thechicagoschool.edu.

won't admit sex offenders who committed violent crimes, for instance. But whatever your policy is, it should be consistent."

The date of the conviction also is important, Sax says. If the person was convicted 20 years ago and there has been no evidence of criminal activity since then, it may be safe to assume the risk from that resident is lower than from a resident who was convicted a year ago.

"But at the same time, don't be lulled into thinking that older people won't commit these crimes," Sax says. "I'm dealing with two defendants now who are 78 and 80 years old." ■

## States acting on risk from sex offenders

As the evidence mounts that patients and long-term care residents can be threatened by the presence of sex offenders in their facilities, some communities are responding with efforts to protect the vulnerable.

One advocacy group, A Perfect Cause, based in Oklahoma City, reports that it has documented more than 50 crimes committed between 2002 and 2006 by 44 sex offenders and other criminals living in long-term facilities. Those crimes include sexual assaults, rapes, and four murders. A Perfect Cause is urging lawmakers to require public notification when a sex offender is admitted to a health care facility, says the group's president, **Wes Bledsoe**.

Lawmakers in some communities are taking notice. Legislators in Ohio are pushing a proposal that would require long-term care facilities to post notices if sex offenders are present. The bill was proposed after an 18-year-old patient was raped by a 43-year-old sex offender living in the same facility in 2005. The woman is mentally disabled and schizophrenic, and she had only been in the facility for 10 days when she was raped, Bledsoe says. The rapist pleaded guilty and is serving three years in prison.

The U.S. House of Representatives small business investigations subcommittee recently held a hearing on sex offenders in long-term care facilities, considering a proposal to require that law enforcement and social service agencies inform long-term care facilities about a patient's sex offender status. Some states already are taking action. California, Illinois, Minnesota, and Oklahoma have passed laws that mandate notifying long-term care facilities when sex offenders are admitted. Oklahoma also recently began investigating the possibility of opening a long-term care facility just for sex offenders.

Hillsborough County, FL, enacted a law that says sex offenders may not be admitted to long-term care facilities unless their status is disclosed, and then the facility must separate them from other residents. ■

## Assess each patient to determine risk

Never assume that all sex offenders are the same, cautions **Michael Fogel**, PsyD, a forensic psychologist at The Chicago School of Professional Psychology. Doing so will lead you to either overreact to some patients who pose little harm or underreact to those who truly pose a risk to others.

Illinois requires that anyone being admitted to a long-term care facility be evaluated for criminal history, he notes, which at least helps the provider realize the risk and then respond.

"The risk is not static, and it is not the same for every individual," he says. "It's a matter of looking at the past behavior and where they are at the time of the assessment. Do they continue to maintain the same beliefs and the same behavior? Until you know that kind of information, you won't know whether this person is a real ongoing risk, or whether this is someone with a bad history but who isn't likely to repeat the behavior."

Fogel also notes that risk managers must remember that staff could be assaulted by patients, particularly younger residents. The true risk from any particular resident cannot be determined without thoroughly understanding the background, he says. Simply assigning a sex offender label and treating them all the same is a big mistake, Fogel adds.

"They are not all the same, absolutely not," he says. "This is a very heterogeneous population."

**Robin Sax**, JD, deputy district attorney for Los Angeles, points out, however, that you must not discount the risk just because the sex offender's past victims were unlike most long-term care residents. If the offender preyed exclusively on young children, for instance, that does not mean that you don't have to worry if your residents are all elderly.

"If one of your residents is visited by her grandchildren, there is the risk," she says. ■

# Normalization of deviance a constant risk

It is human nature to take shortcuts or ignore the burdensome steps sometimes involved in doing a task the right way, and when there is no negative consequence, the deviation can be reinforced.

Then the next time that person does the task, it becomes easier to take the shortcut. Before long, it doesn't even seem like a shortcut. It just seems like the normal way to do the task.

That acceptance of a wayward behavior is called "normalization of deviance," and it poses a significant risk in health care, says **John Banja**, PhD, assistant director for health sciences and clinical ethics at Emory University in Atlanta. The problem can occur in any industry, but the deviation from proper procedure can have a direct effect on safety in health care, he says.

"System operators — in this case, doctors, nurses, and other health care workers — will often perform a task differently from how they were taught to do it, or the way policy and procedure, or regulations, or standards of care say they should," he says. "They don't deviate to be malicious. Usually, they deviate to save time or because they think the regulation is unnecessarily burdensome. They firmly believe they are not heightening risk, and when they start doing things their way, everything initially is fine. But sooner or later, disaster happens."

Normalization of deviance doesn't affect just one person, Banja says. It can spread throughout a workplace even if it starts with just one person, he says.

"Interestingly, as their deviance continues, people around them start noticing it, and if the deviator is a role model or someone with authority, underlings might start performing the deviation as well," Banja says. "It becomes the norm. Doctor Jones is doing it, so it must be OK, right?"

The normalization of deviance can be insidious, and it may stay under the radar of risk managers and upper management, Banja warns. Quite often, he says, health care providers are conscious of their deviation from the proper way to perform a task and are ready to respond with the correct answer when asked what they should be doing. But everyone on the floor knows that they really do the task differently because their way is "better" or "faster" or "easier" and "that's just how we do it here."

