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IN THIS ISSUE

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Professional intimidation threatens risk managers, but law offers protection

Risk managers continue to report that they experience harassment and retaliation for doing their jobs, with health care executives making them the scapegoat for lapses in policy and quality by the health care institution. This age-old problem may be ameliorated by new federal laws that provide greater protection for risk managers and whistleblowers, and a direct line to upper management may help avoid some of the conflict.

The dilemma is illustrated by the ongoing case of a risk manager who says she was fired by her hospital for reporting an Emergency Medical Treatment and Active Labor Act (EMTALA) violation after hospital executives discouraged reporting it for fear of a large penalty.

Margaret O'Connor, RN, was the risk manager at Jordan Hospital in Plymouth, MA, until her firing on May 19, 2010. She had been employed by Jordan Hospital for 38 years, working in various positions related to quality control before becoming risk manager, according to the complaint filed in the U.S. District Court, District of Massachusetts. O'Connor claims in her lawsuit that she was fired for her actions after an incident at the hospital on March 26, 2010, involving a patient in labor who was transferred to another hospital.

O'Connor responded by conducting a full investigation and concluding that Jordan Hospital had violated EMTALA, the claim says. When she reported her findings to senior management, she indicated that she planned to notify the Centers for Medicare & Medicaidimmediately, because the

EXECUTIVE SUMMARY

Risk managers continue to face intimidation and threats of retaliation for complying with the law when it may mean financial harm to the institution. New federal laws offer some protection for those facing such a dilemma.

- Risk managers must seek the same whistleblower protections afforded other employees.
- A direct reporting line to the board will eliminate some harassment.
- An emphasis on the total cost of not reporting problems may persuade some critics.

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law required her to do so — and because the hospital would fare better if it self-reported, rather than risking that the other facility would report the incident.

According to O'Connor, her boss discouraged reporting, and soon after she reported the EMTALA violation to CMS, she was fired. She is now suing the hospital, which denies her allegations. O'Connor's attorney, **Jared Burke**, JD, of Needham, MA, says there has not yet been a settlement, and he is continuing to press forward with the lawsuit. (*For more on the O'Connor case, see* **Healthcare Risk Management**, *November 2010, pages 121-125.*)

Direct line to board crucial

Although he is not familiar with the specifics of the O'Connor case, **Reid Bowman**, JD, general counsel with ELT Inc., a company in San Francisco that provides compliance and ethics training, says the allegations in the lawsuit illustrate one important point regarding professional intimidation of risk managers.

"It is absolutely essential that health care risk managers have clear and unequivocal support from the top," Bowman says. "The risk manager must have a direct line of communication to the senior administrators and the board of the health care institution, so that his or her message does not get filtered, watered down, or somebody puts their own spin on it."

The law recognizes the importance of such a direct line of reporting, Bowman says. Recent amendments to the Federal Sentencing Guidelines specifically address the reporting structure of health care organizations, saying that the chief compliance officer should report directly to the organization's board of directors, or an appropriate subdirectory such as an audit committee, he says. In most health care organizations, the risk manager will either fill the role of chief compliance officer or report to that person, he notes. (*For more on the Federal Sentencing Guidelines, see the story on p. 4.*)

Sentencing guidelines address problem

That reporting structure serves to reduce friction for the risk manager, but it also offers practical benefits in the case of a prosecution.

"If you do that, then you are likely to get the benefits under the Federal Sentencing guidelines," Bowman says. "If your organization gets in trouble with the feds, and you're criminally charged, you can lower your ultimate penalty by as much as 95%. If you're really serious about this, you have to have a direct pipeline to the board or a related committee."

At the same time, however, Bowman says it is imperative for risk managers to ensure that they

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maintain a high degree of professionalism and not tolerate a lack of quality in their own departments. Too often, he says, risk management can be seen as a dumping ground for administrators who didn't make the cut elsewhere or "executives in transition."

"Maybe that person's department has been shut down, so they park that person in risk management until they find something the person is really competent in, but in the meantime you have someone in your department who is not what you really need," he says. "You have to avoid that kind of reputation in your organization, and if your own credentials are not up to par, you have to address that immediately."

Of course, the problem of retaliation is not limited to risk managers. Any employee who brings a problem to the attention of superiors or reports an issue to regulators may face retaliation from the employer, and Bowman says that possibility must be addressed head-on during compliance and risk management training. Too often, he says, the issue is mentioned as an afterthought — as a throwaway line at the end of the session where employees are told that retaliation will not be tolerated.

