Healthcare RISK MANAGEMENT

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$78.5 million verdict blamed on poor maintenance, documentation

OB says fetus is dead after faulty ultrasound, then C-section delayed 81 minutes

A jury in Philadelphia has awarded a family $78.5 million on behalf of a child who suffered severe brain damage as a result of a delayed cesarean section, and legal experts are warning that the case illustrates a risk that can go overlooked in hospitals. Maintenance of equipment might seem a mundane issue, they note, but failure to properly maintain crucial machinery – and document that maintenance – can lead to a significant verdict such as the one in Philadelphia.

> *"He performed an ultrasound examination with outdated, insensitive, and poorly maintained equipment provided to him by the hospital."*

The family obtained a $78.5 million verdict on behalf of the now 3-year-old child who has severe spastic quadriplegic cerebral palsy. The cerebral palsy resulted from an 81-minute delay in performance of an emergency cesarean section delivery. The damages award against Pottstown Memorial Medical Center in Philadelphia includes payments for future medical care, lost earnings, pain and suffering for the baby, as well as emotional distress for the baby's mother, Victoria Upsey.

"Birth injury cases are always emotional matters, but the facts of this case were particularly shocking because the reason this delivery was delayed was that the obstetrician thought the baby was dead," says **Daniel S. Weinstock**, JD, of the law firm Feldman Shepherd Wohlgelernter Tanner Weinstock & Dodig in Philadelphia, who represented the family in the case. "He performed an ultrasound examination with outdated, insensitive, and poorly maintained equipment provided to him by the hospital. He actually told my client her baby had died, then 81 minutes later, the baby had come back to life."

The case arose in August 2008 when Upsey, then 36 weeks pregnant, presented to the hospital with signs of a placental abruption. Fetal monitoring was inconclusive, which led the obstetrician to perform a bedside ultrasound examination. Weinstock and G. Scott Vezina, JD, also of the law firm Feldman Shepherd Wohlgelernter Tanner Weinstock & Dodig, submitted evidence in the case

INSIDE

cover

Huge verdict blamed on equipment problem
p. 76

Public relations fallout for hospital is a problem
p. 76

Insurance coverage available for HIPAA breaches
p. 78

Hospital will pay $750,000 for data breach
p. 78

Arbitration provisions must be fair, court says
p. 79

Take these four steps to improve arbitration policies

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that the ultrasonography equipment provided by Pottstown Memorial Medical Center was antiquated and lacked the sensitivity of modern ultrasound machines. When questioned by Weinstock during the trial, the hospital's risk manager admitted there was no evidence the equipment had even been serviced for more than 10 years, whereas the manual indicates that annual maintenance is necessary.

'100% certainty' it was proper

Throughout the discovery process, during his deposition and even when first questioned during trial, the obstetrician steadfastly maintained with "100% certainty" that he performed the ultrasound properly, Weinstock says. The doctor said the reason he did not identify the fetal heartbeat is because the baby had died, and he insisted that the baby then "came back to life" some 81 minutes later.

The hospital did not have an ultrasound technician present in the hospital because it was a Sunday, and the plaintiffs contended that not having one present amounted to hospital administration negligence. The technician had to come from home to verify the obstetrician's incorrect findings. A spokesperson for Pottstown Memorial Medical Center declined Healthcare Risk Management's request for comment, other than to say hospital leaders are disappointed in the verdict and plan to appeal. *(See the story on p. 75 for more on the hospital's failure to settle the case.)*

The award is thought to be the largest medical malpractice award in Pennsylvania. **Daniel P. Slayden**, JD, a partner with the law firm of Hinshaw & Culbertson in Joliet, IL, says the verdict might be the largest he has ever seen in a birth injury case.

"That's huge. Normally in these types of cases, you'll have future health care costs in the $10 million to $12 million range, plus pain and suffering and some other liability," Slayden says. "In my 20 years of experience, I don't think I've ever seen one that large."

Most birth injury cases do not go to trial because there is significant risk on both sides, Slayden says. It is likely that the hospital offered a settlement and the plaintiff wanted more, and then both parties decided to gamble by going to a jury. In this case, the gamble paid off

Executive Summary

A Pennsylvania jury awarded $78.5 million after a cesarean section was delayed 81 minutes, which resulted in severe injuries to the child. Trial testimony indicates that the ultrasound machine provided a false reading, which led the doctor to conclude the fetus was dead.

- ✦ The jury placed all liability on the hospital. The physician testified against the hospital.
- ✦ The hospital could not provide evidence that the ultrasound machine had been properly maintained.
- ✦ Maintenance of critical machines must be considered a risk management priority.

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Editorial Questions

Questions or comments? Call **Greg Freeman,** (770) 998-8455.

big for the plaintiff, he says. *(See the story on p. 76 for more on the damage to the hospital's public image.)*

The jury probably focused much more on the emotional aspects of the case because the medical issues were relatively simple, says **Jonathan Rosenfeld**, JD, a partner with Rosenfeld Law Offices in Chicago. Unlike some medical malpractice cases in which the clinical issues are complex for a lay jury, this case was relatively straightforward, he says.

"A lot of times the jury never gets past the negligence issue because it is so complex, but here I think they understood the negligence quickly and easily," Rosenfeld says. "That freed them to focus on the damages."

The case should serve as a reminder that huge awards are always possible, particularly in birth injury cases, Rosenfeld says. Most medical malpractice cases are decided in favor of the defendant, but relying too heavily on that statistic can mean trouble, he says.

"You can say that about 80% of cases are won by the defendant, but you have to look at your case in particular," Rosenfeld says. "If this is a case in which there clearly is negligence, it may stand out from that 80% of typical cases. This may be a case you want to resolve before trial."

Lack of documentation was key

Slayden notes that the risk manager's admission that there was no evidence of maintenance on the machine must have influenced the jury. Hospitals should have a policy requiring service on equipment that complies with the manufacturers' suggestions, he says.

Documenting that maintenance is extremely important, Slayden says, but too often it can be overlooked because it is not seen as a direct patient care activity. In the Pottstown Memorial case, he says it is unlikely that the ultrasound machine had never been calibrated or maintained for 10 years, but the risk manager was unable to provide any documentation to prove the maintenance.

