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Katrina lawsuit could bring new liability risk for hospitals

Suit alleged lack of emergency preparedness led to patient death

A recent legal battle in New Orleans could have far-reaching implications for health care providers across the country, opening up new areas of vulnerability related to emergency preparedness. Ultimately, hospitals and other providers may have to decide how much they can afford to spend on emergency preparedness, choosing to make their facilities ready for even the most unlikely scenarios, or risking the liability that will follow if that event does occur.

The New Orleans case was one of the most significant lawsuits following the devastation wrought by Hurricane Katrina in August 2005. The case of *LaCoste v. Pendleton* Methodist Hospital involves the death of 73-year-old Althea LaCoste, who was recovering from pneumonia and needed a ventilator to help her breathe when her family took her to Pendleton Methodist Hospital the day before Hurricane Katrina struck New Orleans, according to a ruling from the state supreme court.[1] She was admitted and subsequently died when the hospital lost power during the hurricane, and its backup generator failed because of flooding. The lawsuit alleged that the hospital did not prepare adequately for power loss during an emergency and that Pendleton had an inadequate evacuation plan, according to the state's supreme court ruling.

EXECUTIVE SUMMARY

A recent lawsuit related to Hurricane Katrina in New Orleans could establish a new liability risk for health care providers. The plaintiff claimed that a hospital did not take adequate steps to provide emergency power during a disaster.

- Hospitals may be exposed to similar suits, regardless of the outcome of this case.
- Emergency preparedness may be limited by financial concerns.
- Meeting local building codes may not be enough for compliance and risk reduction.

After a week of trial testimony, the hospital's owner, Universal Health Services Inc. of King of Prussia, PA, announced that the litigation had come to an end with a confidential settlement. Without a verdict, the thorny questions raised by the lawsuit are left with no definitive answer.

Nevertheless, the case already is putting more focus on the issue of emergency preparedness, and that means trial lawyers are likely to see more opportunities, says **M. Michael Zuckerman**, JD, managing director with the consultant and insurance broker Aon Risk Services Central in Philadelphia.

"We're talking about New Orleans today, but we may be talking about northern California tomorrow with an earthquake or Chicago next week with a blizzard," he says. "There's no one solution to how to prepare for the catastrophe, but this case is going to cause much more attention to be focused on this issue. The very fact that the case went to trial, that alone is enough to encourage plaintiffs' attorneys to pursue similar actions."

Lack of emergency preparedness could be a new theory of liability against hospitals, says **Kristin D. McMahon**, JD, chief claims officer with IronHealth, a hospital insurer in Simsbury, CT.

"The courts are going to be looking at what standard of care to apply, so to me it screams out for the need for a national framework that determines crisis standards of care," she says. "After a disaster, there will be efforts to hold facilities to standards of care that would apply in ordinary times, but the question is whether that is the standard you should be applying in times of crisis."

McMahon notes that some states, such as Indiana, have laws that provide some immunity from standard of care issues during an officially declared disaster.

"We provide insurance, and we understand that our insureds are sometimes between a rock and a hard place," McMahon says. "The courts need to recognize that also, because it is not always reasonable to demand that the hospital provide the same care in the midst of a huge disaster as it does on a nice, clear day."

McMahon points out that Pendleton's generator systems met all local standards, but that does not necessarily mean they met requirements from The Joint Commission. **(See p. 29 for more information on Joint Commission requirements related to emergency preparedness.)** She also notes that, in addition to the generator issues, the plaintiffs alleged that the hospital failed to properly evacuate the hospital, an issue that comes with its own conundrums. **(See p. 28 for more on evacuation issues.)**

The *LaCoste* plaintiffs sued under a premises liability theory, the tort theory used to sue businesses for accidents on their premises, such as slip-and-fall cases, rather than malpractice, arguing that business decisions not related to patient care are to blame for the death, according to the state supreme court ruling. Pendleton countered by claiming that the lawsuit was governed by the Louisiana Medical Malpractice Act (LMMA), which requires that all medical liability lawsuits go to the state's Patient's Compensation Fund Oversight Board and be reviewed by a medical panel — three health care

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professionals and an attorney, in most cases. Damages for medical malpractice are capped at $500,000.

An appeals court initially found in favor of the hospital, saying that a failure to have appropriate or working backup equipment was equivalent to a failure to have necessary medical supplies with which to treat a patient, but the dispute went all the way to the Louisiana Supreme Court, which ruled that the case does not fall under the LMMA. **(See p. 28 for excerpts from the Supreme Court ruling and the plaintiff's allegations.)**

Generators central to suit

With that ruling, the case already set a precedent even before the trial began. When the state's Supreme Court decided the allegations were based on general negligence claims, and not medical malpractice, the hospital owners' potential liability greatly increased.

Officials report that more than 100 patients died in New Orleans-area hospitals and nursing homes after Hurricane Katrina when emergency backup power systems failed and patients waited for days awaiting transport in sweltering heat. About 200 lawsuits have been filed in Louisiana alleging negligence related to those deaths and the suffering of other patients.

LaCoste's family claims Pendleton was negligent for having inadequate emergency power systems, evacuation plans, and floodwater protection. An emergency generator on the roof shut down after a fuel pump on the first floor was submerged in floodwaters, and the family claims that could have been prevented by spending less than $10,000 on a submersible pump. In court filings, the hospital's owners describe Hurricane Katrina as an "act of God" that could not be foreseen and say that it would be unreasonable to require that a hospital provide uninterrupted care in such extreme and unlikely catastrophes.

The hospital's owners say the emergency power system "met or exceeded applicable electrical codes and standards," according to court papers. Evidence filed as part of the lawsuit includes a memo from Cameron B. Barr, an executive vice president with the hospital at the time, in which he says, "The first question is, do we have generators placed to accommodate an emergency flood with 15 feet of water? The answer to that question is no." The document goes on to explain that although one of the two main generators was located on a roof, the second would cease to operate with "about 2 feet of flood water around the generator." As it turned out, the floodwaters shut down the rooftop generator as well.