"It's mentioned when people are shuffling their papers and getting ready to walk out the door," Bowman says. "In reality, it's a huge issue. Retaliation is now the number-one reason for Equal Employment Opportunity charges. Retaliation has to be built into your education just like all the other important topics, and you have to provide real-life examples."

The examples are important, because professional intimidation can be subtle. Retaliation also is a natural human reaction, Bowman says, so it is important to acknowledge that even otherwise well-meaning managers can be tempted to punish someone who has rocked the boat.

Culture must support reporting

That kind of education can help build an organizational culture that recognizes the possibility of professional intimidation, but it also establishes a zero tolerance policy, Bowman says. That culture should protect not only whistleblowers who bring problems to the risk manager, but it also should also protect the risk manager who reports that problem to the board.

In the event that all of these precautions fail and the risk manager is facing pressure for trying to do the right thing, what recourse is there? Bowman says that all-important access to the board or audit committee is the best hope for resolving the issue. The risk manager must go to the board and explain directly that the hospital's policy against retaliation is being violated, he says.

"You also have to explain to the board that, as unpleasant as it is to have a risk manager bring you bad news, it is far better than having an outside agency or a plaintiff's lawyer bring it to you," Bowman says.

State and federal laws can help

Ultimately, the risk manager may have to rely on the protections afforded by law, says **Kevin Troutman**, JD, an attorney with the law firm of Fisher and Phillips in Houston. The whistleblower protections afforded by various federal and state laws more commonly are thought of in terms of protecting lower-level employees from retaliation by employers, but they can just as effectively protect the risk manager who passes on that information or reports violations to outside agencies, he says.

Many states have broad whistleblower protection statutes that protect employees, Troutman notes.

"All that person needs is a good faith belief that he or she is reporting a violation," he says. "Some states include a rebuttable presumption, saying that if a person is terminated in a certain amount of time after making the report, the presumption is that the termination was the result of their report."

Those applicable laws should be incorporated into the health care organization's policies and educational efforts, Troutman says. Don't stop with saying that retaliation is not acceptable. Spell out the protections afforded by state and federal law, he says.

Consider committees, outside groups

The culture of the organization should be considered when risk managers are offered positions in risk management at another institution, or when offered the chance to advance with the current employer, Troutman suggests. An organization that is dedicated to continuous quality improvement and transparency will be less likely to put the risk manager in a difficult position than one that is more focused on hiding its flaws, he says.

Troutman also suggests that many incidents of professional intimidation can be avoided by not having the risk manager shoulder all the responsibility for difficult decisions. With

more difficult decisions or costly ramifications of reporting, the risk manager probably should involve others to avoid a showdown between two individuals, he says.

"When you know that there is going to be a department or a powerful physician who doesn't like your decision, set it up so that that determination or that course of action doesn't all fall to just the risk manager," he suggests. "A committee or some advisory resources can spread the responsibility and avoid having all the anger or dissatisfaction falling on the risk manager's head. You can still take responsibility for your job by making a decision and acting on it; but you can back it up by saying that you went to the professional group or consulted with outside resources, and they confirmed that your course of action is correct."

Educate board about compliance

A risk manager who faces stiff resistance from senior leadership in the health care organization over reporting a violation may have failed in educating those people about the benefits of self-reporting, suggests **Kenneth S. Springer**, president of Corporate Resolutions Inc. in New York City, which provides fraud investigation services to corporate clients.

"Is this an old boy network that has been doing things the same for years and years, and they don't want some young buck changing things?" he says. "Education is important in showing the executive board and everyone else at that top tier that trying to hide the bad news and hope no one notices isn't the way to do business any more. The laws have changed, and they need to understand how much better — how dramatically better — it is to self-report in most cases."

In the O'Connor case, if the risk manager's allegations are true, Springer says he suspects the board and senior leadership made the mistake of thinking that an EMTALA violation could be swept under the rug and that there was little risk in not reporting it. That's old-school thinking, he says.

"If there were no grounds for this woman to be fired, I suspect she'll end up owning the hospital," Springer says. "The law recognizes that you need people like her to make these complaints and follow through with reporting to the authorities. If she truly was pressured, and she was the victim of wrongful termination, I think over time her case will send a message."

Caving in to pressure no solution

Risk managers under pressure not to report a violation should remind senior leadership that they are putting themselves at risk, says **Michael Diaz**, JD, managing partner with the law firm of Diaz Reus in Miami. The law generally does not hold an employee responsible for not reporting a violation because he or she was pressured by upper management to keep quiet, he says. So, for instance, a nurse who is discouraged from reporting a problem probably would not be prosecuted.