> *"There may be better machinery out there, and you don't want to be in court trying to explain why you're using what is, in relative terms, an antique."*

"Documentation has to be there. With nursing, a lot of times we can argue that it's their custom and practice, and even though they didn't document it this one time, we know they did it because they have always done it that way for years," Slayden says. "If the engineer comes in and says he didn't document the maintenance, but he's sure he did it over the past 10 years, imagine the cross examination that opens up for him. You did all the maintenance for 10 years, and you don't have documentation of even one instance?"

Maintaining equipment is not enough, however. Obstetrics should be given special consideration regarding diagnostic equipment because the potential effects of a wrong diagnosis, as in this case, are extraordinary, says **Herbert S. Subin**, JD, partner with the law firm of Subin Associates in New York City. The maintenance and calibration of this equipment might need to be performed even more often than required by the manufacturer, he suggests.

There also should be a policy in place that requires the engineering department or individual clinical units to review key equipment periodically and determine if newer, better versions are available, Slayden says.

"You don't have to change it every time a new model comes out, but after 10 years, that equipment might be obsolete," Slayden says. "There may be better machinery out there, and you don't want to be in court trying to explain why you're using what is, in relative terms, an antique." *(For more legal analysis of this case, see* Legal Review & Commentary *inserted in this issue.)*

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Case never should have gone to trial, lawyer says

The $78.5 million verdict against Pottstown Memorial Medical Center in Philadelphia could have been avoided. Letting the case go to a jury was a mistake for the hospital, says **Herbert S. Subin**, JD, partner with the law firm of Subin Associates in New York City.

The $78.5 million is not necessarily too large considering the devastation wrought on the entire family of the injured child, he says, but the hospital probably could have gotten away with paying less.

"A lot of times nobody has the guts

on the defense side to say 'hey, we have to pay tens of millions of dollars because we really caused that much damage,'" Subin says. "Sometimes the people involved would rather have it to go a jury because they can pin all the blame on a crazy jury, rather than being the one who decided that a large settlement was appropriate. The risk is that you get a monster verdict like this."

The jury placed all the blame and liability on the hospital and none on the physician, who during the trial pointed the finger at the hospital and claimed that his incorrect diagnosis was caused by the hospital providing faulty equipment. That testimony could be expected from a physician who did not want to be blamed for such a tragedy, but Slayden says the verdict does not necessarily mean the jury believed him entirely. Nonetheless, the jury did not want to make a lone physician liable for even part of such a huge award.

"That seems to me to be a jury that didn't want to stick a doctor with such a huge verdict because it could bankrupt him, so they nailed the hospital with it," he says. "You may have a situation where they decided this kid deserved a lot of money and that verdict would have a lot more impact on the doctor than the hospital, so they went for the deep pocket. That does happen."

The doctor must have been the plaintiff's most compelling witness, Subin says.

"I'm sure they turned the doctor into a secondary victim by having him testify that he was provided antiquated equipment by the hospital and he did the very best he could, but was horribly misled," Subin says. "He probably told the jury how terrible he felt when he realized that the faulty machinery had led him astray." ✦

Hospital's image with public will suffer

The reputation of Pottstown Memorial Medical Center in Philadelphia will take a big hit from the recent $78.5 million malpractice verdict against it, says **Scott Sobel**, president of Media & Communications Strategies in Washington, DC.

No matter how complicated the clinical issues in a malpractice case, and they were not that complicated in this one, the public always distills the story down to its essence, Sobel says. In this case, he says, the story will be that Pottstown provided inadequate equipment to the physician.

"There can be an education strategy with the general media and also with social media," Sobel says. "We have done empirical research indicating that a certain percentage of judges admit anonymously that they are affected by media reports, so the effect goes beyond just the reputation among the general public."

The hospital and other local hospitals are at risk because of the public's heightened awareness of the verdict and the issue, Sobel says.

"There is a likelihood of copy-cat allegations, and certainly other plaintiffs' attorneys will see blood in the water," Sobel says. "The hospital in this case, and others, should be doing both internal and external communications to mitigate these risks."

Examples of internal communications are distribution of news articles with the hospital point of view attached; employee town hall meetings; official statements on the hospital web site; and letters and emails to other internal hospital stake holders such as board members, employees, patients, donors, regulators, unions, and professional groups. External communications include news conferences and distribution of information through social media such as Facebook and blogs.

"External communications should include monitoring of all social media and news that might mention the hospital, along with creation of an overarching crisis and a media plan that addresses short term, mid-term and long-term actions and goals, especially reputation and business goals," Sobel says. "The goal is a constant drum-beat of good news stories sent to all stake holders and media."

SOURCE

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Insurance available for HIPAA breaches

Boston Children's Hospital has informed more than 2,000 patients that their names, birth dates, diagnoses, and treatment information were contained in a laptop file lost by an employee in Buenos Aires. While the laptop was password-protected, the information was not encrypted and easily accessible to anyone able to crack the password.

Such breaches are in the news regularly, and some insurers are responding by offering insurance packages to cover the costs related to a data breach.

The Boston breach is an example of how email can lead to a data breach violating the Health Insurance Portability and Accountability Act (HIPAA), says **Mark Bower**, data protection expert and vice president at Voltage Security in Cupertino, CA, which provides data security.

"The organization was emailing insecurely, showing that even an inter-

nal email can be leaked when it's on a laptop that mistakenly gets lost," Bower says. "End-to-end encryption of email messages from inside the organization to and from mailboxes, as well as to outside recipients, can prevent this type of incident from ever happening. Organizations only leveraging gateways to protect emails traveling outside are not addressing this risk."

"Cyber liability" is a growing area for the insurance industry, says **Jay Sheehan**, JD, senior vice president of Preferred Advantage in Hartford, CT, a division of national insurance provider Preferred Concepts. In some cases a general liability policy will provide minimal coverage for cyber liability, but it rarely is enough to make a dent in the cost of a data breach, Sheehan says.

Standalone cyber liability coverage is readily available from most carriers, he says. Policies can cover expenses such as forensics to determine how a breach happened, notification costs, remediation costs, and claims for damages from the parties involved. Although policies can be tailored for individual needs and budgets, Sheehan says any cyber liability coverage should pay for notification,

"People don't realize how much money goes into the notification process because it's not as easy as writing a letter and putting an ad in the paper."

which can be surprisingly expensive.

"People don't realize how much money goes into the notification process because it's not as easy as writing a letter and putting an ad in the paper," Sheehan explains. "Hospitals have to pay attorneys to research the appropriate way to notify the affected parties, which must be in a particular way. Part of what you get with some of these policies is a third-party vendor who already knows what needs to be in the letter and how the process works."