Barr wrote in the memo that fixing the problem would require not only relocating the generators, but also the fuel supply, power plant, and an underground tunnel — a project he estimated would cost $7.5 million.

There has to be a limit to what a hospital can reasonably spend on emergency preparedness, Zuckerman says.

"Obviously, all organizations — including hospitals — have an obligation to recognize their exposures and to manage their exposures, but what I'm struggling with as a risk management consultant and insurance broker is where do you draw the line," Zuckerman says. "How much does a hospital have to invest to prepare for extreme types of catastrophes like Katrina? We can say they knew that this tragedy was possible, and they could have prepared for making their generators viable in even the most extreme conditions. But on the other hand, in this era of health care reform and shrinking reimbursements, there might be a line where you say the hospital can only go this far and continue to function financially."

Risk managers should not see *LaCoste* as reason to push for unlimited spending on emergency preparedness, says **Marco Salazar**, JD, a partner with the law firm of Maltzman Foreman Law in Miami. The case can rightly be seen as a reminder that emergency preparedness is a genuine risk issue, but it would be foolhardy to devote endless resources, he says.

"Even if you had unlimited funds, where would you stop? How can you anticipate everything that might possibly happen in a disaster?" he says. "It is necessary to prepare for what is reasonably anticipated, but that's the big question. What is reasonable?"

Salazar says he suspects health care providers will devote more resources to emergency preparedness because of the *LaCoste* case, which will in turn result in higher health care costs.

"The cat's out of the bag. We're going to see more of these lawsuits, and that's going to prompt more providers to act defensively and shore up their emergency plans, possibly beyond a point that we should consider reasonable," he says.

Salazar points out that the Barr memo documenting the generator issue was a key piece of evidence in *LaCoste,* and he suggests risk managers take a look at what similar evidence might be used against them. Do you have documentation showing that

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the provider knew of potential deficiencies in emergency preparedness? Is there a paper trail showing that you dealt with those issues or why you didn't?

"That kind of memo can be powerful in court if it makes you look like you saw the problem and just moved on without doing anything," he says.

Zuckerman worries that *LaCoste* and similar allegations about emergency preparedness will have a negative impact on enterprise risk management. When Standard & Poor's does a credit evaluation to establish a credit rating, it now looks specifically at enterprise risk management with its broad view of all risks within the organization. Zuckerman wonders if this litigation will result in Standard & Poor's taking a closer look at emergency preparedness.

"Regardless of the *LaCoste* trial verdict, the whole issue of emergency preparedness has been brought to the forefront and specifically as a risk and liability issue," he says. "Now, we have the question of how far the hospital has to go on its own before we can say that, at this level of catastrophe, we have to depend on the government for relief. If it's going to cost $8 million or $16 million to meet the most extreme situations, can we really demand that hospitals go that far?" Zuckerman advises risk managers to work closely with those most responsible for emergency preparedness, helping them understand the risk and liability implications of some of their decisions. Documenting the decision process also can be important, he says.

"I think you're always going to be in a better position if you can show that you considered the possibilities and made a decision, rather than just being negligent and not even addressing them," he says. "You can say you had to make some tough decisions about expenditures and you opted to spend the money here, on a cancer center that is desperately needed in your community, rather than on extreme preparedness for a once-in-a-hundred-year event."

Reference

- *LaCoste v. Pendleton Methodist Hospital,* 966So.2d 519 (La. 2007). ■

Suit claims failure to prepare for flood

In its ruling that *LaCoste* did not fall under Louisiana's medical malpractice law requiring a panel review and imposing a $500,000 cap on jury awards, the Louisiana Supreme Court summarized the case against Pendleton Memorial Methodist Hospital:

"In the petition for damages, the plaintiffs alleged that Althea LaCoste was admitted to defendant's hospital on or about Aug. 28, 2005, at which time she was recovering from pneumonia and required the use of a ventilator. The plaintiffs alleged that, during Hurricane Katrina and its aftermath, the hospital lost electrical power and emergency power, resulting in the failure of life support systems used to sustain the lives of individuals like Mrs. LaCoste, who were dependent on such systems. The plaintiffs alleged the loss of use of the emergency power and the defendant's failure to implement an adequate evacuation plan were a direct and proximate cause of Mrs. LaCoste's death. Specifically, the plaintiffs alleged negligent and intentional conduct of the defendant in: a) designing, constructing, and/or maintaining a facility in such a manner that the hospital did not have sufficient emergency power to sustain life support systems; b) designing, constructing, and/or maintaining a facility in such a manner that allowed flood waters to enter the structure, thus endangering the safety of patients; and c) failing to implement an adequate evacuation plan." ■

Evacuation insurance can address some disasters

When disaster strikes, deciding whether to flee or stick it out can be difficult even for individuals, but it is a particularly vexing problem for

health care providers. In addition to the sheer logistical complexity, evacuating a hospital brings the risk of injury to patients, the associated liability, and major expenses.

Some of those problems can be mitigated with evacuation insurance, suggests **Kristin D. McMahon**, JD, chief claims officer with IronHealth, a hospital insurer in Simsbury, CT. IronHealth is one company offering its insureds the option to purchase "evacuation expense coverage." This coverage is intended to defray the transportation and lodging expenses incurred by the health care facility once it has made the determination to remove the majority of its patients as a result of any natural or man-made occurrence that, in the reasonable judgment of the insured's management, causes or could potentially cause such facility to be unsafe for such patients.

McMahon advises risk managers to seek evacuation coverage that pays even if the anticipated disaster never materializes. With some policies, there must be damage to the property to trigger coverage of the evacuation, she explains. If the hospital evacuates because flooding is feared, but the flood never comes, for instance, some policies will not pay. Instead, McMahon advises shopping for a policy that will cover the evacuation costs if the management decides that it is prudent to evacuate at least half of the patients.

About 61% of IronHealth's hospital professional liability policies include the evacuation coverage, but 98% of nursing homes include the option in their coverage, she says. ■

Joint Commission may expect more than local codes

Pendleton Memorial Methodist Hospital in New Orleans pointed out that it had met all local building and safety codes regarding its emergency generators, but that may not be a high-enough standard. The Joint Commission in Oakbrook Terrace, IL, has expectations regarding emergency preparedness that may exceed any local requirements.