But the board and other senior leadership can be held accountable. And in most cases, that includes the risk manager. So, caving in to pressure not to report a problem won't make the problem go away.

"More and more, we're seeing legislation make those at the top of the business, such as the members of the board, personally responsible both civilly and criminally for their non-action," Diaz says. "Within that group lies the risk manager. If the risk manager is not made civilly, administratively, criminally liable for his or her performance, what's the purpose of having a risk manager?"

SOURCES

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Guidelines stress whistleblower protection

New 2010 Amendments to the Federal Sentencing Guidelines and Dodd-Frank Wall Street Reform and Consumer Protection Act ("Dodd-Frank Act") make clear that prosecutors and regulators expect to see an effective compliance program that protects whistleblowers, including risk managers, says **Reid Bowman**, JD, general counsel with ELT Inc., a San Francisco company

that provides compliance and ethics training.

Under the rules, organizations must implement internal reporting, reviewing, and training activities that demonstrate a true commitment to compliance and a "living" compliance program with support from and responsibility by senior leaders, Bowman says. This trend is only going to accelerate in the future, he cautions.

"There has been and will be a continued emphasis and reliance on whistle blowing — creating a real need for managers and workers to understand the importance of reporting, and the legal protections afforded whistleblowers," he says.

The U.S. Sentencing Commission approved amendments, which were effective Nov. 1, 2010, to its Sentencing Guidelines, clarifying what actions will result in more lenient sentencing. Bowman says the amendments specify that the organization must take these actions once it has been made aware of criminal conduct:

• The organization should respond appropriately to the criminal conduct. The Amendments provide that the "organization should take reasonable steps, as warranted under the circumstances, to remedy the harm resulting from the criminal conduct. These steps may include, where appropriate, providing restitution to identifiable victims, as well as other forms of remediation. Other reasonable steps to respond appropriately to the criminal conduct may include self-reporting and cooperation with authorities."

• The organization should act appropriately to prevent further similar criminal conduct, including "assessing the compliance and ethics program and making modifications necessary to ensure the program is effective." The Amendments provide that "steps taken should be consistent with subsections (b)(5) and (c) and may include the use of an outside professional advisor to ensure adequate assessment and implementation of any modifications."

The Amendments also address the kinds of reporting structures organizations must adopt. They provide:

• The Chief Compliance Officer (CCO) should report to the board or appropriate subcommittee of the board, such as compliance or audit.

• Organizations are also encouraged to have a hotline and other mechanisms to detect any compliance and ethics violations internally.

Bowman says that in this environment, it is increasingly difficult for organizations to simply "go through the motions" of implementing compliance and training programs in order to qualify for the critical legal benefits under the Federal Sentencing Guidelines.

"Increasingly, the Federal Sentencing Guidelines — and skeptical judges — require organizations to demonstrate that they have adopted thoughtful training programs that identify and target learner needs and which are periodically reassessed and refined — with the support and accountability of senior leaders," he says.

The recently enacted Dodd-Frank Act also includes a new whistleblower program which provides substantial cash rewards for whistleblowers who voluntarily provide information to the Securities and Exchange Commission (SEC) leading to the successful prosecution of securities law violations. Whistleblowers who report securities violations, including violations of the Foreign Corrupt Practices Act (FCPA) that result in monetary sanctions greater than $1 million, may receive between 10% and 30% of the total recovery, Bowman says.

The whistleblower provision also provides anti-retaliation protections, which permit civil causes of action for wrongful termination, suspension, harassment, or other discrimination because of the whistleblower's reporting to the SEC.

If successful, an anti-retaliation claim can result in reinstatement of seniority, two times the amount of back pay otherwise owed with interest, and compensation for litigation costs, expert witness fees, and reasonable attorneys' fees, Bowman says.

The Dodd-Frank act also amends the Sarbanes-Oxley and the False Claims Act to provide broader protection for whistleblowers.

"The Dodd-Frank Act makes it more important than ever to train your managers and employees on the role of reporting and the importance of retaliation protections," Bowman says. "Retaliation is a particularly important subject, because most managers either do not understand the concept at all, or do not fully understand the many kinds of conduct which may give rise to a retaliation claim." ■

Avoid being seen as the enemy

Most incidents of intimidation of risk managers emanate from a lack of understanding of the role of the risk manager in the hospital or health system, poor communication, and an

absence of clarity regarding chain of command, says **Patrick Hurd**, JD, senior counsel and leader of the Healthcare Industry Group with the law firm of LeClair Ryan in Norfolk, VA.