Investigating the breach and determining how to prevent a recurrence also can be expensive, and so that cost also should be included in the coverage, he says.

As with most insurance coverage, the cost for cyber liability coverage will vary widely, depending on the size of the healthcare organization and many variables that can determine the likelihood of a loss. To obtain the lowest rates, carriers will want to see evidence that the organization has a solid data protection and HIPAA compliance plan in place, Sheehan says.

Executive Summary

Data breaches are common in healthcare and can come with substantial costs. Insurers are now offering products that will cover the expenses associated with a data breach.

- ✦ Policies should include coverage for notification expenses and investigating the breach.
- ✦ A good HIPAA compliance plan can reduce the cost of coverage.
- ✦ Associated providers, such as imaging centers, might underestimate the need for coverage.

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Some providers not taking cost of data breach seriously

Hospitals are adopting cyber liability policies in growing numbers, but other healthcare organizations are lagging behind, says **Jay Sheehan**, JD, senior vice president of Preferred Advantage in Hartford, CT, a division of national insurance provider Preferred Concepts.

He encourages risk managers to consider not only the protection needed for the hospital itself, but also for any imaging centers, physician practices, and similar groups associated with the hospital. Depending on the financial relationship, they might need standalone policies, and they're not likely to pursue them unless prompted by the risk manager, Sheehan says.

Leaders at these smaller centers can become complacent and think they have sufficient safeguards in place and don't need cyber liability coverage, he says. Sheehan recalls one incident in which he was talking about his company's cyber liability policies with a physician practice and was told it wasn't necessary because they secured their data well.

He asked what was in all the boxes stored in the conference room where the meeting was held and learned they were medical records. The rest were stored in an apartment that the practice rented nearby.

"If someone broke into the office, or even easier, the apartment building one night, they could get away with thousands of records in 15 minutes. They would have no idea whose records were missing and would have to notify everyone," Sheehan says. "That's when you realize how expensive a data breach can be." ✦

South Shore Hospital to pay $750,000 for data breach

South Shore Hospital in Boston has agreed to pay $750,000 to resolve allegations that it failed to protect the personal and confidential health information of more than 800,000 consumers, Massachusetts Attorney General **Martha Coakley** announced recently.

The investigation and settlement resulted from a data breach reported to the attorney general's office in July 2010 that included individual's names, Social Security numbers, financial account numbers, and medical diagnoses.

"Hospitals and other entities that handle personal and protected health information have an obligation to properly protect this sensitive data, whether it is in paper or electronic form," Coakley said. "It is their responsibility to understand and comply with the laws of our commonwealth and to take the necessary actions to ensure that all affected consumers are aware of a data breach."

The consent judgment includes a $250,000 civil penalty and a payment of $225,000 for an education fund to be used by the attorney general's office to promote education concerning the protection of personal information and protected health information. In addition to these payments, the consent judgment calls for another $275,000 in damages but credits South Shore Hospital for that amount already spent on security measures it took subsequent to the breach.

In February 2010, South Shore Hospital shipped three boxes containing 473 unencrypted back-up computer tapes with 800,000 individuals' personal information and protected health information off-site to be erased. The hospital contracted with Archive Data Solutions to erase the back-up tapes and resell them.

"Hospitals and other entities that handle personal and protected health information have an obligation to properly protect this sensitive data ..."

The hospital did not inform Archive Data, however, that personal information and protected health information were on the back-up computer tapes, nor did South Shore Hospital determine whether Archive Data had sufficient safeguards to protect this sensitive information. Multiple companies handled the shipping of the boxes containing the tapes.

In June 2010, South Shore Hospital learned that only one of the boxes arrived at its destination in Texas. The missing boxes have not been recovered, although there have been no reports of unauthorized use of the personal information or protected health information of affected individuals.

The allegations against South Shore Hospital in the lawsuit are based on federal and state law violations, including failing to implement appropriate safeguards, policies, and procedures to protect consumers' information, failing to have a business associate agreement in place with Archive Data, and failing to properly train its workforce with respect to health data privacy.

According to the consent judgment, South Shore Hospital has also agreed to take a variety of steps to ensure compliance with state and federal data security laws and regulations, including requirements regarding its contracts with business associates and third-party service providers engaged for data destruction purposes. The hospital also agreed to undergo a review and audit of certain security measures and to report the results and any corrective actions to the attorney general. ✦

Courts demand fairness with arbitration provisions

With so much to cover in employee orientation, it is tempting to include a lot of dry legalese in the employee handbook and be satisfied that you have fulfilled your obligation to notify. That position might have to change now in light of recent court rulings concerning arbitration, says **Elliot Zemel**, JD, formerly an associate at the law firm of Fenton Nelson in Los Angeles, which advises healthcare facilities on regulatory compliance requirements.

"There's an idea that employers can kind of throw the book at an employee and shove whatever they like in that handbook, but now the law will not tolerate the handbook policies being prejudicial against the employee and in favor of the employer," Zemel says. "Specifically with regard to arbitration, hospitals have to re-examine the remedy that they provide for a conflict that could arise with an employee."

Zemel suggests that many hospitals' arbitration provisions could be invalidated by the recent court rulings. Risk managers should review the policies and how they are presented to employees immediately, he says. *(See the story on p. 79 for more on how to review and improve arbitration policies.)*

Failing to update an arbitration policy could result in a big surprise for the hospital if the policy is thrown out during a dispute with an employee, Zemel says. Arbitration is intended to lessen the potential damage from an employee dispute by avoiding court,

Executive Summary

Recent legal decisions suggest courts are taking a harder look at arbitration provisions in employee handbooks. Policies prejudicial to the employer might be invalidated.

✦ Policies must not be one-sided by imposing restrictions on the employee but not the employer.

✦ Risk managers should review current policies and revise them as needed.

✦ An arbitration policy must be fully explained in the employee handbook, including details of the arbitration process.

but if the policy is thrown out, then all bets are off. "The policy will be stricken from the handbook, and the court will not compel the employee to go to arbitration. You're in civil court," Zemel says. "It's no longer a controlled explosion where you can be confident of avoiding the worst outcome."