The Joint Commission has two standards that concern emergency generators, says **Jerry Gervais**, CHFM, CHSP, BSME, associate director engineer with The Joint Commission, who worked as an engineer in hospitals for more than 30 years. The first applicable standard is "EC.02.05.03 — The hospital has a reliable emergency electrical power source." That standard has six elements of performance that outline the locations in the hospital that must be supplied with emergency power. The next standard is "EC.02.07 — The hospital inspects, tests, and maintains the emergency power systems." Exactly where to install the generator is not prescribed by The Joint Commission in any standard, but Gervais says the standards require that the hospital be able to generate emergency power in an emergency, and the New Orleans experience shows that placement can be critical to that effort.

Gervais spent 2½ years inspecting hospitals in the New Orleans area after Katrina, looking at how systems failed, what might be learned from the experience, and ensuring hospitals could safely reopen. Generators were a key issue, he says.

"Exactly where they are placed is governed by the authority that has jurisdiction to approve their plans, most typically the state. Installing these things in the lower levels is very common, but in areas that are prone to flooding, these problems can occur," he says. "Why do they install them in lower levels? It's just physics. These things weigh tons and tons. It's a big, giant diesel engine."

Moving the engine and fuel supply to a higher level can require extensive reinforcement of the structure, and some states will not allow fuel storage above ground, especially within a hospital building, because of the fire hazard. That may mean there is no easy solution, but Gervais says hospitals in some communities will have more obligations to site the generator appropriately because of their local conditions.

The emergency generators in New Orleans survived the hurricane, which is a common risk in that region, but they were not located in such a way that they could remain operational once the levees broke and the city flooded. The placement had been approved by local authorities, apparently with the reasoning that such a flood was not a high enough risk to justify a different placement, Gervais explains.

Gervais advises risk managers to study the

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utilities requirements in the hospital's licensing act, searching for guidance on placement. Any new facility design should consider the local potential for disasters and place the generators out of harm's way.

"Obviously, installing these generators below sea level with no way to protect them from flooding was a recipe for disaster, and that is what occurred," he says. "I was standing on the second floor of a hospital in New Orleans and looking at the generator in the subbasement, so it was under four floors of water." ■

Hospital's apology ends contentious litigation

For three weeks, lawyers representing Kent Hospital in Rhode Island were in Kent County Superior Court in Warwick, RI, battling with the attorneys representing the family of actor James Woods. The malpractice case alleged that the hospital was negligent in the 2006 death of Woods' brother Michael, and the presence of the celebrity in court every day brought television cameras and plenty of bad media exposure for the hospital.

And then on a Tuesday afternoon, Woods stood just outside the courthouse doors with his arm around hospital president **Sandra Coletta** and announced that he was withdrawing the suit. In a dramatic turnaround from the seemingly angry, resentful Woods who had been seen in the courtroom for weeks, Woods now smiled and even defended Coletta when reporters peppered her with questions.

What brought the sudden change of heart? Coletta had apologized to Woods and his family on behalf of the hospital.

Coletta tells *Healthcare Risk Management* that as the litigation moved forward in court, she was compelled one evening to call Woods and talk to him directly. She made the call not as an orchestrated strategy, she says, but simply because it felt like the right thing to do.

"As I was going through the case, there were a few times when I wanted to talk to James directly, but of course plaintiffs and defendants don't normally talk face to face, so that was the response when I suggested it," she says. "But he was still very angry. The anger and the pain was very clear in court, and I didn't know how we could get through this without talking to him."

EXECUTIVE SUMMARY

A hospital president's impromptu apology immediately ended a highly publicized lawsuit involving a celebrity. The case illustrates the power of saying "I'm sorry," even when the litigation is far along.

- The hospital president apologized on the spur of the moment.
- There had been no apology to the family up that point.
- The hospital is now formalizing its efforts to apologize and communicate more openly following adverse events.

Coletta arranged a meeting with Woods, which the attorneys thought was highly unusual and ill-advised. She planned to discuss her idea for starting a foundation in memory of his brother.

"I walked in, and I literally had not given any thought to saying, 'I'm sorry,' but it was just the right thing to do," she says. "I walked in and said I was sorry, apologized for his loss, and acknowledged the fact that we didn't do the right thing. We had a physician place an order, and we did not carry it out."

The effect on Woods was immediate, she says. It wasn't until that point that Coletta realized that no one at Kent had ever apologized and expressed remorse for the loss of his brother. She did not go into the meeting thinking she was going to make the bold statement that had been lacking; she just said what seemed appropriate, and it turned out to be what the Woods family had been waiting to hear all along.

Apologizing and communicating clearly with patients and family is nothing new at Kent, and Coletta would have expected that the family heard a sincere apology much sooner after the incident. But somehow that crucial conversation never happened.

"This is also an example of what happens when you don't say you're sorry. We were late. This didn't happen until the middle of the trial," Coletta says. "Had it happened earlier, I don't know if we would have even gotten to trial."

Lisa Greenlund, CHSP, ARM, director of risk management and safety at Kent Hospital, says she also was surprised that the family waited so long for an apology.

"This case evolved very quickly, and many things weren't discovered until the trial took place. We learned some things in the discovery

process and didn't really understand what had occurred until the trial took place," she says.

Court records indicate that Michael Woods was 49 years old when he went to the Kent Hospital emergency department on July 26, 2006, complaining of a sore throat and vomiting. An electrocardiogram showed he had an abnormal heartbeat, and a doctor testified during the trial that she had ordered him placed on a heart monitor. Coletta acknowledges that the nursing staff never carried out that order. After returning from the X-ray department, his gurney was parked by a wall near a nurses' station in the ED. He suffered a fatal heart attack there.