Often, confrontations occur between physician and nursing staff who consider risk managers the enemy, spies, and even "the goon squad," he says.

"I actually heard that term from a colleague," Hurd says. "Because physicians and nurses are sources of revenue for the hospital, and risk managers are overhead, hospital administration may be reluctant in some instances to defend the risk manager."

The best way to counter such issues is for the risk manager to be visible on the floors and communicate with departments when there is not a risk incident, i.e., when everything is fine, he says. This will enable employees to get comfortable with the risk manager's true role and to foster an "I've got your back" atmosphere," he says.

"If the risk manager stays in the office doing claims management and only appears on the floors to investigate an adverse event, such conduct leads to the negative caricatures," he says. "Also, keeping those up the chain of command aware of your activities, focusing on preventive programs and processes using a collegial buy-in approach can bring dividends in the long run. It's also helpful to know when to 'pick your fights.'"

Also, if your organization is prone to killing the messenger, make sure you are really supposed to deliver that message. Risk managers preparing to deliver bad news should understand the exact nature of their roles within the health care organization and the protections afforded them by corporate policy, says **Pamela Verick**, director and solution leader for fraud risk management with the Vienna, VA, office of Protiviti, a global business consulting and internal audit firm.

The specific responsibilities of a risk manager will differ from one organization to the next, and that includes what reportable issues are the direct responsibility of the risk manager vs. some other departments, such as human resources or compliance, Verick says. Knowing those distinctions can help keep you from putting your head on the chopping block unnecessarily, she says.

"Depending on the reporting line, the risk manager's responsibility may be to provide the information to legal counsel, for instance, if the matter is privileged, and then counsel would escalate that matter to the board," she says. "That provides some insulation, rather than getting caught up in unfortunate situations with management."

The risk manager also should be familiar with the protections afforded not only by federal and state law, but also by the organization's own policies, Verick says. For a risk manager, those policies are the first line of defense when facing professional intimidation, she says.

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Hospital may face numerous lawsuits

A former radiology technician accused of improperly entering negative results on mammograms at Perry (GA) Hospital has pleaded not guilty to the charges. Legal observers say the hospital is facing a storm of lawsuits over the alleged fakery.

Rachael Michelle Rapraeger, 30, of Macon, GA, entered the not guilty plea recently in Houston County Superior Court, according to her Macon attorney, **Floyd Buford**, JD. Rapraeger was indicted by a Houston County grand jury on 10 felony counts of computer forgery and 10 counts of misdemeanor reckless conduct. Judge Katherine K. Lumsden said the earliest Rapraeger's case could be heard would either be the trial week of April 4 or April 11 of 2011.

Buford tells *Healthcare Risk Management* that Rapraeger maintains her innocence and intends to fight the charges. He declined to discuss her case further or to address speculation that someone else must have known about fraud on such a large scale. **Victor Moldovan**, JD, an Atlanta attorney

EXECUTIVE SUMMARY

The radiology technician accused of faking mammography results has pleaded not guilty. The hospital may face numerous lawsuits.
• The question of whether anyone else was involved with the alleged fakery has not been answered.
• The hospital likely would argue that it is not responsible for intentional misconduct of an employee.
• A court would consider whether the employee's actions were foreseeable.

representing Houston Healthcare, which operates Perry Hospital, did not return a phone call inquiring about whether the hospital has been sued yet, but he issued a statement earlier saying an anomaly in patient records was discovered April 2.

As hospital officials investigated, a technician admitted to the fakery on April 5, 2010, confessing that she signed off on mammograms as if she were the radiologist, Moldovan said. Rapraeger was sent home that afternoon and dismissed April 6, he said. (*For more on the Rapraeger case, see* **Healthcare Risk Management**, *November 2010, pp. 125-128.*)

Tech banished from county

Rapraeger is accused of entering negative results for 1,289 mammograms at Perry Hospital from Jan. 22, 2009 to April 1, 2010, that were not read by a radiologist. Of the 1,289 mammograms entered as negative, 10 were actually positive, prosecutors have said.

The defendant was released on bond, which was conditioned on Rapraeger being on electronic monitoring, that she has no contact with any of the alleged victims, and that she may not work or volunteer in any medical or health-related areas, Buford says. She also was banished from Houston County as part of the agreement while on bond, except for court appearances and appointments related to the electronic monitoring.