The recent changes derive from two California cases. Though in a strict sense they affect only California cases, Zemel points out that California has been a trendsetter for healthcare policies and procedures. *(See the story below for more on the two court cases.)*

"This could be a new trend nationwide," Zemel says. "California has brought this issue to the fore, and I think we are likely to see courts across the country having the same reactions."

It is important to seek advice and periodically revisit company handbooks and employment policies to make sure they are compliant with recent developments and changes in the law, Zemel says.

"Most importantly, the arbitration policy must be fair and not one-sided," Zemel says. "The courts are against the idea that the employer has the upper hand and can throw anything at the employees, who have to agree. It can no longer be so prejudicial and unfair to the employee."

SOURCE

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Court decisions say policies must be fair to both parties

Two recent legal decisions signal a change in the way courts will view arbitration provisions, says **Elliot Zemel**, JD, an associate at the law firm of Fenton Nelson in Los Angeles.

In Wherry et al. v. Award, California's Fourth Appellate District Court of Appeal addressed an arbitration provision in an independent contractor agreement that was handed out with the instruction that the worker was required to sign it if he wanted to work. The court found that the provision, coupled with the instruction, rendered the terms procedurally and substantively unconscionable and invalidated the provision altogether. The absence of a meaningful opportunity to review or negotiate the agreement's terms was decisive as to procedural unconscionability. It was substantively unconscionable because the terms were overly harsh and unfairly one-sided when the company imposed costs of arbitration on the workers. As a result, the court invalidated the provision.

In Zullo v. The Superior Court of Santa Clara County Court of Appeal, another case involving a take-it-or-leave-it approach to employment terms, the court of appeal assessed the validity of a questionable arbitration provision. The court found that simply sticking an arbitration provision in an employee handbook created a contract of adhesion, that is, one that presented no opportunity for negotiation. In this case, the arbitration provision in the handbook required the use of American Arbitration Association (AAA) rules, but the employer did not provide the rules to the employee.

"Another condition for the employee was that they had strict timelines in which to comply with the arbitration provisions or they would forfeit their rights, whereas the employer had no special limitations or restrictions," Zemel says. "The court used the legal term 'unconscionable,' but really this was just unfair. It was severely prejudicial and one-sided."

Additionally, the court stated the policy was one-sided because it did not impose a mutual obligation to arbitrate. The court invalidated the policy. ✦

4 steps to making arbitration policy valid

Recent healthcare decisions should compel healthcare risk managers to reconsider their hiring process and company policies.

There are four issues employers should examine and change if necessary, says **Elliot Zemel**, JD, an associate at the law firm of Fenton Nelson in Los Angeles, which advises healthcare facilities on regulatory compliance requirements:

1. Employers must allow sufficient time for the employee to review and inquire about an agreement that contains an arbitration provision. They should tell the employee to take it home for the night and mull over the terms.

2. The agreement must be as fair to

the employee as possible. For example, the arbitrator must be neutral and separate from the company; the arbitration agreement should not limit the employee's abilities to conduct discovery of facts and evidence; it should require a written decision so that it may be reviewed by a court; it should not require the employee to pay costs or fees not normally incurred if litigated in court.

3. Arbitration provisions should be explicit and impose the same rules upon the employer as they do on the employee. The courts are likelier to invalidate agreements that are one-sided in their requirements for the employee, limiting a fair chance for employees to vindicate their rights while affording wide latitude to the employer.

4. When using of American Arbitration Association (AAA) or any other method of arbitration, the related rules must be provided to the employee with the employee handbook. This provision has never been a requirement but is arising because many employees are claiming unfamiliarity with the system of arbitration being imposed upon them. By giving employees the rules at the beginning of employment the employer ensures that, should arbitration be necessary, the employee understands what his rights are from the beginning. ✦

Telemedicine brings exposures along with innovations

Telemedicine is becoming more common all the time, but risk managers might not be keeping up with all the new challenges that come along with the new technology. The use of telemedicine across state lines, in particular, raises some tricky risk management issues.

Many states consider telemedicine to be just a part of the general practice of medicine, explains **Laura Podolsky**, JD, an attorney with the law firm of Fenton Nelson in Los Angeles. Many consider it to be another tool that requires no special regulation or requirements, Podolsky says. Other states, however, require registration or licensure for physicians and others who practice telemedicine.

Licensing can be a concern with telemedicine because each state requires that any physician practicing in the state be licensed in that state, Podolsky says. But where is a physician "practicing" if the physician is in Washington and the patient is in Idaho, connected by a telemedicine link?

"Generally the practice of medicine is wherever the patient is located, so the doctor in Washington is going to have to be licensed in Idaho. That can be a big stumbling block," Podolsky says. "There is a big risk of violating these licensure laws if you're not careful."

Some states have passed laws to allow a consultation by a doctor from another state without requiring licensure, and those laws can be used to facilitate telemedicine, Podolsky says. *(See the story on p. 81 for more on the barriers to telemedicine.)*

"The licensing question can be such a barrier to interstate telemedicine that we hope more states would address it legislatively, but so far they're pretty slow to do so," Podolsky says. "States typically aren't going to be concerned with a one-time incident, but if you start to have an ongoing telemedicine relationship with a patient in their state, some boards could take issue with that."

The compliance picture is so murky and the risks of violation so high that Podolsky says risk managers should urge physicians to avoid interstate telemedicine for now.

"Until states move forward in addressing telemedicine specifically, it's too risky to conduct interstate telemedicine on a regular basis," she says. "That shouldn't prevent the occasional interstate consultation because most states have the consultation exception, but you don't want another state's board of medicine to think you're setting up shop there without a license."

Another issue is whether consultations for therapy meet the state's minimum hours' requirements for those seeking licensure. The Board of Behavioral Sciences has not yet addressed this question, Podolsky says.

Reimbursement also is another concern, with some payers trying to avoid payment for telemedicine, Podolsky says. Some states, including California, are passing laws that require payers to cover telemedicine.

Risk managers should review telemedicine programs to ensure they are compliant with state laws, Podolsky says. Be aware, in particular, that the requirements might be different for

Executive Summary

Laws governing telemedicine are not keeping up with the technology. Interstate telemedicine is posing risk management concerns that are unresolved.

✦ Some interstate telemedicine requires the physician to be licensed in the patient's state.

✦ It might be prudent to avoid interstate telemedicine until licensing issues have been resolved.

