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Are providers pumping up the volume and putting your patients at risk?

Recent cases raise question: Should you draw a line?

By **Joy Daughtery Dickinson**

Multiple malpractice lawsuits have been filed against a New York orthopedic surgeon who reportedly performed as many operations in two days as the typical orthopedic surgeon averages in one month. The law firm representing about 150 of the 250 former patients who are suing says that two hospitals and a surgery center will be included in some of the lawsuits.[1] A published news report questions the administrative oversight and patient safety in these cases.[2]

The physician was terminated by his medical group, and he voluntarily surrendered his medical privileges at both of the hospitals.

The role that fatigue might have played in these cases isn't certain. However, in The Joint Commission's examination of harmful and sentinel events, "We think we can conclude that fatigue is in fact a factor, more than an incidental finding," says **Ronald M. Wyatt**, MD, medical director in the Division of Healthcare Improvement at The Joint Commission (TJC).

Outpatient surgery providers and others need to recognize this area as one that needs improvement, Wyatt says. "This is the message that we need to get out

Same-Day Surgery addresses risks of liability

In this special issue of *Same-Day Surgery*, we warn you about areas where you could be at risk for lawsuits. In our cover story, we discuss some recent lawsuits involving a surgeon with a very high volume of cases, and we tell you what lessons can be learned. Other stories in this issue address prescribing errors and a settlement over alleged over-billing of outpatient cases. We also cover a gender discrimination case and tell you how ambient background noise is a patient and surgical safety factor

We hope you enjoy this special issue of *Same-Day Surgery*. ■

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the word [by saying], 'Organizations, this is a major patient safety issue,'" he says.

Indeed, some providers are performing too many procedures in a limited time period, says **Lynn Reede**, CRNA, DNP, MBA, senior director of professional practice at the American Association of Nurse Anesthetists. "Many of these surgeons are going to many facilities," Reede says. "One insurance carrier may be at one or another facility, so they're packing in the volume on a given day."

Another contributing factor is that advances in technology mean more procedures can be performed in shorter timespan, says **Marsha Wallander**, RN, associate director of the Accreditation Association for Ambulatory Health Care (AAAHC).

At the same time, outpatient providers don't normally dictate how many procedures can be performed because it depends on the type of case, Reede points out. "Some procedures take minutes, and others take hours," she says. Also, it's not unusual for surgeons to use two operating rooms and two teams in order to be efficient, she says.

And there are other factors, Wallander says. She recently was involved in a discussion about an endoscopic surgeon who has cases that run 2-3 minutes longer than the average time. "My response was, is that the person getting all the difficult cases?" Wallander says. "There's sometimes a reason, so look at the reasons before you jump to conclusions." For example, one provider may be doing all of the diagnostic endoscopy for patients who are post cancer surgery. "I want him to slow down and take longer," Wallander says.

Consider these suggestions for tackling the complex issue of physician caseload:

• Ensure providers are paying attention to their own level of fatigue.

In small facilities there might not be additional staff to relieve the surgical team, Reede points out. A fatigued staff member should be comfortable suggesting a break of 15 to 30 minutes, Reede says. "The anesthetist is responsible for their patient's safety," Reede says. "Part of that responsibility if to be aware of their fatigue level and ability to focus. They may request a break or even relief."

Also, it is the responsibility of the nurse clinical manager or the OR nurse supervisor to make sure that the nursing staff have breaks and meal coverage, sources say.

The Joint Commission advises healthcare providers

EXECUTIVE SUMMARY

An orthopedic surgeon who reportedly performed as many operations in two days as the typical orthopedic surgeon averages in one month is facing multiple malpractice lawsuits, as are the surgery center and hospitals where he operated.

- Have an atmosphere that encourages staff to speak up when fatigued. Offer surgeons scheduling options so they can spread out their caseload.
- Have a policy in place to address issues such as a surgeon being up all night on call and not feeling comfortable doing elective cases the next day.
- Track physician outcomes, and when provides stray from the standard of care, intervene with a focused professional performance evaluation (FPPE)

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to involve employees in designing work schedules that minimize fatigue. The agency issued a *Sentinel Event Alert* on fatigue risks last year. *(For more information, see "TJC gives wake-up call on fatigue risks,"* Same-Day Surgery*, May 2012)*

• Offer options to surgeons.