## Can have positive deviance

But interestingly, normalization of deviance isn't always about people taking the easy way out. **Maurice A. Ramirez**, DO, BCEM, CNS, CMRO, an emergency physician at Pascoe Regional Medical Center and president of the consulting firm High Alert, both in Kissimmee, FL, says it also is possible for health care providers to normalize a higher level of care than necessary.

"There are two dangers with normalization of deviance. Deviance generally occurs on both sides of the mean curve," he says. "Negative deviance creates a cascade of unforeseen consequences when institutionalized."

Examples of negative deviance include prescribing antibiotics for viral infections, using Betadine on lacerations before suturing, ordering tests before examining the patient, assuming that the irregular waveform on the cardiac monitor is patient motion and not an arrhythmia.

However, Ramirez says a positive deviance (too much of a good thing) also creates a cascade of unforeseen consequences when institutionalized. This deviance also can become the norm if not checked, Ramirez says.

Examples of positive deviance include treating the lab value even when there is no associated disease or symptoms, or assuming that every patient complaint is an accurate and complete account of all aspects of the event before investigating and changing care based on that assumption.

A particularly dangerous aspect of the normalization of deviance is that a deviation can be harmless for a long time and then cause a tragic adverse outcome, Banja says. Disaster analysis has shown that most industrial accidents — everything from the loss of the space shuttle Columbia in 2003 to

### EXECUTIVE SUMMARY

Health care professionals often will perform a task differently from how they were taught, and then that deviation becomes the accepted way of doing the task. This "normalization of deviance" poses a serious threat to patient safety.

- The deviance often is not reported even when others notice.
- People who deviate think they are doing nothing wrong.
- Risk managers should encourage reporting deviation in a positive way.

### SOURCES

For more information on normalization of deviance, contact:

- **John Banja**, PhD, Assistant Director for Health Sciences and Clinical Ethics, Emory University, Atlanta. Telephone: (404) 712-4804. E-mail: jbanja@emory.edu.
- **Maurice A. Ramirez**, DO, BCEM, CNS, CMRO, Kissimmee, FL 34744-5151. Telephone: (407) 301-3458. E-mail: Renaissancedoc@earthlink.net.

the 1984 chemical accident in Bhopal — can be traced to a normalization of deviance.

In health care, as in many situations, the deviation often seems harmless or minimally risky on its own. But over time the deviation eventually leads to a tragedy.

"Examples can include not washing your hands, not gowning up or skipping other infection control measures, not changing gloves or instruments when you should, failing to check wristbands, using abbreviations, not getting the proper consent or approval before proceeding, and violating your policies on the storing and dispensing of medications," Banja says.

### Encourage reporting deviation

So how does a risk manager counter the normalization of deviance? It's not as easy as saying "don't do it," because that's part of the nature of this normalization, Banja says. People know what you expect and do it differently anyway. Banja says a key to interrupting the normalization process is for leadership to become aware of the deviance. If only the people working together in the operating room, for instance, know about a shortcut being taken, then no one will interfere, and the shortcut will be normalized.

"In the case of deviators who take excessive, dangerous risks, they are often not reported although they are known," he says. "That's the point: the gossip does not rise to a high-enough level so that supervisors, et cetera, can attend to it. At any hospital, 80% of the doctors and nurses know which ones should not be in the hospital, because they're not doing things the right way and putting patients at risk. They talk among themselves but not to you."

That is why Banja favors a concept he calls "good gossip." Gossip typically is derided as always negative and counterproductive, but Banja says the health care community should encourage communication about deviations. The risk manager must promote a culture in which people understand that deviance and nonconformity are inevitable, and that those who report them will not be punished. One way to encourage reporting is to show that a deviation will not always result in negative consequences.

"It's possible that once it is brought to your attention and investigated, you will find that the regulation they were trying to avoid is indeed too cumbersome and unnecessary," Banja says. "In that case, you can change it, so that they don't have deviate and try to keep it secret. Of course, there will be other situations in which you have to make sure the deviators don't perform their shortcuts, and that is an opportunity to reinforce your commitment to patient safety."

### Discuss deviation publicly

Banja also recommends these strategies for eliminating deviations before they become normalized:

- frequent rounds;
- surveys of incident reports;
- root-cause analyses;
- focus groups.

Distribute your findings on system deviations at committee meetings, grand rounds, continuing medication education meetings, and inservices. Make deviation a frequent topic of discussion in a nonpunitive way so that it becomes the norm to talk about it rather than not talk about it.

"We should always keep it in the forefront of our organizational mindset," Banja says. "It's just a fact that people will always deviate. People are pressured to perform, they have too much work, too little time, and they are going to cut corners sooner or later. We have to accept that this is human nature and constantly remind people not to let it become normalized." ■

## Sterile break seen as normal deviance

Authority figures in health care have the potential to influence whether deviation is normalized, notes **John Banja**, PhD, assistant director for health sciences and clinical ethics at Emory University in Atlanta.

Banja relates an example of the normalization of

deviance he once heard from a doctor: When the doctor was a medical student, he was observing a surgical procedure and was surprised to see the surgeon inadvertently touch the tip of the instrument he was using to his plastic face mask. Everyone in the operating room paused and looked at the surgeon, waiting to see if he would ask for a new sterile instrument. The surgeon just continued on with the procedure and then accidentally touched his mask again a few minutes later. No one said or did anything, and the surgery was completed. When the medical student asked a nurse why no one had said anything, she told him, "Oh, it's no big deal. We'll just load the patient up with antibiotics."