Meanwhile, Perry Hospital is facing some difficult obstacles from the standpoint of civil malpractice cases brought on behalf of patients affected by the mammogram results, says malpractice plaintiff's attorney **Daniel Hodes**, JD, a partner with the law firm of Hodes Milman LLP in San Francisco.

The hospital likely will admit that it was responsible for the negligent actions of an employee, according to Hodes; but it will probably counter that the actions were certainly intentional, and the hospital is not responsible for the intentional torts of an employee, Hodes says.

Then the question becomes whether the employer is responsible for the intentional wrongdoing of an employee, he says. The court will ask if it was the kind of action that might be considered to be foreseeable under the circumstances.

Many lawsuits expected

As an example, Hodes cites a fertility scandal at an institution in California that involved a situation where several fertility specialists misappropriated eggs and other genetic material from couples and gave them to others. Their actions obviously were intentional and arguably criminal, he says, but the question was whether their acts might be considered to be foreseeable under the circumstances, Hodes says.

"The courts did find the actions foreseeable and held the university responsible for the misdeeds of the doctors," he says. "In this circumstance, a similar ruling could be expected, and I think that the hospital would be held vicariously liable for the misdeeds of this technician."

Hodes says he is certain the hospital will be sued by many of the patients and expects they will fare well.

"I would argue that if you had been vigilant, if you had policies, procedures, protocols, and the like that provided for checks and balances and safeguards, [you] would have detected this a long time before you actually did and a long time before my particular client's mammogram was filed as normal," he says. "That's a cause of action that would be directly against the hospital, and the outcome of that would have nothing to do with whether the court deemed the employer vicariously liable for the misdeeds of the employee."

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'Miracle on the Hudson' offers safety lessons

In 2009, **Jose Gonzalez**, MD, the medical director for the Texas Medicaid/State Children's Health Insurance Program, discovered the devastating results of a medical error in a very personal way. When his niece, Kaelyn Sosa, then 18 months old, was brought into a Miami hospital after receiving a bump on her head from a fall, she was sedated and given an MRI. During the test, her breathing tube became dislodged, resulting in a severe brain injury.

Gonzalez says cases like Kaelyn's are all too common in the United States — and some patients don't even leave the hospital alive. Nearly 100,000 people die every year in hospitals and doctors' offices due to medical mistakes. It's a huge num-

ber: Put in perspective that's the equivalent of one fully loaded 747 crashing every single day for a whole year, he notes.

The frequency of medical errors hasn't motivated enough hospitals and other health care facilities to take action, and that's a message being spread by Gonzalez and his niece's parents, Ozzie and Sandy Sosa. So when Gonzalez saw **Stephen Harden**, an aviator and CEO of LifeWings in Memphis, TN, speak on the issue of patient safety and systems for change, he knew he needed to invite the expert to Texas.

Harden presented "Meeting the Unspoken Expectation of Safety: What Every Clinician Can Learn from the Miracle on the Hudson and the Ditching of Flight 1549" at the recent Texas Pediatric Society Annual Meeting in San Antonio. Harden's organization has adapted the best practices of high-reliability organizations — such as commercial aviation, U.S. Navy aircraft carriers, and nuclear power — to help more than 100 health care organizations provide the highest safety for their patients.

Gonzalez says he can see the value in adopting the best practices of high-reliability organizations in health care, especially the concept of "crew resource management," which encourages pilots and other professionals to work closely as a team.

"Had the back-up systems and cross-check we use in commercial aviation been in place when Kaelyn was being treated, the dislodged tube would very likely have been discovered and her brain damage prevented," Harden says. "The one thing we know from aviation is that people will make mistakes; a good safety system recognizes people aren't perfect and will catch their mistakes before they harm the patient."

Not just a miracle

Harden tells *Healthcare Risk Management* that the "Miracle on the Hudson Flight" is a good illustration of how an organization can prepare for the inevitable accidents that will occur but still avoid disaster. US Airways Flight 1549 had just departed from New York City to Charlotte, NC, on January 15, 2009, when it was disabled by striking a flock of Canada geese during its initial climb out. The bird strike resulted in an immediate and complete loss of thrust from both engines. When the aircrew of the Airbus 320 determined that they would be unable to reliably reach any airfield from the site of the bird strike, they turned it southbound and glided over the Hudson.

The pilot and co-pilot successfully ditched in the Hudson River adjacent to midtown Manhattan six minutes after takeoff. All 155 occupants safely evacuated the airliner, which was still virtually intact though partially submerged and slowly sinking, and were quickly rescued by nearby watercraft.