An interdisciplinary team can meet to address the issues of volume and fatigue. The group can include the medical director and facility leaders, Reede says. This group can approach the person responsible for risk management to discuss options.

"Administration should work with the surgeon to offer a schedule that may be more amendable to their practice and lifestyle," Reede says. For example, the surgeon can be told, "We're doing more cases. We're stretching ourselves thin here. Can we open another day in the schedule for you so you have more hours in the OR in your block? We can work around your office hours," she suggests.

• Have policies in place to address surgeon fatigue, and ensure compliance.

In some hospitals, surgeons may be on call the night before elective surgery and might be covering multiple hospitals, Wyatt says. Surgeons should be able to say, "I'm too fatigued to come in" and have it not seen as a blow against their reputation or against the facility's revenue stream, he says.

Invite your staff to help you establish another system and a policy that addresses this type of unexpected situation, Wyatt says. "We're seeing more and more emphasis in healthcare around patient safety and how you become more highly reliable," he says. "That is the way the organization becomes more highly reliable."

Changes can be built into the informed consent process, he says. For example, patients can be notified that the surgeon was up all night and asked if they want the surgeon to proceed with their elective case. "Eighty percent of the time, the patient says no," Wyatt says. "If they say no, there should be a process for another surgeon to take the case, or efficiency mechanisms in place for that patient to be rescheduled, based on internal processes," he says.

If TJC receives information indicating a surgeon was impaired, from fatigue for example, and there is a poor outcome, the agency will approach the facility to determine if it has policies in place that address issues such as surgeons being on call the night before, and it will determine whether those policies were followed, Wyatt says. *(For more information, see package of stories on sleep-deprived surgeons in March 2011* SDS.*)*

• Track and report patient outcomes.

Facilities should be monitoring patient outcomes as part of the ongoing professional performance evaluation (OPPE) program at their facility. Deviation from the standard of care can be addressed through a focused professional performance evaluation (FPPE), also known as an action plan, Reede says.

For example, organizations should have metrics, such as return to the OR or readmissions, that are measured consistently and communicated to the department, surgeon, and the governing board, Wyatt says. If a sentinel event occurs, the TJC staff would ask if there was anything in the ongoing evaluation that indicated to the organization that a surgeon should be on a focused review for three to nine months. After that period of time, the decision might be made to continue the surgeon on focused review, drop it, or take away or suspend a surgeon's privileges, Wyatt says. If additional mentoring or training is needed, that need should be documented, he says.

The OPPE process can address whether surgeons be limited in the number of procedures they perform in a given time period and how such limitations should be established, Wyatt says. "The TJC won't take a stand on how many or how often, but it's expected that as part of the OPPE process, the organization and governing board will look at those issues, monitor them in an ongoing way, and have a way to address those deficiencies," he says. "Or if a person exceeds a measure, they should have a system in place to say, `It's not safe for you to operate at this point, based on your data and our analysis of that data.'"

AAAHC looks to members of the governing body and the administrator of a facility to ensure patient safety and to take steps when they have a concern, Wallander says. "We don't say, 'if someone is doing X number of procedures, you must do Y and Z,' but if they have a concern, we expect ongoing monitoring," she says. "If a concern appears, we expect that they take action." *(Editor's note: The AAAHC Institute for Quality Improvement provides benchmarks, including procedures times. See "AAAHC Institute releases benchmarks — Knee arthro, cataract, back injection & colonoscopy reported,"* Same-Day Surgery*, June 2013.)*

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Avoid successful suits alleging prescribing errors

(Editor's note: This issue includes the first part of a two-part series on prescribing errors. In this issue, we address liability risks. In next month's issue, we discuss liability with narcotics and also "alert fatigue" with electronic medical records.)