The deviation had become normalized so that it was "no big deal."

"That's what we see a lot with the normalization process. When it's a person in authority, someone you look up to or maybe someone you are afraid to confront, what they do in that situation can become the way everyone does it," he says. "If the doctor in that situation had responded by following the right procedure and getting a new instrument, even if that was a lot of trouble, he would have sent a strong message to everyone in that room about doing it the right way. Instead, he sent a message that it was OK to deviate." ■

# Coded wristbands prompt confidentiality concerns

More hospitals are adopting the use of color-coded wristbands for patients in an effort to improve safety by alerting anyone nearby that the person is a fall risk, for instance, or to provide quick recognition that the patient has a penicillin allergy or even a do-not-resuscitate order. But now there are growing concerns that the wristbands can violate the patient's confidentiality by displaying private information to anyone who sees the wristband.

But is the confidentiality risk real or overstated? Some legal experts and health care leaders say there is reason for concern but no reason to overreact. Don't fall into the trap of thinking that any release of information in a health care setting is automatically wrong, they say. Some information that otherwise would be confidential always is easy to discern from glancing at patients in a health care setting, they say, so the wristbands are no different in that regard.

A prudent plan for how to use the wristbands is needed, but don't overreact and strip this good idea of its usefulness.

### EXECUTIVE SUMMARY

As hospitals adopt color-coded wristbands to signify patients' particular risks or needs, there is growing concern about confidentiality. Some discretion is necessary to avoid broadcasting too much information to anyone who sees the wristbands.

- Complete confidentiality is not a reasonable expectation in a health care setting.
- Too much obfuscation defeats the purpose of the wristbands.
- Consent from the patient negates most confidentiality concerns.

### Wristbands offer benefits

Wristbands have been the subject of some concern for the past few years, as health care leaders realized that they can pose dangers if not used carefully. Many risk managers have endorsed the use of color-coded wristbands on patients to identify allergies, susceptibility to falls, and other risks, but then providers realized that there was no standardization of the colors used.

That meant the same yellow wristband that means "penicillin allergy" in one facility could mean "do not resuscitate" (DNR) in another. With health care workers migrating from one facility to another as they change jobs or work at several sites, the situation was ripe for a tragic misunderstanding.

The Pennsylvania Patient Safety Authority in Harrisburg reports that near tragedy occurred when a patient was almost not resuscitated during cardiopulmonary arrest because she was incorrectly designated "DNR" with a colored wristband by a nurse who worked in multiple facilities and was confused about the meanings of different colors. That incident was a wake-up call for Pennsylvania hospital officials in northeastern and central Pennsylvania, who then worked together to develop standards for the use of color-coded patient wristbands in their facilities. Eleven facilities formed the "Color of Safety Task Force" to develop detailed protocols, including a policy manual and training resources, to reduce the risk of medical error when using color-coded wristbands. **(For**

**more on the risks and how to best use a color-coded wristband system, see *Healthcare Risk Management*, August 2007, pp. 88-92.)**

The American Hospital Association (AHA) recently issued a warning about possible confusion from the wristbands and called on hospitals across the country to adopt a standardized coding system. **(See p. 141 for more on the AHA warning.)**

## Confidentiality concerns legitimate

Some concerns about confidentiality regarding wristbands are well founded because the Health Insurance Portability and Accountability Act (HIPAA) requires that health systems disclose only the minimum patient information necessary for health care workers to do their jobs, notes **A. Kevin Troutman**, JD, an attorney with the law firm of Fisher & Phillips LLP in Houston. So risk managers must consider who really needs to know the information that is displayed by the wristbands. If the health care provider can determine that the information needs to be seen by all employees who encounter the patient — as is the case with a fall risk — then there is a good argument that including that information on a wristband does not violate HIPAA, he says. One might argue that other information, such as a DNR order, does not need to be known by the housekeepers and maintenance workers, for instance, and therefore should not be so visible.

Troutman notes that there is an inherent conflict between the goals of HIPAA and coded wristbands. HIPAA is all about minimizing the release of information, but the purpose of the wristbands is to make important information obvious to anyone near the patient. So unless you implement the coding system with care, HIPAA violations are possible, Troutman says.

"But when you take a good look at how you use this tool, it can be done without conflicting with the provisions of HIPAA," he says. "If you have determined that a housekeeper or a transporter does need to know about a particular risk, then there is not a violation. Determining exactly who needs to know and what is the best way to display that information creates more of a burden, and it may require some significant staff training."

The most concern about confidentiality comes with the DNR wristbands, says **Cathy Munoz**, RN, MJ, CPHRM, who develops clinical-focused risk mitigation strategies with Marsh Risk Consulting in Dallas, and works with facilities on process improvement. Patients can feel "branded" by a band that displays such a serious and private decision to the world, she says. The solution to those concerns is not so obvious, she says.

Some have suggested ways to obfuscate the DNR band by removing the obvious "DNR" or "Do Not Resuscitate" and replacing it with a symbol or a code word that would be understood only by key health care personnel. Munoz has heard suggestions for using doves, for instance, as a symbol to mean DNR but which would be a much softer appearance.

"I worry that that would just increase confusion," she says. "The purpose of the wristbands is to make the information very clear and easily understood, so if we start trying to blur the lines and make it less clear, we're defeating the purpose of the wristbands."