Coletta says the case was not defensible from the start, and her goal was to find a settlement that would satisfy the Woods family. After the apology, the hospital and the Woods family agreed as part of the settlement to establish the Michael J. Woods Institute to help improve safety at the hospital. Kent will spend $1.25 million over the next five years to develop policies and procedures to promote patient safety and improve communication regarding patient care. The initiatives will begin in the emergency department. The institute will be run by a board that includes a Woods family member, and the hospital will hire a patient safety officer to coordinate the efforts.

Greenlund says the hospital has always had an informal policy of apologizing when appropriate, but following the Woods case, Kent is formalizing the effort. Staff and physicians are undergoing education about the importance of apologizing.

The risk manager also points out another lesson from trial: The presence of a celebrity greatly intensifies the media exposure and the stress on all the health care providers testifying and otherwise involved.

"Once they put the cameras in the court room, the whole dynamics of the trial changed. It was not your everyday trial," she says. "This was very traumatic for the staff. Had we anticipated those cameras in the courtroom, we would have provided emotional support before they even stepped through those doors. That was one of the biggest lessons for us."

Simple, honest apology best

John Banja, PhD, professor of rehabilitation medicine and clinical ethicist in the Center for Ethics at Emory University in Atlanta, is an expert on the effects of apology in health care, and he says the Kent Hospital is a good example of how powerful it can be. Coletta's apology probably had so much impact because Woods felt it was sincere, he says.

"When you apologize, you are essentially admitting that you were at fault, that you were in reasonable control of the situation and you made a mistake," Banja says. "What you did somehow harmed or injured this other person, and you're saying this should not have happened, I should not have done this. This can have a tremendous effect emotionally on the other person."

Apologizing can be extremely difficult for some people, because it requires a certain level of humility, Banja says. Admitting to an error, plainly and without excuses, can be challenging for some personality types, he says. Those people are the most likely to use weasel words and try to issue non-apologies such as, "I'm sorry if I offended anyone," or "If my words were misinterpreted, I'm sorry," Banja says.

"The best apologies are straightforward and honest, saying that you did something you should not have done," he says. "Trying to have it both ways, trying to apologize without losing face, can just have the opposite effect and turn people away."

Coletta also cautions against too much formalization of the process. It should come naturally and without hesitation, she says.

"Too much buffer has been put up around everyone in the health care system. There are classes on disclosure and apology, the right wording to use, but to me, if you have to so carefully craft the wording of how to say you're sorry, there's something wrong in the system," Coletta says. "My apology probably would have flunked the class on how to apologize and keep it from being used against you. I said an order was written and we didn't do it. The family just wants to hear

SOURCES

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the unvarnished truth and that you actually care."

An apology should not be strategy or clever maneuvering, Coletta says. It should be sincere and offered without qualifiers.

"We can say we made a mistake," Coletta says. "They don't expect us to be gods, but they get very irritated when we act like we are." ■

Mandatory review panels pushed for tort reform

With the ongoing debate over health care reform, the idea of malpractice tort reform has gotten short shrift, but some analysts are saying the time is right to address out-of-control malpractice risks by instituting a mandatory physician review panel. Others say no, that such a system would inevitably be biased in favor of the health care defendants.

Any effort to improve health care in the country must address the malpractice costs that are forcing many providers into defensive medicine, which drives up the cost of care for everyone, says **Robert A. Levine**, MD, former chief of neurology at Norwalk (CT) Hospital, and associate professor of medicine at Yale University in New Haven, CT.

The total cost of medical professional liability insurance in 2002 was $25.6 billion and has increased at a precipitous rate every year since. According to an American College of Obstetricians and Gynecologists (ACOG) survey, almost 70% of obstetricians have made changes to their practice due to medical liability, Levine says. A study by the Harvard School of Public Health determined that 40% of medical malpractice lawsuits filed in the United States are "without merit." A U.S. Department of Health and Human Services (HHS) study estimates the national cost of defensive medicine is more than $60 billion, or about 3% of overall medical spending.

"The excessive premiums have forced many physicians to go without malpractice insurance or to close their practice entirely," Levine says. "Physicians feel forced to practice defensive medicine, ordering unnecessary tests for fear of a lawsuit."

Despite the frivolous nature of many lawsuits, juries often award hundreds of millions of dollars to the plaintiffs, and since there is no way to predict these costs, every doctor must purchase malpractice insurance at extraordinary expense to protect themselves against lawsuits, Levine says.

"Malpractice actions in the current system do not decrease the incidence of medical negligence, they do not adequately compensate injured patients, they do not remove incompetent physicians, and they usually do not punish those guilty of negligence," Levine says. "The suits are simply a lottery system devised by attorneys, where a small number of injured patients benefit."

Levine says the time is right to consider national legislation that would require a peer panel comprised of physicians in the same field to review all malpractice cases before they could move forward.

"These physicians would have the same training as the accused physician and would be knowledgeable about the standard of practice. They would be from different geographical locales than the accused physician and would not have known that person," Levine says. "Plaintiff's attorneys and defense attorneys would still present their cases, but doing so before this physicians' panel rather than a jury would be fair and equitable."

If the physician panel determined the case had no merit, that decision could be appealed to a panel of malpractice judges, under Levine's plan. These judges would specialize in medical malpractice, and if they agreed that there was no evidence of malpractice, the plaintiff still could take the case to a jury but would then be liable for the defendant's legal expenses if the defendant prevailed.

Some states have similar review panels or a requirement for a certificate of merit, but Levine is pushing for a uniform structure that would ensure the same protection for health care providers across the board, and more protection than some of the state review panels offer.

Not so fast, says **Susan Steinman**, JD, director of policy at the American Association for Justice

EXECUTIVE SUMMARY

Malpractice tort reform could be achieved by requiring a physician panel to review all cases before proceeding to court, some advocates say. The proposal is opposed by trial lawyers, who say the panel would be biased in favor of defendants.

- The panel could decrease the costs of defensive medicine.
- Plaintiffs would have to pay court costs if they proceed without merit.
- The plan would be more extensive than current state requirements.

(formerly the Association of Trial Lawyers in America) in Washington, DC. The physician review panels advocated by Levine would be biased from the start, she says.