Paper-based prescribing errors are common with primary care practices, according to a recent study which found that 27.8% of 9,385 prescriptions had at least one prescribing error.[1] The prescriptions reviewed were for 5,955 patients written by 48 ambulatory care providers in New York and 30 providers in Massachusetts.

Antibiotics had the most prescribing errors, followed by cholesterol medications, narcotic analgesics, and blood pressure drugs. According to the researchers, use of electronic prescribing with a basic clinical decision support system in place could have prevented 32% of prescribing errors, and an advanced system would have prevented 57%.

Medical malpractice claims involving prescribing errors typically involve prescribing an incorrect medication or prescribing the correct medication at the wrong dose, according to **Lisa Lepow Turboff**, JD, a shareholder with Munsch Hardt Kopf & Harr in Houston, TX.

Typically, any prescribing error case does not fall exclusively on physicians' shoulders, says Turboff, as nurses and pharmacists must know the rationale for prescription drugs including basic side effects and dosing information as described in the product labels printed in the Physician's Desk Reference (PDR). "Nurses and pharmacists are required to question a physician's prescription that falls outside of those parameters," she says. "Physicians must be receptive to nurses and pharmacists who question their orders, as these are the medical professionals who can catch a mistake and prevent an injury and avoid a lawsuit."

Here are some liability risks involving drug prescribing:

EXECUTIVE SUMMARY

Electronic prescribing with a basic clinical decision support system could have prevented 32% of paper-based prescribing errors, according to a recent study, but electronic medical records also pose potential legal risks. Claims have resulted from:

• prescribing opioid medication at too short intervals post-surgery;

• Prescribing opioid medication following surgery.

"Typically, opioids are prescribed to control post-surgical pain," says Turboff. "However, they are known respiratory depressants, which could cause decreased breathing in the patient."

On those rare occasions where the patient actually stops breathing, physicians are typically sued on the basis of either not prescribing a weaker medication initially before defaulting to an opioid, or prescribing the opioid to be given at too-short intervals, says Turboff.

• Prescribing off-label.

If a physician is prescribing off-label, the patient's chart should reflect this fact so that the physician can better explain his or her medical judgment in a subsequent lawsuit, says Turboff.

• Prescribing a drug to which the patient is allergic.

Although it's rare for physicians to prescribe penicillin to a patient known to be allergic to penicillin, it's not infrequent that a similar drug might be prescribed that should be avoided in the penicillin-allergic patient, such as cefuroxime axetil or ampicillin and sulbactam, says **John Davenport**, MD, JD, physician risk manager of a California-based HMO. Similarly, erythromycin-sulfisoxazole might be given inadvertently to a sulfa-allergic patient.

"Drug references, the PDR, and your local pharmacist are valuable resources to help avoid allergy cross-reactivity," Davenport advises.

• Prescribing a drug that interacts with a drug the patient is taking.

"Drug interactions with the blood thinner warfarin, and subsequent bleeding, are a common cause of malpractice," says Davenport. "One must be wary of prescribing many drugs to patients on warfarin."

Certain combinations of many common drugs, including selective serotonin reuptake inhibitors (SSRIs), fluconazole, clopidogrel, and anti-inflammatory agents can put patients at risk for bleeding, says Davenport.

"Drug lists that patients present to us are often daunting and inaccurate. But your legal duty is to be aware of the information at hand, including the drugs the patient is on, before prescribing," says Davenport. "Seek out the information a reputable physician in a similar situation would seek out prior to prescribing."

• Overprescribing pain medications.

Malpractice cases and medical board actions are increasingly directed at physicians who prescribe excessive amounts of pain medications without adequate examinations, supporting diagnoses, and proper monitoring, warns Davenport.

"When pain became the 'fifth vital sign,' physicians were encouraged to use whatever pain control was necessary to alleviate pain," he says. "With an increas-

ing incidence of overdose, addiction, and drug diversion, the pendulum is swinging back."