"The whole event is commonly called the Miracle on the Hudson, but I take a contrarian view to calling it a miracle," Harden says. "Rather than being a miracle, it is a great example of the adage that systems are perfectly designed to get the results they produce. That is a message that resonates well in risk management and quality improvement in health care, because any system in their hospital is perfectly designed to get the results it produces."

There was some good fortune involved in the successful ditching of Flight 1549 — good weather and a daytime flight — and certainly great skill from the crew, but Harden says the underlying safety system design factors in commercial airliners are the real reason all 155 people came away with nothing worse than wet shoes.

Teamwork is essential

Harden says there are three important lessons from the Miracle on the Hudson:

- Everyone on the team must have expert teamwork and communication skills. Look at any group of highly trained professionals within the organization, and ask whether it is merely a group of experts or whether it is an expert team.

"The crew on that airplane were [an] expert team, and they got that way through their training," Harden says. "You didn't just have two pilots up there who independently of each other were very qualified in their jobs. You had two pilots who knew how to work seamlessly as a team."

- The organization must use what Harden calls "hard-wired safety tools." These would be checklists, communication scripts, and standard operating procedures that "hard wire" the proper safety procedures.

"If you use these safety checklists or these scripts, you have no choice but to use good teamwork, because the teamwork is built into the checklists," he says.

- The organization's leadership must enable people in the organization to use teamwork and safety tools. In other words, the leadership must make those resources available and support their use in every way.

Even with all the emphasis on patient safety in recent years, the health care industry has not sufficiently adopted the principles of high-reliability organizations, Harden says. The primary cause of patient harm is a breakdown in interpersonal relations, teamwork, and collaboration, he notes, accounting for about 70% of all adverse events.

That figure has been relatively unchanged over the past 10 years, he says. Root cause analyses frequently trace back to communication breakdowns, yet the health care industry still has been slow to adopt the same techniques that produced the Miracle on the Hudson, he says.

"If you look into the root cause, it's not uncommon to find that somebody on the team had a concern, a feeling in their gut, that something was not right," he says. "When you ask them after the patient has been harmed why they didn't speak up, they tell you that they didn't think administration would support them if they stopped the line — or they thought some doctor would bite their head off."

But when you ask the physicians and supervisors whether they expected the employee to speak up, they always say yes, that they encourage that kind of initiative, Harden says. When asked to show where they put that expectation in writing, most can't provide evidence, he says.

"If you want someone to speak up and be assertive if they detect something that is unsafe or not in the best interest of the patient, it's hard to find that kind of language in a policies and procedures manual saying it's a requirement," Harden says.

Must reward employees

Providers also are lax about including such a requirement in their new hire training and inservices, Harden says. They also are remiss in rewarding employees who do speak up by putting a positive notation in their personnel files, he says.

"We don't require it in the policies and procedures manual; we don't train them in teamwork when we hire them; and we don't reward them when they do it; and we don't check that they can do it in their annual performance reviews," Harden says. "Is it any wonder why you're not getting that behavior at the moment of truth? Leadership has done nothing concrete to [foster] that teamwork and make sure that kind of behavior is sustained over time."

Many industries are adopting the high-reliability practices that have proven successful in aviation and other fields, and Harden encourages risk managers to push for a focused effort to improve teamwork. As experience in other fields has shown, merely saying you encourage teamwork is not enough. The health care organization must implement concrete steps to make teamwork a necessity rather than just a good idea, he says.

The tools for health care teamwork may have to be the first objective. Harden believes checklists and similar tools have not been used as extensively in health care as in other industries, because they have not been well-designed.

"Our health care professionals are some of the best in the world, so it's not a matter of lacking expertise or not wanting to do what's right for the patient," Harden says. "It's a question of developing a system that allows them to work together as an expert team. That has not really taken hold across the health care industry, and it has to if we want to see more Miracle on the Hudson type endings when something goes wrong."

SOURCES

• **Stephen Harden**, CEO, LifeWings, Memphis TN. Telephone: (800) 290-9314. Web site: www.saferpatients.com.

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Doctors flee Illinois due to malpractice policy

Half of all graduating medical residents or fellows trained in Illinois leave the state to practice medicine elsewhere, in large part due to the medical liability environment in Illinois, according to a new study from Northwestern University Feinberg School of Medicine in Chicago. The study warns Illinois will face a critical physician shortage — especially in rural areas — if new strategies aren't adopted to stem the exodus.