"You would have a physician on the screening panel substituting for the role of a judge in a courtroom," she says. "We would be denying a lot of plaintiffs their day in court."

Steinman says trial lawyers do not necessarily oppose a system that requires a certificate of merit before a malpractice case can proceed, but she says that procedure must be in the hands of the court rather than physicians.

"A group of physicians are going to be more inclined to side with their fellow physicians than with the patient," she says. "Even if it is not technically biased, it will be perceived that way. It will undermine confidence in the system."

Steinman says review panels established on the state level have not really worked. They slow down the process and add significant expense for both parties.

"Depending on how the screening panels work, you're trying your case once for the screening panel and again for the trial," she says. "You're paying your attorneys and your expert witnesses twice."

Any concerns about the physician panel being biased in favor of the defendant should be allayed by the fact that, under Levine's plan, the plaintiff is not barred from proceeding with the case even if the physician panel disapproves, he says. If the case truly has merit and the physician panel is acting out of bias, the plaintiff can still go to court and prove the case. The only risk is that they would be liable for court costs at that point, but that shouldn't be a concern if the plaintiff is so sure that there was malpractice, he says.

Levine says trial lawyers oppose the idea, because they win many cases in which there is "maloccurence" rather than malpractice, meaning something did go wrong and there was an adverse outcome for the patient, but the health care provider was not negligent. Sometimes bad things happen and there's no one to blame, Levine says, but in today's malpractice system, the jury will feel so much sympathy for the patient that they still find the provider liable.

"Birth injuries are the best example. There have been multiple studies showing that the overwhelming majority of cerebral palsy cases are not caused by a birth injury, yet a malpractice lawyer brings one of these poor people into court and urges them to make a decision based on an emotional response rather then the evidence," Levine says. "A review panel could make a decision based on the facts to determine if that case has merit. The malpractice lawyers don't want decisions to be based on the facts."

Levine recalls being sued for malpractice, along with one of his partners and another physician, and sitting through a six-week trial before the jury found in their favor after a 20-minute deliberation. After the trial, the jurors went to the judge and said the case never should have been brought to trial.

"It cost our insurer $350,000 to defend us. That $350,000 is reflected in all the premiums of all insured doctors. Even though we won the case, we wound up losing, and the medical profession wound up losing," Levine says. "I think doctors would be much more cooperative with the malpractice process if they thought they were getting a fair shake." ■

CT AG is first to file suit under HITECH

It has begun. Connecticut Attorney General **Richard Blumenthal**, JD, has taken the first action by a state attorney general involving violations of the Health Insurance Portability and Accountability Act (HIPAA) since the Health Information Technology for Economic and Clinical Health Act (HITECH) authorized state attorneys general to enforce HIPAA.

Blumenthal sued Health Net of Connecticut, Inc. for failing to secure private patient medical records and financial information involving 446,000 Connecticut enrollees and promptly notifying consumers endangered by the security breach. He also is seeking a court order blocking Health Net from continued violations of HIPAA by requiring that any protected health information contained on a portable electronic device be encrypted.

"Sadly, this lawsuit is historic — involving an unparalleled health care privacy breach and an unprecedented state enforcement of HIPAA," Blumenthal said in announcing the suit. "Protected private medical records and financial information on almost a half-million Health Net enrollees in Connecticut were exposed for at least six months — most likely by thieves — before Health Net notified appropriate authorities and consumers."

The action in Connecticut should be a wake-up call for risk managers, says **Gretchen Hellman**,

vice president of security solutions with Vormetric, a data security firm in Santa Clara, CA.

"This makes the regulation real and immediate," Hellman says. "Previously, HIPAA was lightly policed and considered toothless. This is a real example of HIPAA teething. Whether it's molars or fangs, we'll have to wait and see."

Hellman notes that most patient health data are not encrypted and the majority of state data breach laws do not include health data in their provisions. This lawsuit is a reminder that HIPAA-covered entities must rapidly alter their practices to address HITECH compliance, she says.

"Earlier this month, we saw research indicating that the average cost of a data breach has risen to more than $200 per record," Hellman says. "In all likelihood, the cost of future data breaches will rise to include attorney fees and additional legal penalties. There is a strong likelihood that this action sets a precedent for other state AGs to respond to data breaches with a similar response in the future."

CEO **Christian Renaud** of Palisade Systems in Des Moines, IA, which provides services to prevent data loss, agrees that the action in Connecticut is surely just the beginning of the HITECH lawsuits to be brought by state attorneys general.

"With this action by the attorney general, we expect to see more health care entities realize that they need solutions to ensure that their employees are well trained and educated, as well as protected from accidentally sending out patient information covered by HIPAA," he says. "Expect to see a rush from the smallest doctors' offices to large insurance providers and hospitals to make sure that information does not leak, and that they have the right technology in place, such as data-loss prevention."

According to the lawsuit, on or about May 14, 2009, Health Net learned that a portable computer disk drive disappeared from the company's Shelton office. The disk contained protected health information, Social Security numbers, and bank account numbers for approximately 446,000 past and present Connecticut enrollees. The missing information included 27.7 million scanned pages of more than 120 different types of documents, including insurance claim forms, membership forms, appeals and grievances, correspondence, and medical records.

Health Net reported to the state that the data were not encrypted or otherwise protected from access and viewing by unauthorized people or third parties, but rather were viewable through the use of commonly available software. Health Net did not respond to *Healthcare Risk Management's* request for comment.

Blumenthal alleges that Health Net failed to promptly notify his office or other Connecticut authorities of this missing protected health and other personal and private information. It wasn't until six months after Health Net discovered the breach that it posted a notice on its web site, and then sent letters to consumers on a rolling mailing basis beginning on Nov. 30, 2009.

Blumenthal's lawsuit alleges that Health Net failed to effectively supervise and train its work force on policies and procedures concerning the appropriate maintenance, use, and disclosure of protected health information. ■

SOURCES

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Doctor accused of covering up transplant patient switch

A surgeon who was the director of the liver transplant program at St. Vincent Medical Center in Los Angeles was indicted recently by a federal grand jury for allegedly lying to the national organ transplant network. The U.S. Attorney's Office in the Central District of California announced that the indictment was sought after a liver accepted on behalf of one patient was instead transplanted into another patient who was significantly lower on the national wait list.