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Risky EMR practices can cause med/mal suit

It's an 'evolving area of risk exposure'

Providers are increasingly becoming aware that in many cases, electronic medical record (EMR) documentation creates legal risks that didn't exist with paper charting.

"EMR is an evolving area of risk exposure," says **Richard E. Moses**, DO, JD, a Philadelphia-based gastroenterologist, risk management and compliance consultant, and adjunct assistant clinical professor at the Temple University's School of Medicine and Beasley School of Law. "As more healthcare providers move to EMR charting, we are going to see new areas of risk and theories of liability emerging." For example, copying and pasting portions of a progress note has the potential to carry an error throughout the patient's chart and medical record.

Current EMRs are not designed as physician workflow tools, but as a data repository tool that evolved from hospital billing systems, according to **Luke Sato**, MD, chief medical officer and senior vice president of CRICO, the Cambridge-MA based patient safety and medical professional liability company serving the Harvard medical community. "Doctors are overwhelmed with information, time constraints, and the pressures of seeing 20 to 30 patients a day," says Sato. "The result is a huge potential risk that, in the average eight-minute patient/physician encounter, something is bound to be missed."

EMRs increase this risk to some extent, says Sato, because doctors have to comb through the EMR to search for information needed to care for their patients.

Defense is complicated

EMRs often complicate defense against medical malpractice allegations, according to CRICO's recent analysis of more than 40 claims occurring in 2007-2012 involving an EMR. When a physician is sued, the insurer receives a printout of the entire medical record, but this record is a poor representation of the actual information the doctor used to make a decision, Sato explains.

"You can't make judgments on the physicians' cognitive or decision-making capabilities, because the paper record is not an accurate representation of how that information was seen by the physician in the EMR," says Sato. "That is the biggest challenge right now in defending physicians dealing with errors related to today's EMRs."

EHRs can hinder physician defendants from demonstrating that the standard of care was met, says **Ron Sterling**, CPA, president of Sterling Solutions, a Silver Spring, MD-based firm that guides medical practices in the use of technology, and author of Keys to EMR/EHR Success (Greenbranch Publishing; Phoenix, MD; second edition, 2010). "Unfortunately, inadequate use of EHRs can undermine the ability of the physician to show that proper care was provided," he says. "The biggest risk is that that information entered in the system will tell a story different from the physician's actions, when the computer records are examined in the course of discovery."

Physicians have to take a carefully planned approach to EHR use, argues Sterling. "Indeed, they literally need to make sure that their charts are properly maintained on a daily basis," he says. Consider these practices to reduce legal risks involving EMRs:

- **Validate, correct, or update data automatically filled by the system when using templates.**

Kathy Ferris, ARM, CPHRM, a healthcare risk management consultant at Physicians Insurance in Seattle, says, "If the data is not validated or updated consistently, the result can be a series of encounters that appear to be exactly the same." When the chart is reviewed, it might appear as though the physician or organization didn't pay attention to the patient and cared more about administrative efficiency than the individual patient. "This can contribute to clinical decision-making based on bad information and may also call into question whether or not the care being billed for is appropriate," Ferris says.

EXECUTIVE SUMMARY

Electronic medical record (EMR) documentation creates some legal risks that didn't exist with paper charting. Information that doesn't accurately represent patient encounters is more easily added to the medical record. To reduce risks, have your staff do the following:

- Correct or update data automatically filled by the system.
- Validate patient history documented by previous providers.
- Use free-text entry in addition to system tools.

• Don't assume previous providers validated the patient's history.

Electronic information can be copied easily from one record to another or from one encounter to another, but this step creates a risk of copying incorrect information that might be used for future clinical decision-making, says Ferris.

In a recent case reviewed by Ferris, multiple providers cared for a single patient, and each allowed the history information to automatically fill without adequately reviewing it with the patient. "Significant inaccuracies were contained in the history because one provider, trying to be efficient, had copied history from a different patient record and failed to make patient-specific changes," says Ferris. "Fortunately, the patient had not suffered a medical injury caused by the inaccurate information."

• Use free-text entry in addition to system tools.