Many of those who leave are just heading across the border to Wisconsin or Indiana, says **Russell Robertson**, MD, a lead study author and professor and chair of family and community medicine at the Feinberg School and of family medicine at Northwestern Memorial Hospital.

"Many of these new graduates cite Illinois' toxic medical malpractice environment as a major reason," Robertson says. "The Illinois Supreme Court's decision to lift the liability caps seems to

send the message that the potential for litigation supersedes the need for residents of Illinois to get needed health care."

With the national shortage of physicians, Illinois must change its malpractice policies and improve recruiting to remain competitive with other states, the study says. The situation will become more critical as the implementation of health care reform and aging Baby Boomers' medical needs escalate the demand for health care, Robertson says. Compounding the shortage, more doctors nearing retirement age are in general internal medicine, he says, while newly graduating doctors are more likely to be specialists.

The 2010 Illinois New Physician Workforce Study surveyed 561 graduating Illinois medical students in the spring of 2010. It examined graduating residents' and fellows' plans for entering the workforce and the reasons for their choices. The study was commissioned by Feinberg in partnership with the Illinois Hospital Association and the Illinois State Medical Society.

It is no shock that Illinois is losing its new doctors, says **Steven M. Malkin**, MD, president of the Illinois State Medical Society and an Arlington Heights internist.

"If a graduating resident sets up shop in any of our neighboring states, the liability premiums will be about a third to half of what he or she would pay in Illinois," Malkin says. "Six-figure medical education debt is the norm for many new doctors. Graduates feel it often doesn't make sense to stick around, unless they have a strong Illinois family connection."

Malkin says the study points out the urgent need for policy-makers to understand the importance of Illinois having a practice-friendly environment that encourages physicians who are educated and trained in Illinois to stay there.

One way to retain new doctors is to help them find jobs in Illinois, says **Maryjane Wurth**, president of the Illinois Hospital Association. The state has a healthy physician job market, but many new graduates don't know where to look, she says. Robertson points out that many young physicians rely on Google and other Internet searches to find a job, whereas health employers are not using those options as widely as they could.

Illinois also needs to better align its medical education system with physician supply needs to better serve patients, Wurth said. "Many hospitals across Illinois have already been facing physician shortages, especially in rural and underserved areas," she says.

The full study is available at http://www.ihatoday.org/uploadDocs/1/phyworkforcestudy.pdf. ■

TJC warns of ED suicide risks

A new Joint Commission Sentinel Event Alert warns that non-psychiatric patients are committing suicide in emergency departments and medical/surgical inpatient units. The alert urges greater attention to the risk of suicide for these patients and recommends education for caregivers about warning signs that may indicate when patients in general hospital units are contemplating harming themselves.

The alert cautions that many patients who kill themselves in general hospital units do not have a psychiatric history or a history of suicidal attempts. Some risk factors for these patients include dementia, traumatic brain injury, chronic pain or intense acute pain, poor prognosis or terminal diagnosis, and substance abuse.

Suicide is one of the five serious events most frequently reported to The Joint Commission, notes **Mark R. Chassin**, MD, MPP, MPH, president of The Joint Commission. Nearly 25% of the reported cases occurred in non-psychiatric settings. The Centers for Disease Control and Prevention (CDC) ranks suicide as the 11th leading cause of death in the nation.

"It is evident from the number of incidents reported that general hospitals must take action to prevent patient suicides. The mental as well as physical needs of patients must be addressed to prevent these tragic occurrences," Chassin says. "The recommendations in this alert give hospitals and caregivers practical strategies to identify patients at risk and to prevent suicides."

The Joint Commission's Sentinel Event Alert newsletter suggests that hospitals take a series of specific steps, including the following:

- Educate staff about suicide risk factors such as family history of suicide, anxiety, and use of antidepressants; warning signs that may indicate imminent action; and how to be alert to changes in behaviors or routines.
- Empower staff to call a mental health professional or resource person if changes in a patient are noted.
- Empower staff to take action, such as placing a patient under constant observation if the patient exhibits warning signs.

In addition to the recommendations contained in the alert, The Joint Commission urges hospitals to follow the accreditation requirements to prevent suicide. A Joint Commission National Patient Safety Goal calls for hospitals and behavioral health care facilities to conduct a risk assessment that identifies specific individual characteristics and environmental features that may increase the risk for suicide and to address safety needs. Furthermore, suicide prevention information, such as a crisis hotline, must be provided to at-risk patients and their families when they leave the facility.