✦ A single consultation for a patient out of state does not pose the same problem as an ongoing telemedicine relationship.

the various people using telemedicine, she says. For example, there might be requirements for radiologists that don't apply to other practitioners.

"This is a situation in which the law has not kept up with the technology," Podolsky says. "We're hoping to see movement from the legislatures and the medical boards so that this is just a temporary problem."

SOURCE

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Licensing, financing seen as barriers to telemedicine

Regulatory issues such as state-by-state licensing continue to be a serious hurdle in the expansion of telemedicine, according to a survey of clinicians using the technology.

The authors, from two California hospitals, asked telemedicine users from 63 facilities across the country about seven topics related to barriers to implementing telemedicine. "Respondents proclaimed that [telemedicine's] success was still hampered by licensing, credentialing, and malpractice protection, as well as costs, billing, and reimbursement issues," the authors reported.

Licensing was a key problem, with 61% agreeing or strongly agreeing that out-of-state licensing was a barrier to implementation. Reimbursement also was cited, with 73.3% agreeing or strongly agreeing that government reimbursement is a barrier to implementation.

"The majority of all respondents indicated that cultural issues did not constitute meaningful hurdles, technological matters were generally favorable, and that most personnel were agreeable to both achieving the buy-in to start a [telemedicine] program and to maintaining [it] once started," the report says.

When asked to name the most significant motives for implementing telemedicine programs, the respondents cited providing clinical support (84%), maintaining patient satisfaction (80%), achieving immediate patient access (69.5%), overcoming service gaps (60%) and improving quality (59%).

The authors recommend more flexible credentialing and interstate licensing regulations, as well as improved payment models for telemedicine. They also urge more telemedicine training and education for physicians that includes information about the benefits of telemedicine, including safety, efficacy, and improved outcomes.

An abstract is available at no charge at http://tinyurl.com/84jfvs5. ✦

State of California reduces medmal premiums by $23 million

The California Department of Insurance has saved doctors and other medical providers $23 million in just two months by reducing unjustified medical malpractice insurance premiums using the state's prior approval rate regulation authority.

California law prohibits excessive malpractice insurance premiums for doctors. California insurance reform law Proposition 103 gives the state insurance commissioner authority to modify or deny medical malpractice and other property-casualty insurance rates that are unfair or excessive.

The Department of Insurance announced recently that two malpractice insurance companies would reduce premiums by nearly $4 million, which is an 11.9% reduction for medical providers with Medical Protective Co. (MedPro) and a 7.25% reduction at National Chiropractic Mutual Insurance Company (NCMIC). In the previous month, the department announced savings of $19 million for physicians and other medical providers at three other insurance companies. A challenge to rates at the Doctors Company, the state's largest medical malpractice insurance provider, is pending. ✦

$31 billion was paid for medmal premiums in '11

Physicians, hospitals, dentists, therapists, and a host of other healthcare providers paid about $31 billion in medical malpractice premiums in 2011, which is a new record, according to a study released recently by Patients for Fair Compensation, a group based in Alpharetta, GA, that seeks to educate the public about the costs of defensive medicine.

The data showed that all healthcare providers spent that amount last year to protect themselves from lawsuits. Economists claim that malpractice premiums are built into the escalating costs of healthcare for consumers, notes **Richard L. Jackson**, chairman of Patients for Fair Compensation.

In addition, the study found that 19,000 patients received compensation from medical malpractice occurrences

in 2011. Of the $31 billion in premiums, about 20% or $6 billion went to patients. The remaining $25 billion went to attorneys' fees and other legal costs, administrative costs, and insurance company profits.

"You can't find a more ineffective system for compensating injured patients than what we have in the United States," Jackson says. "We take in far too much money and get so few dollars to medically injured persons. The system is just not working for patients."

A fact sheet outlining the new data and a detailed description of the methodology can be viewed at http://tinyurl.com/bqevory.

Patients for Fair Compensation estimates that more than $650 billion is wasted each year on unnecessary medical procedures ranging from X-rays, biopsies, CT scan, MRIs, and other tests that doctors order to keep from being sued. ✦

Tenet to pay $42.75 million for overbilling Medicare

Tenet Healthcare Corp. has agreed to pay the United States $42.75 million to settle allegations that it violated the False Claims Act by overbilling the federal Medicare program, the Justice Department has announced.

The settlement resolves allegations pertaining to the various inpatient rehabilitation facilities (IRFs) that Dallas-based Tenet owned and operated throughout the country. Because the patients treated at these facilities require more intensive rehabilitation therapy and closer medical supervision than is provided in other settings, such as acute care hospitals or skilled nursing facilities, Medicare generally pays IRFs at a higher rate for rehabilitation care than it pays for such care in other settings.

The Justice Department alleged that between May 15, 2005, and Dec. 31, 2007, Tenet improperly billed Medicare for the treatment of patients at its IRFs when, in fact, these patient stays did not meet the standards to qualify for an IRF admission. The settlement is the United States' single largest recovery pertaining to inappropriate admissions to IRF, said **Stuart F. Delery**, acting assistant attorney general for the Justice Department's Civil Division.

"~ e Department of Justice is committed to protecting the Medicare program against all types of overcharging by healthcare providers."

"The Department of Justice is committed to protecting the Medicare program against all types of overcharging by healthcare providers," Delery says. "Inpatient rehabilitation facilities will not be permitted to bill Medicare for patients who were not qualified for admission."

Tenet disclosed the overcharging as required under its corporate integrity agreement, according to the Justice Department.

The settlement is part of the government's emphasis on combating healthcare fraud and is another step for the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, which was announced by Attorney General Eric Holder and Kathleen Sebelius, secretary of the Department of Health and Human Services, in May 2009. The partnership between the two departments has focused on efforts to reduce and prevent Medicare and Medicaid fraud.

The Justice Department has used the False Claims Act to recover more than $6.6 billion since January 2009 in cases involving fraud against federal healthcare programs. The Justice Department's total recoveries in False Claims Act cases since January 2009 are more than $8.8 billion. ✦

Study says most doctors win litigation, but few go to trial

Not all specialties are the same when it comes to the likely outcome of a malpractice case, according to a new study.

Internists and internal medicine subspecialists are more likely than other physicians to have suits against them dismissed by courts, according to the study from the Archives of Internal Medicine. The study found that 62% of suits against internists and internal medicine subspecialists were dismissed, while only 37% of cases against pathologists were dismissed, which was the lowest rate among specialties. The average across all specialties was 54% of cases dismissed.