Richard R. Lopez Jr., MD, was indicted on one count of conspiracy, one count of concealment of a material fact, and six counts of falsification of records in a matter under the jurisdiction of the United States Department of Health and Human Services. If convicted of the eight counts in the indictment, Lopez faces a statutory maximum penalty of 130 years in federal prison. A call to Lopez's office seeking comment was not returned.

According to the indictment, in September 2003, St. Vincent was offered a liver for a St. Vincent patient, identified as A-H, who ranked second on the match list for that liver, but who was in his home country of Saudi Arabia. The backup patient for the liver was at another local hospital. Instead of advising the organ procurement organization that A-H was out of the country and allowing the organ to be offered to the backup patient, Lopez approved acceptance of the liver and its transplantation into a patient at St. Vincent — a patient identified in the indictment as A-B, who was ranked 52nd on the match list behind nine other St. Vincent patients.

After A-B received the liver, Lopez and his co-conspirators falsely told authorities at the national organ transplant network that A-H had received the liver, and later submitted a falsified pathology report on A-H's "explanted" (removed) liver, according to **Steven M. Martinez**, assistant director in charge of the FBI's Los Angeles field office. As a result of the false reporting, A-H was removed from the liver transplant wait list in September 2003, and was thereafter deprived of the opportunity to have this life-saving operation, according to the indictment. However, Lopez continued to tell A-H that he was on the liver transplant wait list and instructed A-H to return to the United States in April 2004, when A-H was found to be too ill to be transplanted, authorities report. He subsequently returned to Saudi Arabia, where he later died.

The indictment alleges that in reports filed until 2005 with the authorities operating the national organ transplant network, Lopez and unnamed co-conspirators continued to maintain the fiction that A-H had received the liver transplant. In 2005, the switch and cover-up were discovered by senior management at St. Vincent, and the matter was reported to authorities, the U.S. Attorney's office reports. Lopez has not been associated with St. Vincent since late 2005. The hospital has fully cooperated with federal authorities since the beginning of the investigation.

Martinez says authorities pursued the matter aggressively, because it has the potential to undermine public confidence in the organ transplant system. ■

Joint Commission updates site-marking procedure

Site marking to eliminate wrong-site surgery is not required when the incision site is not certain before surgery begins, according to a clarification from The Joint Commission in Oakbrook Terrace, IL.

There had been some confusion about whether the site-marking section of The Joint Commission's Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery required preoperative marking interventional procedure cases for which the catheter or instrument insertion site is not predetermined, such as with cardiac catheterization and pacemaker insertion.

The Joint Commission acknowledges that the second bullet in the note under UP.01.02.01 element of Performance 5 conflicts with an existing interpretation published in the Standards FAQs on The Joint Commission web site, so the note is being revised to state that site marking is not required for such procedures. The change will appear in the July 2010 update to The Joint Commission manual. ■

CNE objectives

Upon completion of this educational activity, participants should be able to:

- **describe** the legal, clinical, financial and managerial issues pertinent to risk management
- **explain** the impact of risk management issues on patients, physicians, nurses, legal counsel and management
- **identify** solutions to risk management problems in health care for hospital personnel to use in overcoming the challenges they encounter in daily practice. ■

COMING IN FUTURE MONTHS

- Defining standard of care in psychiatry
- HIPAA: What can you tell the cops?
- Tips for protecting wandering patients
- MMSEA Section 111 reporting requirements

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. After completing this semester's activity with the **June** 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.

9. Why did Pendleton Memorial Methodist Hospital seek to have *LaCoste v. Pendleton* Methodist Hospital tried as a malpractice case rather than a general liability case?
A. The hospital felt it could defend the case better on the clinical facts.
B. The Louisiana Medical Malpractice Act requires that all medical liability lawsuits be reviewed by a medical panel and damages for medical malpractice are capped at $500,000.
C. A malpractice trial would garner less media attention than a general liability case.
D. The statute of limitations had expired for a malpractice case but not for a general liability case.

10. Which of the following is true regarding Joint Commission standards and emergency generators?
A. Exactly where to install the generator is not prescribed by The Joint Commission in any standard, but the standards require that the hospital be able to generate emergency power in an emergency.
B. Two Joint Commission standards outline where generators must be placed.
C. There are Joint Commission standards that prescribe where generators must be placed, but they are applicable only to high-risk coastal areas.
D. There is no Joint Commission standard that addresses emergency power generation.

11. In the malpractice case against Kent Hospital involving actor James Woods, how was the case resolved?
A. The family withdrew the case, and there was no further agreement with the hospital.
B. The family and hospital settled, and Kent agreed to spend $1.25 million over the next five years to develop policies and procedures to promote patient safety and improve communication regarding patient care.
C. The hospital agreed to pay the family $1.25 million and the family withdrew the case.
D. The case was dismissed by the court over the objections of the Woods family.

12. In the HITECH lawsuit, how were the data in question stored?
A. The data were fully encrypted and not usable.
B. The data were not encrypted but rather was viewable through the use of commonly available software.
C. The data were partially encrypted, but Blumenthal alleges the method was insufficient.
D. Only part of the data was encrypted, but the defendant claims the rest was not sensitive data.

Answers: 9. B; 10. A; 11. B; 12. B.

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

Jury awards $200,000 in Indiana invasion of privacy case

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News: A girl was admitted to a psychiatric facility after her parents found evidence of the girl having suicidal thoughts. The parents requested in writing that the hospital not send any records of the admission to the girl's school. A hospital therapist faxed a letter to the girl's school to an open fax machine where many school employees viewed the letter. Subsequent letters were sent. The girl and her parents sued the hospital alleging invasion of privacy. The jury found in favor of the girl and awarded $200,000.