The warning about suicides in hospitals is part of a series of alerts issued by The Joint Commission. Much of the information and guidance provided in these alerts is drawn from The Joint Commission's Sentinel Event Database, a comprehensive voluntary reporting system for serious adverse events in health care.

The complete Sentinel Event Alert is available at http://www.jointcommission.org/sentinel_event_alert_issue_46_a_follow-up_report_on_preventing_suicide_focus_on_medicalsurgical_units_and_the_emergency_department/. ■

$17.7M settlement after officer left quadriplegic

The University of Illinois at Chicago Medical Center has reached a $17.7 million settlement with a former Stone Park, IL, police officer who suffered a brain injury due to medical negligence, according to the officer's law firm.

George Nissen, 47, of Melrose Park also will receive $1.5 million from a nursing agency. The University of Illinois Board of Trustees approved the hospital's portion of the settlement — $16.2 million, and the Circuit Court of Cook County is expected to make final approval, according to Nissen's attorneys Steven M. Levin, JD, and Margaret P. Battersby, JD, of Levin & Perconti; and Louis Berns, JD, of Favil David Berns & Associates.

The attorneys claim Nissen suffered a brain stem herniation when hospital staff failed to properly monitor his intracranial pressure during an external ventricular drain. As a result of the nursing staff's negligence, attorneys said, Nissen now suffers from quadriplegia. He cannot eat or speak, and can only communicate to family, friends, and caregivers through eye movements and head shaking.

On Feb. 13, 2005,according to the lawsuit, as provided in a summary by the attorneys, Nissen was admitted to the neurosurgical intensive care unit of UIC after suffering a stroke believed to be caused by an injury suffered during an altercation while making an arrest as a Stone Park police officer. Physicians attempted to drain excess fluid from his brain, and on Feb. 21, Nissen's doctors ordered the nursing staff to test the drain by clamping it to determine if he was stable enough to remove it.

The lawsuit alleged that during this test, nursing staff failed to properly monitor Nissen's intracranial pressure. Throughout the night, Nissen's intracranial pressure was at dangerous levels, but his caregivers failed to recognize changes in his neurological condition or notify a physician, the lawsuit claimed.

The lawsuit was filed against two UIC staff nurses caring for Nissen, along with a health care staffing agency and an agency nurse who cared for Nissen that evening. The UIC staff nurse and the charge nurse assigned to Nissen failed to report Nissen's changing condition to a physician and did not give the agency nurse who took over Nissen's care an adequate patient report at the end of her shift, Nissen's lawyers said. The agency nurse had no prior experience caring for patients in the neurosurgical intensive care unit and was not qualified to care for Nissen, according to the lawsuit. ■

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

■ New national electronic record safety system

■ Renewed focus on OB risk management

■ Hospital captures more data, uses it better

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 credit letter will be mailed to you.

1. According to Reid Bowman, JD, general counsel with ELT Inc., a company in San Francisco that provides compliance and ethics training, which reporting line is best for risk managers?
A. The risk manager should report directly to the board or a subdirectory such as the audit committee.
B. The risk manager should report directly to the CEO.
C. The risk manager should report to a senior executive, but not the board.
D. The risk manager should report to the director of quality.

2. According to Michael Diaz, JD, managing partner with the law firm of Diaz Reus in Miami, who can be held accountable for failing to report knowledge of a crime or fraud?
A. The employee who originally reported the problem to leadership.
B. The board and senior leadership, which usually includes the risk manager.
C. Only the risk manager.
D. Only the board.

3. In the case of the alleged fake mammogram reports at Perry Hospital in Georgia, what does malpractice plaintiff's attorney Daniel Hodes, JD, a partner with the law firm of Lopez, Hodes, Milman and Skikos in San Francisco, think would be the outcome of a court case claiming the hospital was responsible for the technician's actions?
A. The court would find that the hospital was not responsible for intentional misconduct by an employee.
B. The court would find the hospital liable only for the latter portion of the crimes, on the basis that enough time had passed for the hospital to become aware.
C. The court would find that only the involved physician radiology groups held liability.
D. The hospital would be held vicariously liable for the misdeeds of the technician.

4. According to Stephen Harden, an aviator and CEO of LifeWings in Memphis, TN, what is the primary cause of patient harm related to adverse events in health care?
A. Outdated equipment.
B. Lack of education.
C. Inadequate teamwork and crew resource management.
D. Lack of motivation.

Answers: 1. A; 2. B; 3. D; 4. C