An additional concern is that the wristbands are visible not just to health care workers but also to anyone else in the vicinity — family members, other patients, vendors, anyone who happens to be in the health care facility and passes by the patient. Clearly those people do not need to know about the patient's allergies or DNR status, so isn't that a confidentiality breach?

Troutman says risk can be minimized by using color coding or symbols whose meaning is not obvious to nonhealth care personnel, but that can cause problems if the meaning is not clear to those who need to know. Even if the meaning of the wristband is clear to passersby, that may not necessarily constitute any HIPAA violation.

"We have to balance the practical with the technical requirements," he says. "If your main concern is the patient's safety and you have put some thought into how to best use these wristbands, you have to find a balance. If you've made a good-faith effort to comply with the HIPAA standards, I think you're going to be on solid ground even if someone can discern information from the wristbands."

**Molly Procuniar**, a nurse and health care subject matter expert for Standard Register's Document Systems group in Dayton, OH, points out that patients are more likely to be concerned about their health information being on display to visitors and strangers in the waiting room than whether you are violating HIPAA. But she also suggests that patients may not be nearly as concerned about the issue as risk managers and other health care administrators.

"Confidentiality is an important concern for patients, but I think patients are going to be much more interested in whether we are doing everything

## SOURCES

For more on confidentiality concerns and wristbands, contact:

- **Cathy Munoz**, RN, MJ, CPHRM, Marsh Risk Consulting, Dallas. Telephone: (214) 303-8608. E-mail: cathy.a.munoz@marsh.com.
- **Molly Procuniar**, Healthcare Subject Matter Expert, Standard Register, Dayton, OH. Telephone: (800) 755-6405. E-mail: molly.procuniar@standardregister.com.
- **A. Kevin Troutman**, JD, Fisher & Phillips LLP, Houston. Telephone: (713) 292-5602. E-mail: ktroutman@laborlawyers.com.

we can to provide good care and prevent any errors," she says. "Minimizing the release of private information should be a priority, but I think it would be a mistake to focus so much on that concern that we miss the opportunity to use wristbands in the most effective ways possible to improve patient safety. Standardizing the colors that everyone uses is the key first step there."

Procuniar says educating patients and family members should be an important part of any wristband system. Don't just slap a wristband on a patient without explaining its purpose and why it is important for that information to be easily seen rather than kept only in the patient's medical chart. Munoz also suggests that confidentiality concerns can be overcome by making the use of wristbands voluntary and obtaining consent from the patient or family.

"That becomes an opportunity to discuss why the wristbands are important, how they help protect the patient and ensure their wishes are carried out," she says. "Once you've explained that and obtained consent to use them, all the other concerns about confidentiality are minimized."

Troutman also cautions risk managers not to fixate too much on the idea that visitors and other nonhealth care personnel may learn something about a patient from the wristbands. Broadcasting private information is never a good idea, but he says anyone in the vicinity can glean certain information from a patient just by looking. Simply seeing the patient and the situational details already tells the observer a lot, so true confidentiality doesn't exist even without the wristbands.

"If we see an elderly, frail patient making her way down the hall very slowly, we can pretty much guess that she's a fall risk. If I see a man in the cardiac unit with a big scar on his chest, I can be pretty sure he's got a heart problem," Troutman says. "So we don't want to get carried away with trying to comply with HIPAA to such an extreme that it becomes ridiculous and defeats the whole purpose. There has to be room for some common sense." ■

# AHA calls for standard wristband color scheme

The American Hospital Association (AHA) in Washington, DC, is urging the health care community to adopt a standardized color scheme for patient wristbands in order to avoid dangerous confusion about what the wristbands mean from one facility to another.

In a recent warning to health care leaders, the AHA notes that more than 25 state hospital associations have provided their hospitals with voluntary guidelines on standardized patient wristband colors. "Standardizing the colors that hospitals use to alert staff to certain patient risks is a common-sense approach to improving patient safety," the AHA states. "Many physicians and nurses work in multiple hospitals within their communities and even across state lines. In states that have adopted the consensus wristband colors, caregivers have welcomed the standardization and report reduced confusion caused by the numerous previous variations.

The AHA is urging a national standardization, focusing on three condition alerts that have been adopted by the states that have addressed standardization. These are the standardized codes recommended by the AHA:

- **Red: Allergy**

"Red means stop. Caregivers will be alerted to stop and check the medical record to see if the patient is allergic to the medication, food, or treatment he or she is about to receive," the AHA states.

- **Yellow: Fall risk**

"Yellow is a warning to slow down, pay attention, and take special precautions. Nurses review patients all the time to determine if they need extra attention to prevent a fall. Sometimes a person may become weakened during an illness or because of surgery," the AHA says. "When a patient has this colored alert wristband, it says that this person needs to be assisted when walking or transferring to help prevent a fall."

- **Purple: Do not resuscitate**

"When a patient is wearing a purple wristband, it alerts the hospital staff to check the patient record for important information on patient end-of-life directives," the AHA says.

The AHA offers this other advice for making the best use of color-coded wristbands:

• Clearly define which staff members are responsible for the initial assessment and subsequent reassessments that may determine whether a patient has a condition related to one of the alerts.