The authors noted that the lower rate of dismissals for pathology could be because pathology lawsuits generally relate to failure to diagnose a disease.

The authors examined more than 10,000 claims that closed between 2002 and 2005 from an undisclosed national medical liability insurer. They found that the frequency of claims ending in a trial verdict was low across specialties. Only 2% of cases against anesthesiologists ended with a jury decision, and only 7% of claims against pathologists ended

with a jury decision.

Internists also were among the least likely to face a jury, with only 3% of their cases ending with a verdict. General surgeons were most likely to have a jury find in their favor, while pathologists lost the most.

Eighty percent of cases resolved after trial were in favor of physicians. Nevertheless, doctors spend significant time fighting lawsuits. The average resolution time for a litigated claim was 25 months. For cases that ended in dismissals, doctors spent 20 months defending the case, while claims resolved at trial took 39 months.

The full study can be found at http://tinyurl.com/6nu3xvh. ✦

Hospital shared medical files with reporters, state says

State regulators have determined that a California hospital owned by Prime Healthcare Services violated patient confidentiality by sharing a woman's medical files with journalists and sending an email about her treatment to 785 hospital workers.

The California Department of Public Health found that Shasta Regional Medical Center in Redding had five deficiencies related to the unauthorized disclosure of medical information on a diabetes patient treated there in 2010. Prime Healthcare, based in Ontario, issued a statement saying it is appealing the state's findings.

"Shasta Regional Medical Center believed and continues to believe that the disclosures, if any, were permitted under both federal and state law," the statement said.

The hospital was seeking to respond to a story published by California Watch, a nonprofit news organization, that featured patient Darlene Courtois and allegations that the hospital was overbilling Medicare. This alleged breach of patient confidentiality was revealed in a column in the Los Angeles Times.

State investigators said the hospital's chief executive and chief medical officer violated state law by disclosing the patient's medical information to media organizations, including the Times, without her authorization and failed to report the violation as required under law. The hospital also sent an email to all hospital employees and medical staff in December 2011 with details about the patient's treatment.

The California Department of Public Health reports that Prime Healthcare, which owns 16 hospitals, could face fines up to $250,000 under state law. The state agency said it would consider levying penalties after reviewing the hospital's efforts to correct the problems cited. ✦

COMING IN future MONths

✦ Hospital reduces medication-related adverse events

✦ New ways patients are suing doctors, hospitals

✦ Strategies for eliminating elective deliveries pre-39 weeks

✦ Hospital reduces falls 88%, med errors 30%

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 healthcare for hospital personnel to use in overcoming the challenges they encounter in daily practice.

CNE INSTRUCTIONS

Nurses participate in this CNE program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ✦

CNE QUESTIONS

1. **In the medical malpractice case involving Pottstown Memorial Medical Center, what was the key issue?**
   A. The physician blamed a delayed C-section on being too busy with other patients.
   B. The physician blamed faulty, outdated, and poorly maintained ultrasound equipment for a delayed C-section.
   C. Severe birth injuries were traced to hospital policies that limited the use of ultrasound.
   D. Severe birth injuries were traced to the use of an unqualified ultrasound technician.

2. **In Zullo v. The Superior Court of Santa Clara County Court of Appeal, what did the court of appeal find when it assessed the validity of a questionable arbitration provision?**
   A. The court found that simply sticking an arbitration provision in an employee handbook created a contract of adhesion, that is, one that presented no opportunity for negotiation.
   B. The court found that putting an arbitration provision in an employee handbook is sufficient to create a legally binding contract with the employee, with no evidence that the employee read or agreed to the provision.
   C. The court found that the manner in which arbitration provisions are presented in employee handbooks is irrelevant to the legality of the agreement.
   D. The court found that arbitration agreements need not be included in employee handbooks in order to be enforceable.

3. **In the recent court decisions involving arbitration and employee handbooks, what was one of key findings?**
   A. Arbitration is unfair to employees and might not be required as a condition of employment.
   B. Arbitration is allowed as a condition of employment, and details are not necessary in the employee handbook.
   C. Arbitration requirements must not be one-sided and favorable only to the employer.
   D. Arbitration requirements must be provided in a detailed document entirely separate from the employee handbook.

4. **What does Laura Podolsky, JD, an attorney with the law firm of Fenton Nelson in Los Angeles, advise regarding interstate telemedicine?**
   A. The risk management issues are settled and interstate telemedicine is reasonably risk-free.
   B. Interstate telemedicine is not allowed by federal law.
   C. Interstate telemedicine should be conducted only if the physician will be establishing an ongoing interstate telemedicine relationship with the patient.
   D. Interstate telemedicine should be avoided until state legislatures and state medical boards make more progress with relevant laws and requirements.

Legal Review & Commentary

A Monthly Supplement to HEALTHCARE RISK MANAGEMENT

Failure to timely administer Acyclovir in patient with viral encephalitis yields $23 million verdict

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News: A 36-year-old woman was transported to the emergency department (ED) at 12:55 p.m. after exhibiting symptoms consistent with a viral infection. A lumbar puncture was performed, the results of which revealed herpes viral encephalitis. Acyclovir was ordered stat; however, the nurse on duty did not administer the medication until three hours later, by which time the patient had become comatose. The patient is now severely mentally handicapped and requires 24-hour care. The patient's sister brought a lawsuit against the hospital on her behalf and alleged negligent care. The jury returned a verdict of $23 million against the hospital.

Background: A 36-year-old woman was transported to the ED at 12:55 p.m. with complaints of altered mental status, left facial droop, aphasia, fever, and disorientation. She was seen by the ED physician at 1:15 p.m., who documented an initial diagnosis of altered mental status with plan to rule out encephalitis. A neurology consult was obtained at 3:30 p.m. and a lumbar puncture was performed at 4 p.m. with results consistent with herpes viral encephalitis. The patient was admitted and examined by an internal medicine physician in the ED at 6 p.m. The case was discussed with an infectious disease physician at 6:30 p.m. who directed that Acyclovir be ordered stat. However, the internal medicine physician placed the order without urgency, and the medication was not administered. At 7:30 p.m., the infectious disease physician arrived to examine the patient, noted that Acyclovir had not been administered, and ordered the medication stat at 8 p.m. The nurse on duty, however, failed to administer the medication until 11 p.m., by which time the patient had become comatose. The patient remained hospitalized for three weeks and then was transferred to an inpatient rehab facility where she underwent cognitive therapy for severe short-term memory loss. She is unable to perform simple tasks or live independently, and requires 24-hour care.