"This can strengthen documentation of the history of the physician-patient partnership that defines quality care," says Ferris.

If physicians rely too heavily on templates and preformatted lists, discussions and clinical details unique to individual patients might become lost. "Free text entry in available fields or notes can document clinical decision-making more clearly than a time stamp followed by a preformatted order," she underscores.

• Be sure that use of drop-down menus, default information, macros, and templates don't lead you to inadvertently document interventions that weren't performed.

"The philosophy has changed from 'If it's not documented, you didn't do it," to 'You documented it, but did you do it?'" says Moses.

Use of prepopulated templates can create inaccuracies in the record, such as failing to document certain abnormalities, documentation of abnormalities that do not exist, or creating conflicts between different entries, he warns.

Providers need to read the chart after it's created and make any corrections as appropriate, advises Moses.

"Providers don't always read what they've typed, dictated, or clicked on," he says. "Ultimately, you are responsible for that note."

RESOURCE

• **CRICO,** the patient safety and medical professional liability company serving the Harvard medical community, has produced a video on how electronic medical records can be embedded into the physician workflow in a manner that would improve healthcare, with a dramatization based on real malpractice cases. To view the video, go to: www.rmf.harvard.edu/EMR. ■

Shands to pay $26 million for claims marked inpatient

Shands Healthcare in Jacksonville, which operates a network of healthcare providers in Florida, will pay the government and the state of Florida $26 million to settle allegations that six of its healthcare facilities submitted false claims to Medicare, Medicaid, and other federal healthcare programs for inpatient procedures that should have been billed as outpatient services, the Justice Department announced.

The six Florida hospitals are: Shands at Jacksonville; Shands at Gainesville, also known as Shands at the University of Florida; Shands Alachua General Hospital; Shands at Lakeshore; Shands Starke, and Shands Live Oak.

From 2003 through 2008, the six hospitals knowingly submitted inpatient claims to Medicare, Medicaid and TRICARE for certain services and procedures that Shands Healthcare knew were correctly billable only as outpatient services or procedures, the Justice Department alleged. In a released statement, Shands Healthcare said its officials fully cooperated with the state and federal investigation and negotiated the settlement agreement to avoid long and costly litigation. There was no admission of liability, the statement said.

"We hold ourselves accountable for the highest standards of care and service. The case in question does not involve the failure to provide high-quality patient care, but rather inconsistent billing processes," **Timothy M. Goldfarb**, CEO of Shands HealthCare in Gainesville, said in a released statement. "We proactively initiated an independent audit that identified some opportunities to improve billing processes at Shands. We took immediate steps to make improvements."

According to Shands, changes included:

• improvements to case management protocols and utilization review processes with an improved team approach to accurately assess and code the care provided;

• the use of improved software;

• implementation of new policies and procedures;

• supplemental employee training;

• the engagement of expert physician advisors who help assess coding and are on staff 24/7.

The six hospitals were named as defendants in a qui tam, or whistleblower, lawsuit brought under the False Claims Act, which permits private citizens to sue on behalf of the government and receive a portion of the proceeds of any settlement or judgment awarded

against a defendant. The lawsuit was filed in federal district court in Jacksonville, FL, by Terry Myers, the president of a healthcare consulting firm, YPRO Corp. According to a statement from Shands Healthcare, the whistleblower had been hired as an independent consultant by Shands in 2006 and 2007 to conduct a routine audit of its billing practices. The audit showed inconsistent billing processes in 2006 and 2007. "Allegedly, for some patients, Shands may have billed Medicare and Medicaid for short overnight inpatient admissions rather than for less expensive outpatient or observation services," the statement said.

Of the $26 million settlement, $25.2 million will go to Medicare and other federal health care payers. The settlement also resolved allegations under the Florida False Claims Act; the state of Florida will receive $829,600. Myers' portion of these recoveries has yet to be determined.

The Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative was announced in 2009 by the attorney general and the HHS secretary. The partnership between the two departments has focused efforts to reduce and prevent Medicare and Medicaid financial fraud. Since January 2009, the Justice Department has recovered a total of more than $14.8 billion through False Claims Act cases, with more than $10.8 billion of that amount recovered in cases involving fraud against federal healthcare programs. ■

Consumer Reports rates hospitals for surgeries

For the first time, Consumer Reports has rated U.S. hospitals on how patients fare during and after surgery. The ratings include an overall surgery rating, which combines results for 27 categories of scheduled surgeries, as well as individual ratings for five procedure types: back surgery, hip replacement, knee replacement, angioplasty, and carotid artery surgery.

Up to 30% of hospital patients suffer infections, heart attacks, strokes, or other complications after surgery, Consumer Reports says. However, consumers have very little to go on when selecting a hospital, because it's not clear which hospitals are doing the best job at keeping surgery patients safe, according to the organization.

"Although hospitals are required to report to government agencies, and some submit data to national registries to see how they stack up against one another, vital safety information remains largely hidden from consumers," Consumer Reports said in a released statement.

The surgery ratings are based on an analysis of billing claims that hospitals submitted to the Centers for Medicare and Medicaid Services (CMS) from 2009 through 2011. The claims cover 2,463 hospitals in all 50 states, Washington, DC, and Puerto Rico.

The surgery ratings are based on the percentage of a hospital's Medicare patients who died in the hospital or stayed longer than expected for their procedure. Research shows that mortality and length of stay correlate with complications, and some hospitals themselves use this approach to monitor quality, Consumer Reports said. To develop the ratings, the organization worked with MPA, a healthcare consulting firm with expertise in analyzing billing claims and clinical records data and in helping hospitals use the information to improve patient safety.

"We wish we had access to more comprehensive, standardized information, but this is the best that is available," said **John Santa**, MD, MPH, medical director of Consumer Reports Health. "We know the ratings aren't a perfect measurement, but we think they're an important first step in giving patients the information they need to make an informed choice. And we hope that by highlighting performance differences, we can motivate hospitals to improve."

In its statement, Consumer Reports said, "Though there are many dimensions to hospital quality, and no single measure captures everything, Consumer Reports' surgery ratings give patients more of the information they need to make informed choices about hospital performance before choosing where to have surgery."

According to the organization, some interesting and surprising findings include:

• Teaching hospitals often fell short. Teaching hospitals, thought to represent the nation's best and the recipients of generous federal funding, on average performed no better than other hospitals in the surgery ratings. Nonetheless, some standouts earned a high rating.

• Urban and rural hospitals can and do excel. Several urban hospitals did well despite often serving poorer, sicker patients, including Mount Sinai Hospital in New

EXECUTIVE SUMMARY

Consumer Reports has rated U.S. hospitals on how patients fare during and after surgery, based on 2009-2011 data submitted to the Centers for Medicare and Medicaid Services.

- Teaching hospitals on average performed no better than other hospitals.
- Several urban hospitals did well despite often serving poorer, sicker patients.
- Big-name hospitals don't always live up to their reputation.
- Consumer Reports found wider variation for several surgeries, including hip and knee replacements and back surgery, than for others.

York and University Hospitals Case Medical Center in Cleveland. Rural hospitals did better, on average, than other hospitals.

• Big-name hospitals don't always live up to their reputation when it comes to these ratings. For example, although several Mayo Clinic hospitals did well, others rated only average, and one received a low overall rating.

• Specialty hospitals were more likely to do better. Six of the top performers for carotid artery surgery were heart hospitals. But that's not always the case. For example, despite earning high marks in other Consumer Reports' ratings that focus on infections related to surgical incisions, the Hospital for Special Surgery in New York, which specializes in orthopedics, received low marks in the new hip and knee surgery ratings, which look at how surgery patients fare over their entire hospital stay.

• For patients, hospital choice matters more for some procedures than for others. For example, Consumer Reports found wider variation for several surgeries, including hip and knee replacements and back surgery, than for others, such as colon surgery and hysterectomy.