• Colored alert wristbands should be placed on the same extremity as the patient ID band by a nurse or licensed professional and documented in the patient's chart per hospital policy. In the event that a colored alert wristband has to be removed for a treatment or procedure, a nurse should remove the band and then reconfirm the patient risks and replace the band as appropriate immediately following the treatment or procedure.

• Use wristbands with the alert message preprinted or embossed on the band. To minimize confusion, refrain from hand writing anything on the band.

• If a patient is wearing a "social cause" wristband, the nurse should explain the risks associated with the social cause wristband and ask the patient to remove it. If the patient refuses, you may request that the patient sign a refusal form acknowledging the risks associated with social cause wristbands.

• Verify the patient's risks during handoffs in care, such as before invasive procedures or during changes in the level of care.

• Wristbands should not be removed at discharge. For home discharges, patients are advised to remove the bands at home; for discharges to another facility, the bands are left intact as a safety alert during transfer.

*(Editor's note: For the AHA advisory on safe use of wristbands, go to http://www.aha.org/aha/advisory/2008/080904-quality-adv.pdf.)* ■

# FTC delays Red Flags Rule to May 2009

Responding to concerns that some health care providers would not have enough time to comply, the Federal Trade Commission is moving the deadline for its so-called Red Flags Rule to May 1, 2009, six months later than originally planned.

The Red Flags Rule requires financial institutions and creditors with covered accounts have identity theft prevention programs to identify, detect and respond to patterns, practices, or specific activities that could indicate identity theft. The rule could apply to hospitals that meet the FTC's broad definition of "creditor" and which have patient accounts that fall within the scope of "covered accounts."

The American Hospital Association has issued a statement saying that hospitals will need to consolidate procedures into a written format and obtain board approval of the initial written policy in order to comply with the Red Flags Rule.

The FTC announced that it will suspend enforcement of the Red Flags Rule until May 1, 2009, to give creditors and financial institutions additional time in which to develop and implement written identity theft prevention programs. The Red Flags Rule was developed pursuant to the Fair and Accurate Credit Transactions (FACT) Act of 2003. Under the rule, financial institutions and creditors with covered accounts must have identity theft prevention programs to identify, detect, and respond to patterns, practices, or specific activities that could indicate identity theft.

The rule applies to creditors and financial institutions. Federal law defines a creditor to be: any entity that regularly extends, renews, or continues credit; any entity that regularly arranges for the extension, renewal, or continuation of credit; or any assignee of an original creditor who is involved in the decision to extend, renew, or continue credit. Accepting credit cards as a form of payment does not, in and of itself, make an entity a creditor, the FTC explains.

Some examples of creditors are finance companies, automobile dealers, mortgage brokers, utility companies, telecommunications companies, and nonprofit and government entities that defer payment for goods or services. Financial institutions include entities that offer accounts that enable consumers to write checks or to make payments to third parties through other means, such as other negotiable instruments or telephone transfers.

The FTC launched outreach efforts last year to explain the rule to the many different types of entities that are covered. The agency published a general alert on what the rule requires, and, in particular, an explanation of what types of entities are covered by the rule. (The alert can be found online at www.ftc.gov/bcp/edu/pubs/business/alerts/alt050.shtm.)

During the course of those efforts, the FTC learned that some industries and entities within the FTC's jurisdiction were uncertain about their cov-

erage under the rule. Those entities indicated that they were not aware that they were engaged in activities that would cause them to fall under the FACT Act's definition of creditor or financial institution, according to the FTC statement.

Many entities also noted that, because they generally are not required to comply with FTC rules in other contexts, they had not followed or even been aware of the rule making, and therefore learned of the rule's requirements too late to be able to come into compliance by the original deadline. The Commission's delay of enforcement will enable those entities sufficient time to establish and implement appropriate identity theft prevention programs, in compliance with the rule, the FTC states. ■

# First online drug alerts go to U.S. doctors

The newly launched Health Care Notification Network (HCNN) has delivered the first online drug alerts to U.S. physicians. The alert focused on a widely manufactured and commonly used class of antibiotics and was sent immediately via the HCNN to health care providers, who are no longer forced to wait days or weeks for a traditional "Dear Doctor Letter" to arrive via U.S. mail, reports **Nancy Dickey**, MD, former president of the American Medical Association (AMA) and chair of the iHealth Alliance, the not-for-profit board in San Francisco, that governs the HCNN service.

"The HCNN dramatically improves the process of notifying physicians of time-sensitive and important patient safety information," she says. "With the success of this first notification, the HCNN is well on its way to moving patient safety into the Internet age."

The effort was praised by **Janet Woodcock**, MD, director of the FDA's Center for Drug Evaluation and Research. "E-mail notification offers significant advantages over traditional mail delivery, and helps ensure that we can adequately protect the health and safety of Americans," she says.

In just six months and as a result of the joint efforts of the AMA, state and specialty medical societies, health plans, consumer advocacy groups, government leaders, and industry — the HCNN already reaches physicians across the country. The HCNN is promoted by those organizations, as well as most medical liability carriers and many university medical centers, because it significantly reduces delays in notifying physicians of important medication and device safety alerts, which dramatically improves patient safety.

The HCNN replaces traditional U.S. mail delivery of urgent drug warning and recall letters to physicians. Physicians not yet enrolled in the HCNN will receive the alert in paper via U.S. mail later in the month. Free to all licensed U.S. physicians and their staff, the HCNN is used solely for FDA-mandated Patient Safety Alerts, fulfilling the recently updated FDA guidance for the electronic delivery of the alerts. It is not used for advertising or marketing.