Background: The parents of a 14-year-old girl found a note from their daughter that articulated suicidal thoughts and tendencies. Following a meeting with a school counselor in which the counselor referred the parents to a local adolescent psychiatric hospital, the parents decided to have the girl evaluated at the hospital.

A psychiatric nurse at the hospital determined that the girl needed to be admitted for treatment. At that time, the girl and her parents received assurances from the hospital that the girl's school would not be notified of the girl's condition and indicated the same on the hospital's confidentiality agreement. Living in a small town, the family was concerned that the girl would be subjected to ridicule in the community should the information be disseminated.

The day after admission, a hospital therapist, unaware of the confidentiality agreement signed by the girl's parents, faxed a letter to the high school counselor revealing the girl's status at the hospital and thanking the counselor for the "referral." The letter was faxed to an open fax machine that was available to all school staff and students working in the area. Evidence was presented that a number of teachers and administrators had viewed the fax and learned of the girl's hospitalization.

Upon returning to school following her treatment, the girl was informed that many people at the school, including students and teachers, knew of her hospitalization. The girl became distraught and was eventually readmitted to the hospital on suicide watch. During this time, another release of information form was signed that indicated that the school should not be notified of the repeat hospitalization. Once again, the hospital sent two letters to the school, both of which were satisfaction surveys sent by the hospital's CEO. After being released, the girl refused continued treatment from the hospital and moved to another city with her family seeking a fresh start.

The girl and her parents sued, claiming that the hospital had invaded her privacy by sending the facsimile to an open fax machine at the school. Given that the fax contained language such as "[t]hanks for the referral" and "thanks again," the plaintiffs argued that transmission of the fax was based on a desire for the hospital to gain repeat business from the school rather than done in the interest of the girl.

Initially, the trial court granted summary

judgment in favor of the hospital, citing that the case fell under the state's medical malpractice act and the plaintiff had not followed the required procedures in instituting the claim. The Court of Appeals, however, held that reckless or negligent dissemination of confidential health information was not covered by the act and remanded the case back down to the trial court.

The hospital claimed that the girl had not suffered any damages as a result of the dissemination. In terms of mitigation of damages, the hospital also contended that the girl contributed to her damages by not returning for follow-up treatment. The girl prevailed on the invasion of privacy claim, and the jury valued her damages at $200,000. Due to the comparative fault rules, the award was offset by 45%, making the net verdict $110,000 for the girl.

What this means to you: The lesson here is simple: Two wrongs do not make a right. What part of no do you not understand, as in, "Do not, I forbid you, do not send or make contact with my child's school to acknowledge she has been hospitalized, not once, but twice. In writing and verbally, I tell you this."

Private health information (PHI) is confidential under most state's laws and the federally enacted Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), and release of treatment for psychiatric care requires a special release. This case involved an adolescent psychiatric hospital where the rules, regulations, and laws governing the release of medical information, especially treatment related to mental health, should be well known.

While emphasis on the protection of health care-related information always has been emphasized, with the enactment of HIPAA, the emphasis was broadened. Part of the emphasis includes appointment of a privacy officer, intense education of all employees, and periodic HIPAA rounds to further emphasize protection of medical information. There often are news stories highlighting the termination of employees who access a patient's medical record without the proper authorization.

All of this points to a larger question: With all this increased emphasis, visibility and education, how could someone make contact with an outside party to convey medical information that was not authorized, and in disregard of a written, specific request not to make contact with the minor patient's school?

This situation is disturbing and sad, primarily because it involves a minor who was suffering from underlying issues that formed the basis of her suicidal thoughts. The disclosure of her hospitalization created other social and potential mental health issues that necessitated a second admission. Further, this scenario is frustrating from the point of view of the therapist's failure to review the medical record, which contained the explicit written request not to contact the minor patient's school. One might question why we, as health care providers, document in the record if other health care providers do not read or heed what is written? As a result, the risk manager, as a part of the root-cause analysis of this event, might explore why it was not reviewed and how to better document such information to ensure that it will be honored. What makes it even more frustrating is that on the second admission, the same request was again made and ignored. One might question what corrective steps were taken in the interim between the first discharge and second admission (i.e., was the therapist interviewed, counseled, and disciplined in any way?).

The risk manager, working with the hospital's privacy officer, should review all policies and procedures regarding release of PHI, including what, how, and where faxes containing PHI can be sent. Faxes containing PHI should be sent only to those parties who have a reason to know, who are authorized to have access to the PHI, and when at all possible, should not be sent to open faxes.

The privacy officer and risk manger should collaborate in the development and delivery of an inservice program to senior management to reiterate and emphasize the ramifications of seemingly innocent communications that can breach confidentiality rules, in particular reference to the satisfaction survey sent by the CEO to the school. Patient satisfaction surveys should be sent only to patients or their legally authorized representative. Risk management and the privacy officer should review the marketing practices and material to be sure that patient-identifying information is not used.

This is a situation that lends itself to utilizing the disclosure process after the first admission/discharge. A meeting with the parents and the patient to apologize and convey the steps being undertaken to guard against similar behavior in the future might have defused the situation and prevented the second breach. Absolutely after the second, repeat breach, a meeting to disclose and apologize should have taken place.

One asset a health care organization protects is its reputation. Reputation is a major factor that can

affect patient, staff, and donation attrition. This scenario is newspaper fodder that can besmirch a psychiatric facility's reputation, especially when culture and society still do not understand mental illness and fully accept it as a medical illness. A black mark on a facility's reputation is a risk exposure that should be carefully considered by all health care facilities.

Reference

• Case No. 53C06-0511-PL-2132, Circuit Court of Indiana, Tenth Judicial Circuit, Monroe County. ■

Alleged failure to diagnose, monitor: Case settled

News: A woman presented at two hospital emergency departments (ED) complaining of a number of respiratory symptoms. She was not admitted and was sent home with a prescription. A couple of days later, the woman saw her primary care physician with more severe symptoms. The primary care physician sent her to the ED. The on-call physician admitted the woman and placed her on respiratory therapy with high IV doses of three drugs. The physician noticed signs of overmedication but did not adjust the dosage amounts. After a number of administrations of drugs over the next few hours, the woman was found unresponsive and was later pronounced dead. A settlement was reached between the hospital and her family for $950,000. The physician settled for $225,000.