Lisa McGiffert, director of Consumers Union's Safe Patient Project, said, "Consumers have very little to go on when trying to select a hospital for surgery, not knowing which ones do a good job at keeping surgery patients safe and which ones don't. They might as well just throw a scalpel at a dartboard."

These new surgery ratings are part of an ongoing effort by Consumer Reports to shed light on hospital quality and to push the healthcare industry toward more transparency.

The complete report is available in the September issue of *Consumer Reports* and online at www.ConsumerReports.org/cro/hospitalratings0913. ■

GUEST COLUMN

Gender discrimination leads to a $7 million settlement

Pain clinic to be named in the plaintiff's honor

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In 1980, a female doctor joined the medical staff of a hospital. Over the next 20 years, she wrote two books, expanded the hospital's pain clinic into an internationally known program, was promoted to a full professor, and in 2000 became the first woman to head the hospital's anesthesia department. A year after she became the head of anesthesiology, the hospital appointed a new chief of surgery.

The female doctor claimed that the new chief was abusive and demeaning toward her. She claimed that he let doors shut on her when she was following him and that he replied to her male colleagues when she spoke to him. She also claimed that she had compiled emails, internal hospital memos, and testimony from other doctors and nurses which confirmed that the chief was uncomfortable working with women generally and that he preferred to hire residents who were "tall, light skinned Western-taught men."

The female doctor claimed that when she complained to the hospital's CEO, he did nothing. Instead, the female doctor claimed that the CEO accused her of "playing the victim" and that he viewed the situation as a problem between her and the chief. She additionally claimed that he told her that she created a "culture of whining" and on another occasion told her that "Joe can't help himself." Lastly, the female doctor claimed that the chief tried to have her fired for incompetence while she was on sabbatical in 2007. She stated that shortly before her return, the CEO demoted her as anesthesiology chairwoman by email. When the CEO met with her colleagues the next day, the female doctor claimed that he told them she was demoted because she was too aggressive and had failed to maintain a good relationship with the chief.

As a result, the female doctor filed a lawsuit against the hospital, the chief of surgery, the CEO, and the hospital's physicians group in 2008. [1] She alleged that she had been discriminated against based on her gender, and she cited her claims above. The defendants sought to move her claims to arbitration based on an employment arbitration agreement; however, the courts ruled that she could proceed with her claims. The parties agreed on a settlement in which the female doctor would collect $7 million. As part of the settlement agreement, the hospital

also agreed to name its pain clinic after her, to "reaffirm and clarify its policies and procedures" for employees reporting discrimination and retaliation, and to sponsor an annual lecture series on women's health and the academic contributions of women in surgery.

The chief executive asked the chief of surgery to resign in June 2008, after the lawsuit was filed, and he was told his management style wasn't appropriate for the hospital. The chief of surgery doesn't perform surgery at the hospital, but he has an endowed professorship, and the hospital provides him an office. The chief executive resigned from the hospital in 2011.

What this means to you

Human capital is an important aspect of any business. In healthcare, it is the human factor that provides direct patient care. Stressful work environments can negatively influence efficiency and safe patient care, among other outcomes, such as increased absenteeism and high turnover rate.

This case should be a wake-up call for all businesses, not just healthcare. In healthcare organizations, CEOs, administrators, deans, department and division chairs of medical staffs, and management at all levels should be aware of the factors in this case and undertake assessments to identify hostile workplace environments. Staff responsible for human resources (HR) should study this case and provide education to all staff from the top administrators to all rank-and-file employees. Such educational sessions should be ongoing, as staff and environmental changes occur. The organization's board members should be included in these educational sessions, as the board ultimately is responsible for HR issues such as discrimination, harassment, and wrongful termination. Directors' and officers' insurance brokers or carriers might have specialists within their organizations who can intervene when such an individual hostile workplace situation is identified or suspected or in developing processes to prevent such a situation.

Legal counsel with expertise is this area also can play a role in developing preventive and intervention practices. Not all leaders are good managers of personnel. This area is one that should be assessed by management at all levels, with the assistance of HR staff. Educational courses can be developed to include basics of management styles; legal aspects of human resources; budgeting; basics of finance; basics of oral, written, and social media communication; and other pertinent aspects of successful business and personnel management.