Physicians and health care providers can register to receive electronic alerts at www.hcnn.net or through participating medical societies and other HCNN partners. For more information about the HCNN and online Patient Safety Alerts, visit www.hcnn.net. ■

## CE objectives

After reading this issue of *Healthcare Risk Management*, the CE participant should be able to:

- **Describe** legal, clinical, financial, and managerial issues pertinent to risk management in health care.
- **Explain** how these issues affect nurses, doctors, legal counsel, management, and patients.
- **Identify** solutions, including programs used by government agencies and hospitals, for hospital personnel to use in overcoming risk management challenges they encounter in daily practice. ■

## COMING IN FUTURE MONTHS

- Risks from medical choppers
- HIPAA becoming impractical?
- Reducing employee injury costs
- Finding the best insurance broker

# CNE Questions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. **The semester ends with this issue.** You must complete the evaluation form provided and return it in the reply envelope provided in that issue in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

21. What does Robin Sax, JD, suggest is one good way to mitigate the risk posed by having a convicted sex offender in your long-term care facility?
A. Place a sign on the door to the patient's room indicating the sex offender status.
B. Send a memo to all patients alerting them to the patient's presence.
C. Place the sex offender in a room near the nurse's station so that he or she can be watched closely.
D. Have the sex offender sign a liability release before admission.

22. What does Helenemarie Blake, JD, advise regarding lawsuits against health care facilities after a resident sex offender has assaulted someone?
A. The case always should be settled.
B. The case sometimes should not be settled.
C. The case always should be taken to trial.
D. The case should be publicized to the media.

23. Which of the following is true regarding normalization of deviance, according to John Banja, PhD?
A. Deviance can be harmless for a long time but eventually will lead to a tragedy.
B. Deviance always leads to immediate negative results.
C. Deviance never leads to negative results.
D. Deviance usually indicates a flaw in the prescribed methodology.

24. What does A. Kevin Troutman, JD, say about color-coded wristbands and possible HIPAA violations?
A. The bands violate HIPAA requirements.
B. The bands never violate HIPAA requirements.
C. The bands violate HIPAA requirements only if worn outside the health care facility.
D. If you can show a good-faith effort to comply with HIPAA and a need to display the information on the wristband, there probably is no violation.

**Answers: 21. C; 22. B; 23. A; 24. D.**

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

# Patient suicide leads to $9 million Texas verdict

By **Jon T. Gatto**, Esq.
**Blake J. Delaney**, Esq.
Buchanan Ingersoll & Rooney
Tampa, FL

**News:** A man was admitted to the hospital complaining of anxiety and being under tremendous pressure at work. The man was seen by an internist and a neurologist, and antidepressant and anti-anxiety medications were administered. After a few days, the man's condition improved, and the results of a brain MRI came back normal. The next morning, the man asked his nurse for a razor so that he could shave. Three hours later, he was found dead, locked in the bathroom, having committed suicide with the razor. The man's family sued the hospital for the nurses' negligence in giving him a razor and leaving him unattended for more than three hours. A jury awarded the family $9 million in damages.

**Background:** A 41-year-old attorney visited a neurologist complaining of severe headaches and insomnia, and the neurologist ordered a brain MRI. Two days later, while the results of the test were still pending, the man went to the hospital, this time with principal complaints of anxiety, difficulty concentrating, and a sensation of his heart racing, particularly when he tried to sleep. He also reported being under tremendous pressure at work and feeling unable to think clearly or comprehend or concentrate on his work. He denied feeling depressed.

The man was admitted to the hospital primarily to see if he could sleep and to run tests. On the hospital's telemetry floor, the man was fitted with EKG leads on his chest for continuous monitoring of his heart activity. He was then evaluated by an internist, who prescribed an antidepressant, and by a neurologist, who diagnosed anxiety, depression with insomnia, difficulty in concentrating, and tension headaches. The neurologist recommended anti-anxiety medication and a psychiatric consult, at the discretion of the admitting physician. It is unclear whether a psychiatric consult was ever ordered.

The next day, the man claimed to be feeling better, with less dizziness and headache. The attending physician instructed the nursing staff to discontinue the IV and Hep-Lock, vital sign checks, and nighttime visitation. On the third day of the man's admission, the results of the brain MRI came back normal, indicating no physical or organic pathology to explain the symptoms.

At 5 a.m. the next morning, the man desired to take a shower and asked the nurse for toiletries, including a razor "to shave his chest because the EKG leads were hurting him." The nurse complied with the man's request, leaving a double-edge razor with him. Nurses did not check on the man again until 8:30 a.m. that morning, at which point they noticed that the man was not in his bed, his breakfast tray was undisturbed, and the bathroom door was locked. Hospital maintenance opened the bathroom door, and the man was found inside, dead. He had killed himself

with the razor and had left a suicide note.

The man's estate and family sued the hospital for the nurses' negligence in leaving their decedent unattended with a razor for three hours. The man's wife of 13 years, sister, and mother gave very emotional testimony. The man's 5-year-old son, 7-year-old daughter, and 11-year-old daughter were introduced to the *voir dire* panel but did not attend the trial. The plaintiffs claimed unspecified damages for past and future mental anguish, loss of companionship and society, and loss of the decedent's wages. They also sought to recover damages for the man's conscious pain and suffering during the time leading up to his death.