~e nurse on duty did not administer the medication until three hours later, by which time the patient had become comatose.

A lawsuit was filed against the hospital, ED physician, internal medicine physician, and infectious disease physician by the patient's sister on her behalf. The plaintiff alleged the defendants failed to diagnose and timely treat the patient's viral encephalitis and failed to timely administer Acyclovir. Plaintiff's counsel argued that administration of Acyclovir is the standard of care for even the suspicion of viral encephalitis

FINANCIAL DISCLOSURE: Executive Editor **Joy Daughtery Dickinson** and Nurse Planner **Maureen Archambault** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. **Laura A. Russell**, Esq., **Carol Gulinello**, RN, MS, CPHRM, and **Jonathan D. Rubin**, co-authors, have no relevant relationships to disclose.

and should have been immediately administered to the plaintiff. Plaintiff produced an infectious disease expert who testified that the patient's viral symptoms had manifested to her brain with the development of facial drooping, and that the window of opportunity for proper treatment of her condition was closed when the defendants allowed her condition to deteriorate in the ED.

The physicians denied the allegations and argued that an earlier administration of Acyclovir would not have changed the plaintiff's outcome. The defense asserted that the patient's symptoms were consistent with multiple conditions and that the diagnosis was reached promptly after testing. The internal medicine physician contended that she properly carried out the suggestion of the infectious disease consultant by including in her admission orders the order for the administration of Acyclovir, and that there was no standard of care which required her to substitute her judgment for that of the infectious disease consultant by writing a stat order. The internal medicine physician further denied that the infectious disease consultant recommended the medication be ordered stat. The hospital, however, never produced an explanation for the nurse's delay in administering the Acyclovir.

The defendants' infectious disease expert testified that herpes viral encephalitis is extremely rare, with only about 1,500 cases occurring per year in the United States, and noted that the condition mimics many other disease processes. The expert further testified that the alleged delay in the administration of Acyclovir had no bearing on the patient's condition because about 65 doses over several weeks is required to kill the virus.

The case proceeded to a jury trial with only the hospital, ED physician, and internal medicine physician remaining as defendants. The jury determined that all of the defendants were negligent, but it attributed 100% of the causal negligence to the hospital and awarded the plaintiff $23 million in damages.

What this means to you: This scenario raises many questions regarding the manner and sufficiency of communication between providers. Specifically, this case raises questions with respect to the adequacy of communication between the internal medicine physician and the infectious disease physician during their first encounter at 6:30 p.m. when the recommendation was to order Acyclovir "stat." It leads us to question why an internal medicine physician would call a consultation with a specialist and not take the recommendation of that specialist. In addition, this case raises concern as to why the nurse delayed in administering life-saving medication.

Although it is not a requirement for the referring physician to follow the recommendations of a consulting physician, there should be documentation in the medical record outlining the reasoning behind that decision. A comprehensive note can allow interested parties to "get into the mind" of the practitioner and can assist in the defense of their actions.

Additionally, there is no evidence cited in this case that any healthcare provider followed up to ensure the medication was, in fact, administered. It is the physician's responsibility to follow up, not only on the outcome of any diagnostic tests he/she may have ordered for the patient, but for any medications that have been ordered, especially in light of the urgency to treat a potentially grave diagnosis.

It is a nursing custom and practice that a stat medication order is administered between 30 and 60 minutes upon retrieval of the order. Of course, extenuating circumstances might intervene; however, those circumstances must be handled quickly and efficiently and documented in the medical record. Had such documentation occurred in this case, we might have learned of the reasoning behind the delay in medication administration. Unfortunately, the etiology of the three-hour delay, from the 8 p.m. stat order until the 11 p.m. administration of that drug, remains unexplained.

In some cases, a delay in administration of a medication can be caused by the need for a "pre-approval" in pharmacy before a drug can be dispensed. That pre-approval is usually the responsibility of a physician leader in a medical specialty. This pre-approval holds true for drugs that are not on formulary, are in limited supply, or are potentially deadly when not ordered properly. However, this is not the case with Acyclovir, which is considered an unrestricted antibiotic, the dispensing of which would not be questioned.

Moreover, it is considered good practice when verbal communication occurs between the ordering and the administering practitioner, especially as it relates to stat orders. Clear and succinct communication between team members ensures the continuity and timeliness of care.

It is imperative that risk managers be called upon to conduct a comprehensive and thorough investigation of any case where there is an adverse patient outcome. Only then can the timeline, fact pattern, and ultimate strategy to defend the case be fully realized.

Reference:

Court of Common Pleas of Philadelphia County, Pennsylvania. Case No. 081204060. 2011 WL 3154263. ✦

Antiquated equipment, failure to provide trained technician resulted in infant's cerebral palsy and $78.5 million verdict

News: A 34-year-old woman, then 36 weeks pregnant, presented to Pottstown Memorial Medical Center in Philadelphia in August 2008 with signs of placental abruption. Fetal monitoring was inconclusive. A nurse and the obstetrician performed a bedside ultrasound examination and were unable to detect a fetal heartbeat. The obstetrician sought an ultrasound technician's confirmation of his diagnosis of fetal death; however, it took 75 minutes for the ultrasound technician to arrive. Upon arrival, the technician immediately identified the fetal heartbeat, but the placenta was completely disrupted and the fetus was not receiving any blood or oxygen from the mother. The child, now 3 years old, suffers from severe spastic quadriplegic cerebral palsy resulting from an 81-minute delay in performance of an emergency cesarean section delivery. A jury found the hospital 100% liable and awarded the plaintiff $78.5 million in damages.

Background: A 34-year-old woman, then 36 weeks pregnant, presented to Pottstown Memorial Medical Center in Philadelphia with complaints of abdominal pain. Fetal monitoring was inconclusive. A nurse and the obstetrician performed a bedside ultrasound examination and were unable to detect a fetal heartbeat. The obstetrician concluded that the fetus had died and informed the mother, who stated that she still felt the fetus kicking inside her. As such, the obstetrician sought an ultrasound technician's confirmation of his diagnosis, but it took 75 minutes for the technician to arrive at the hospital. Because it was a Sunday, the hospital did not have an ultrasound technician on the premises. The technician had to come from home to verify the obstetrician's findings. Upon arrival, the technician immediately identified the fetal heartbeat. However, the placenta was completely disrupted, and the fetus was not receiving any blood or oxygen from the mother. An emergency cesarean section was conducted.