Background: A 27-year-old female developed an upper respiratory infection and sought treatment at two local hospitals' EDs. She claimed symptoms of asthma exacerbation, shortness of breath, wheezing and dry, nonproductive cough. She was not admitted either time and was sent home with prescriptions for antibiotics and prednisone, a drug that fights inflammation.

A couple of days later, the woman visited her primary care physician's office with similar but more severe symptoms and was evaluated by a nurse practitioner. Her primary care physician sent her to the ED to be evaluated for admission.

After being evaluated in the ED, a physician admitted the woman to the telemetry unit and ordered administration of seven central nervous system (CNS) depressant medications in high dosage amounts. The physician also ordered the woman to undergo respiratory therapy but failed to include an order for her peak flows and FEVs to be monitored. Monitoring of those items would have indicated an improvement or worsening of respiratory symptoms. Records for the first two mornings indicated that the woman was getting adequate levels of medication. However, the physician was concerned about the woman being overmedicated and was informed by a floor nurse that the woman might have been self-medicating. The physician adjusted the frequency of the drug administration but not the dosage. He also ordered that she be moved to an unmonitored medical floor that day. The progress note for the day was left unfinished by the physician.

After being transferred, the woman continued to receive medications that caused either direct or indirect depression of the CNS. The evening of the transfer, the woman received breathing therapy from a licensed respiratory therapist who noted diminished breath sounds with expiratory wheezing, labored respirations, and slight tachypnea. Three hours later, the woman was given additional drugs and was not checked on for 80 minutes. A nurse found the woman unresponsive in her bed, and the woman was ultimately pronounced dead. The autopsy concluded that the cause of death was asthma, due to lack of any other anatomic finding, and a clean toxicology screen.

A suit was filed against the physician and the hospital that claimed that the medical staff at the hospital failed to properly administer IV medications to the woman and that the nursing staff had failed to properly assess and monitor the patient. The respiratory therapist did not notify the physician of her findings following treatment. The plaintiff further contended that the use of CNS depressant medications should have been done with extreme caution, and that the physician had failed to meet the standard of care when he ordered that such high dosages of the medications be administered.

The defense denied that the care and treatment of the woman was below the standard of care or that it failed to meet accepted standards for adequate medical care.

The hospital settled with the plaintiff for $950,000, and the physician settled for $225,000.

What this means to you: Here we have a young woman who is seeking care for persistent respiratory symptoms who ended up dead from what appears to be a drug overdose. This is a classic case of failure to rescue, defined as "failure to recognize

and act upon declines in patients." What was the rapid response process in this organization? Why did staff fail to recognize the decline in this patient's respiratory status, so they could respond and reverse the situation in a timely manner?

Significant emphasis has been placed on medication safety and prevention of medication errors through the National Patient Safety Goals. One element of this goal is medication reconciliation.

In this case, the woman had been to two emergency departments (ED) and to her primary care physician and was given prescriptions. We have no information to indicate whether the drugs ordered by either of the previous ED physicians were reviewed and whether the patient was advised to continue or stop taking any previously ordered medications by her primary care physician or ED staff. Whether the drugs she had been taking on an outpatient basis interacted with the drugs she was given in the hospital is unknown but should be a part of the root-cause analysis performed by the hospital. The risk manager should review the process of requesting all drugs a patient has in their possession, so they can be identified and put in a safe place while the patient is hospitalized.

The risk manager should conduct a root-cause analysis and facilitate a disclosure meeting with family as a part of the untoward event investigation. The credentials and delineation of privileges of the admitting physician should be reviewed to verify his training and background.

In addition to conducting a root-cause analysis, this case should be sent to the medical staff for a peer review to determine whether the CNS depressants were indicated and whether the high doses and rate of administration of the IV medications were appropriate in view of the other signs and symptoms and test results. The incomplete order for respiratory therapy should be addressed as well.

Depending on whether the order for medications goes directly from the physician to the pharmacy or the nurse reviews and sends it to the pharmacy, the nurses and the pharmacist each had an opportunity to question the indication, dosage, and frequency of the drugs ordered. Central nervous system drugs may be indicated in certain situations with respiratory distress, but one should have questioned why seven such drugs were ordered and administered. With seven CNS depressant drugs being administered, the respiratory system should be closely monitored. A telemetry unit would seem to be an inappropriate unit to place a patient who was complaining and exhibiting respiratory symptoms and who was receiving seven CNS drugs in high doses at a rapid infusion rate. While she was ordered to have respiratory therapy treatments, those are intermittent, and a therapist may not have recognized the respiratory depression in a timely manner.

The risk manager should conduct a root-cause analysis and facilitate a disclosure meeting with family as a part of the untoward event investigation. The credentials and delineation of privileges of the admitting physician should be reviewed to verify his training and background. The autopsy showed this patient had asthma with no other comorbidities. We have no information to determine the cause of death. Was it the CNS drugs that caused the death? Were those the correct drugs for asthma? Was asthma considered a diagnosis, or was it ruled out?

The culture of our health care system is that, in order to protect themselves from medical errors, patients should question all medications, treatments, and results, and have a family member or friend be at the their bedside to act as their advocate and monitor their drugs. It is a sad state of affairs when society feels that protection is necessary when obtaining care from health professionals.

Communication was an issue in this case in that both the physician and the respiratory therapist failed to make proper reports. A red flag should have been raised in this case. The risk manager should provide inservice sessions to all nursing and pharmacy staff to reinforce their responsibility to question a physician when they see multiple drugs, high doses, or high rates of administration. Furthermore, as a part of the root-cause analysis and the corrective action, critical thinking skills and physical assessment educational sessions should be required for all nurses. Administering CNS depressant drugs without monitoring and evaluating the patient would unmistakably be practicing below the acceptable standard of nursing care.

Reference

- Anonymous parties, Superior Court, San Diego (CA) County. ■