The plaintiffs called expert witnesses in forensic psychiatry, economics, forensic pathology, and nursing. To support the plaintiffs' claim for damages relating to the man's conscious pain and suffering, the forensic pathologist opined that it took the man 2¾ hours to bleed to death from the cuts in his throat and arms.

The hospital denied negligence, principally arguing that the man was responsible for his own death. The hospital pointed out the man had denied depression when he went to the hospital and that even though he had asked for a razor on the morning of his death, he had requested and been provided with toiletries, including a razor, each of the previous days without incident. The defense also fought back in the battle of experts, entering into evidence the testimony of experts in hospital administration and procedures, pathology, psychiatry, and nursing.

A jury deliberated for two days, eventually returning a verdict in favor of the plaintiffs. The plaintiffs were awarded $9 million in damages.

**What this means to you:** "Clearly, this is a tragic case," says **Ellen L. Barton**, JD, CPCU, a risk management consultant in Phoenix, MD. "However, predicting suicide is *not* a science. There are only very rudimentary tools available to even the most skilled health care providers. When it is present, suicidal ideation and suicidal behavior is generally rather obvious. However, suicides often occur with little or no warning. Practitioners are left to their best judgment and, if the judgment turns out to be wrong, even the most exemplary assessment will not necessarily carry the day for the defense."

This patient was admitted to the hospital's telemetry unit, so that his heart activity could be monitored. He was seen by both an internist and a neurologist who, while suggesting a psychiatric consultation, left it to the discretion of the attending physician. Thus, in the opinion of the neurologist, who had seen the patient previously, and the internist, the patient did not present as suicidal. Under the circumstances, it is difficult to charge the facility with any knowledge, actual or constructive, that a suicide actually occurred. Nevertheless, that is just what the jury did, underscoring the need to be as careful as possible in preventing suicides in a health care facility.

If the patient had indicated "suicidal tendencies" to either health care professional, it would have been appropriate to conduct a full assessment to include:

- a full psychiatric evaluation of the patient;
- suicide risk assessment tools;
- trained staff capable of using screening mechanisms;
- suicide prevention strategies.

In addition, this patient did not at any time exhibit any behaviors that were observed by the nursing staff that would indicate he was "suicidal." Thus, there was nothing to indicate to the hospital's physician or nursing staff that an increased level of supervision and scrutiny was necessary. In fact, the patient had requested and safely used a razor on each of the three days prior to his suicide.

The patient was not in a psychiatric unit and was not being cared for by staff that was specially trained to recognize self-destructive behavior. The patient, in fact, appeared to be feeling better. The results of the MRI indicated that there was no organic pathology to explain his symptoms. We cannot know if a psychiatric evaluation would have made a difference. It does not appear that the staff were lulled into a sense of false complacency, as every indication was that the patient did not have underlying physical issues and, in fact, stated that he was feeling better. Further, there was no behavior that indicated that anything was amiss.

Under the circumstances presented, could the patient's suicide have been prevented? Some experts would certainly say no. That unfortunately is the dilemma that all suicide cases present. Given the facts in this case, it is understandable why the hospital chose to take this case to trial. And the fact that the jury deliberated for two days indicates that it was not an easy decision.

In spite of the fact that suicidal tendencies can be so difficult to detect and diagnose, the event of a suicide in a health care facility can have catastrophic

consequences for the facility, including severe sanctions or termination by the Centers for Medicare & Medicaid Services or state agencies, not to mention the type of civil liability that occurred in this case. Suicides are treated as sentinel events that must be reported to federal and state agencies. Suicides committed at a health care facility also can be a lightning rod for unfavorable media coverage in the community in which the facility is situated. The risks posed by a suicide in a health care facility justify a substantial allocation of resources to training in prevention and assessment of suicides.

All that a facility can do is take every precaution to prevent suicides. Staff should be carefully trained in terms of how to identify, assess, and deal with suicidal ideation and suicidal behavior. Even then, suicides may occur where there are few or no real warning signs, as seems to be the case in this instance. Although the patient had mild psychiatric symptoms warranting a potential referral to a psychiatrist, there was no sign of suicidal ideation or suicidal behavior.

Another aspect of suicide by patients in health care facilities that often is overlooked is how painful it can be for staff who may feel that they should have intervened in some way or detected some sign of suicidal ideation or suicidal behavior. The health care facility should make counseling and pastoral services available to employees who may be in need of such services in the aftermath of a patient suicide.

Legally, this was a tough case for the facility to lose given the apparent lack of any warning signs with regard to the suicide. It seems potentially like an unfair result. It appears that the personal situation of the patient played heavily in the jury's determination. The fact that the patient left a widow and three minor children and a dependent mother would make him extremely sympathetic to any jury. The amount of the award was most likely also tied directly to the fact that he was a young attorney with significant earning capacity. In addition, the fact that the neurologist recommended a psychiatric consult, coupled with the fact that the consult was never ordered, would leave a question in the minds of jury as to liability. That is, if the consult had been ordered, the patient would have received the appropriate care and treatment. Thus, the fact that the psychiatric consult was not ordered and performed was viewed as negligence that led directly to the death of this patient. This is a far easier conclusion to reach than thinking that there was no way to prevent the patient's death. Sadly, such cases happen and seem to be almost impossible to defend. The best defense is prevention before the suicide occurs, which can only occur through appropriate training of staff in the detection, assessment, and handling of suicidal ideation and suicidal behavior.