The patient, individually and on behalf of her baby, brought a lawsuit against the hospital and obstetrician. Plaintiff alleged that she arrived at the hospital with signs of placental abruption that caused her unborn child to be deprived of oxygen and that a prompt delivery could have averted the problem, but the obstetrician initially concluded that the baby had died. Plaintiff further contended that the 81-minute delay in performing the cesarean section caused the condition of the fetus to deteriorate, which resulted in cerebral palsy. In addition, plaintiff asserted that had the hospital provided a trained ultrasound technician and not used antiquated equipment, the delay would have been averted.

Throughout discovery, deposition, and when first questioned during trial, the obstetrician testified that he performed the ultrasound properly and that the reason he could not identify the fetal heartbeat was because the fetus had died. He then insisted that the fetus's heart started again and that was why the ultrasound technician found the heartbeat. However, after experts testified that the ultrasound equipment was antiquated and that the wrong type of transducer was used (part of ultrasound equipment placed on a woman's belly), the obstetrician testified that he believed the equipment was to blame for his inability to detect the heartbeat. Defense experts also agreed that a more up-to-date ultrasound machine was required.

Significantly, the hospital's risk manager testified that there was no maintenance record for the subject ultrasound machine, nor was there any evidence that the equipment had been serviced in the last 10 years, despite the fact that the ultrasound's manual indicated annual maintenance was required.

The jury's $78.5 million award included $1.5 million in emotional distress; $10 million in past, present, and future pain and suffering to the infant plaintiff; $2 million in lost future earnings; and the remainder allocated for future medical expenses. The jury estimated that the infant, who requires around-the-clock nursing care due to quadriplegic cerebral palsy, will live until 2058.

What this means to you: The thread of patient safety runs through the fabric of this case. Most patients inherently trust their provider to render safe care, prudent opinions, and accurate decisions that affect their treatment plan and their ultimate outcome. In cases that involve an obstetrical patient, we might sometimes forget that we are caring for two patients, mother and baby, and the well-being of each must be considered in every treatment decision that is made.

This case presents several areas of vulnerability. The first area is the lack of preventative maintenance and service records on ultrasound equipment in use to provide patient care. Most equipment purchased

within an institution is accompanied by a vendor contract or service agreement whereby the institution can require, as part of that agreement, the vendor to perform preventative maintenance and routine inspection of equipment at a predetermined time interval, usually every 6-12 months. This agreement also should outline the indications for replacement of either specific parts or provide for full replacement of the equipment. Careful crafting of such an agreement can transfer the responsibility, resources, and therefore, the risk from the institution to the vendor.

In addition, standards from The Joint Commission require that an institution inspect, test, and maintain life support and non-life support equipment as articulated in Environment of Care (EC) standards 02.04.01 and 02.04.03. Notably, documentation of this activity is required to prove compliance during the survey process. Typically, the facility's biomedical engineering department "owns" the chapter and the requirements therein; however, risk management needs to be kept apprised of any deviations. The use of maintenance checklists, electronic or otherwise, is a helpful "tickler" tool to ensure compliance with thorough and timely inspections. Moreover, ongoing status reports regarding the maintenance of equipment should be reported to the facility's EC or safety committee on a quarterly basis.

Moreover, accreditation by professional organizations bolsters the institution's reputation for ensuring quality care and patient safety by complying with rigorous requirements. The American College of Radiology, which is the accrediting body for facilities with radiological services, including ultrasound, surveys these facilities every three years for compliance with standards. Specifically, the standards require that each facility institute a continuous quality control program that ensures equipment is inspected and maintained on a semi-annual or annual basis. Compliance with this standard is required to maintain accreditation.

By instituting the above-mentioned risk reduction strategies, the likelihood of using outdated, equipment that has not been maintained diminishes significantly. However, there still must be a mechanism in place, within the institution's hierarchy, whereby clinicians can request and ultimately obtain equipment that would provide the standard of care to patients. Usually the administrator or director of a department can make a capital expense request to replace or repair any outdated or defective equipment. Each manufacturer has varying models of the same equipment based on cost. As such, each model will perform the same function, although some might have more sophisticated features than others. As a result, there is usually a model to suit every budget, so the notion of not providing the community standard of care based on cost is not an option. A facility can create a product value analysis committee to serve as a forum for the initial presentation and discussion of such issues.

Another area of concern in this case is the apparent delay in the arrival of the ultrasound technician. In general, for those facilities that provide on-call ultrasound technologists, the standard response time from initial contact to arrival to the facility is 60 minutes. In this case, it took the ultrasound technician 75 minutes to arrive at the hospital to confirm the physician's diagnosis. Whether the delay in the arrival of the technologist contributed to the ultimate outcome is difficult to determine; however, it is certainly enough to introduce some speculation into the minds of the jurors.

Lastly, this case raises concerns regarding the competency of the ultrasound "operator." Ultrasound is a subjective study and is highly "operator-dependent." The skill and expertise of the operator definitely will impact the findings and outcome of the study, ultimately affecting the diagnosis and treatment plan. Because there were discrepant findings between the obstetrician and ultrasound technician, the competency of the obstetrician in performing the ultrasound study is called into question. Each physician that performs ultrasonography must produce evidence of ongoing competency when requesting privileges through the institution's medical staff office. Additionally, CME credits and, in some cases, proctored observations are required to fulfill this requirement and ensure continued competency. For ultrasonographers, the American Registry for Diagnostic Medical Sonography (http://www.ardms.org) requires that each sonographer renew their registration every three years and provide supporting documentation of CE credits to ensure their competency.

In this case, the jury ultimately found the hospital 100% negligent and absolved the obstetrician of any wrongdoing. The focus of the case quickly turned to the hospital as the target when experts testified that the equipment was antiquated and the risk manager testified that there was no evidence the equipment had been serviced for more than 10 years. Indeed, if the hospital had implemented some or all of the risk management strategies discussed above, it might not have shouldered all of the responsibility in this case.

Reference

Nicholson-Upsey v. Touey, et al. Court of Common Pleas of Philadelphia County, Pennsylvania. Case No. 2001-20863. 2010 WL 1841777. ✦