### *Reference*

• Case No. C-1900-06-H, Hidalgo County (TX) District Court. ■

# $4.875M settlement in eye infection case

**News:** A middle-aged man was suffering from a fever, facial swelling and redness, and nasal congestion. After consulting with his regular family doctor and two other doctors, the man was diagnosed with viral influenza and a mild drug reaction. When the man's symptoms persisted and his eyes began bleeding, however, the family doctor finally realized that his patient was suffering from an eye infection. Subsequent treatment was unsuccessful, though, and the man lost his eyesight in both eyes. The man sued his family doctor's physician group for negligence, and the parties settled the case for $4,875,000.

**Background:** A 44-year-old man who was not feeling well asked his wife to call their family physician's office. But because their regular family doctor was not available, the woman was referred to another doctor's office. The wife contacted the second office and told one of the doctors there that her husband had had a fever between 102° and 103° over the last couple of days, that he had swelling on his face and ears (but no itching), that his face was red, and that he had bad nasal congestion and drainage. The doctor instructed the woman to tell her husband to stop taking any over-the-counter medications and to instead try Benadryl. The woman was to call the doctor again if her husband did not begin feeling any better.

Although the woman followed the instructions, her husband's condition did not improve. So the next day, the woman took her husband to the office of their regular family doctor. At the office, the regular family doctor noted that the man had joint and muscle pain, swelling in and around his eyelids, ears, neck, throat, and eyes, and associated discharge. The man also had a fever — which had

begun two days earlier — of 101.7°. The doctor suspected that the man was suffering from a viral influenza and a drug reaction, possibly to the dyes in the medications he had been taking. Consequently, the doctor restricted the patient to color-free acetaminophen and sent him home after prescribing a steroid, an antihistamine, and a medication to help with digestion. The doctor, however, failed to consider the possibility of infection, and he did not order any blood work.

The next day, the man's wife called the family doctor's office, but this time was directed to another doctor in the office. The woman reported that her husband's eyes were still swollen and that his symptoms had not changed. The family doctor's associate advised the woman to change the dosage of the steroid medication and to follow up with the regular family doctor later. Yet again, however, the man's condition did not improve, and his eyes remained swollen shut.

Two days later, the woman called the office again and reported that her husband's eyes were matted shut with blood coming out. Although the man had an appointment for later that day, he wanted to come in earlier. But the family doctor's office instructed the man to keep his originally scheduled appointment. At the appointment, the regular family doctor finally recognized that the man had an eye infection — known as orbital cellulitis — and that he required immediate hospitalization. Although hospital staff administered antibiotic medications and performed emergency surgery, the man lost his eyesight in both eyes and was unable to return to his job.

The man sued the family doctor's physician group, claiming that the defendant failed to properly hire, train, and supervise its medical staff, that it failed to timely diagnose and treat the plaintiff's medical condition, and that it failed to perform additional diagnostic tests to determine the cause of the plaintiff's symptoms. The thrust of the man's claim was that the infection should have been part of the doctor's differential diagnosis, and if antibiotics had been administered earlier, the man would not have lost his vision. After all, the man complained, a simple blood test would have disclosed an elevated white blood cell count, which would have confirmed a bacterial process and led to the administration of antibiotics. The physician group denied liability, maintaining that the plaintiff's symptoms were caused by other factors and not by orbital cellulitis. Before trial, the parties settled the case for $4,875,000.

**What this means to you:** "This case underscores the importance for every health care facility to take all patient complaints seriously until a diagnosis can be made," says **Patricia S. Calhoun**, Esq., an attorney for Buchanan Ingersoll and a former registered nurse. "Staff often find themselves in the position of filtering telephone complaints from patients and family members, which are sometimes panicked, with overstated complaints. It is critical to avoid the temptation toward malaise when faced with such complaints, and to inform patients of the option to seek alternative medical treatment at the earliest juncture possible at a local emergency room or elsewhere." It presents a potential risk management nightmare when clinical staff become inoculated against the possibility that symptoms described by patients and family members can potentially be very serious. A panicked family member who contacts a health care facility may well have good reason to be panicked.

The physician's office contacted by the patient's wife in this case could have avoided this multimillion-dollar liability in its entirety had it simply informed the patient of the option to present at the nearest hospital emergency department or other facility, and documented such. Instead, the physician's office almost literally advised the patient to "take two aspirin and call me in the morning." The physician's office had no obligation to see the patient on an emergent basis, but it should have advised the wife of the patient to go to the emergency department.

"This case also underscores the danger from a risk management perspective of providing medical advice over the telephone without an examination of the patient," says Calhoun. In retrospect, it was a mistake for the physician to provide medical advice over the telephone without examining the patient at all. Days later, another physician made the same mistake. These physicians could have limited their liability if they had either made an appointment for the patient to come in within a reasonable time, or recommended that the patient seek treatment at a local emergency department or another clinic that could see him sooner. Unfortunately, the clinic paid the price for those individuals taking a more casual approach and underestimating the gravity of symptoms described by a family member over the telephone.

## Reference

• Forsyth County (NC) Superior Court, Docket information withheld. ■

Healthcare Risk Management™

# 2008 Index