Staff responsible for risk management and HR should collaborate to monitor employee complaints, formal and informal, to identify trends or issues. While gossip is always discouraged, monitoring gossip in an organization often can identify areas of employee discontent. Legal counsel, and staff responsible for risk management and HR, should review the employee handbook, especially the section relating to reporting hostile workplace situations, and revise it as necessary. If revisions are undertaken, all employees should be provided a copy of the revised handbook or section and return a written acknowledgement of receipt and understanding. This acknowledgement should be maintained in the individual employee's personnel file or physicians' medical staff file. While all members of the medical staff probably are not employees of the organization, they should be included in the distribution and acknowledgment of receipt of the policy and procedure and expected behavior while in that respective organization.

Bullying and harassment are social issues affecting schoolchildren of all ages, workers, and even the elderly and disabled. In healthcare, the disruptive physician is a frequent issue addressed with varying degrees of success. An increasing number of hospitals are employing physicians and buying physician practices. The ongoing changes to healthcare delivery settings will continue to reflect the changes in employment practices of physicians and physician extenders/allied health professionals.

The medical staffs of hospitals, ambulatory surgery centers, and other healthcare organizations are made up of independent practitioners, contracted physicians, and employed physicians. Members of the medical staff serve as members of committees, and in such capacity, they are agents of the organization. In many states, physician professional liability insurance policies exclude coverage for claims for activities arising from participation in medical staff peer review and other types of hospital/organizational committees. This exclusion puts the appropriateness of these activities squarely in the lap of the organization to monitor or oversee.

EXECUTIVE SUMMARY

A female doctor claimed to have suffered years of gender discrimination from a hospital's chief of surgery. The doctor claimed she presented complaints to the hospital's CEO, and she said he did nothing. She also claimed that the discriminatory treatment culminated with her demotion from chief of anesthesiology.

- The doctor sued the hospital, the chief of surgery, the hospital's CEO, and the hospital's physician group.
- The lawsuit resulted in a $7 million settlement, and the hospital's pain clinic will be named in the female doctor's honor.

This case is a sad commentary on the negative relationships between some physicians and in particular between any person of power and a subordinate. Such negative relationships often are played out between physicians and nurses and are frequently underreported and unreported.

In this case, others were aware of the interactions between the principle parties, and the claimant actually made a formal complaint that was disregarded. One wonders how many others were treated in this hostile manner by this chief of surgery. In reading the facts of this case, the female head of anesthesiology reported this information directly to the CEO, who also exhibited gender bias rather than initiating a referral to the dean, if appropriate, and to the hospital's HR department to initiate a full HR investigation. The CEO should have been sensitive to the ramifications of this situation, engaged risk management to collaborate with HR in this investigation, and set out a directive to control and intervene so it would not escalate.

Had this organization instituted a policy of zero tolerance for harassment at any level and a culture of valuing its employees at ALL levels, and had all levels of the organization "walked the talk," this situation might never have occurred, or it would have been identified early and addressed in a positive way to benefit all employees. *(For more information, see package of stories on sexism among physicians,* Same-Day Surgery, *June 2012.)*

REFERENCE

1. SJC-10375 (Mass 2009). ■

Study: Noise in OR can compromise safety

Ambient background noise — whether it is the sound of loud surgical equipment, talkative team members, or music — is a patient and surgical safety factor that can affect auditory processing among surgeons and the members of the OR team, according to a recent study.[1]

The findings are the first to demonstrate that a surgeon's ability to understand spoken words in the OR is directly affected by noise in the environment, says study coauthor **Matthew Bush,** MD, assistant professor of surgery at the University of Kentucky Medical Center, Lexington. "To minimize errors of communication, it is essential that we consider very carefully the listening environment we are promoting in the OR," he says.

To assess the effects of ambient noise on communication in the OR, the researchers created a noise environment similar to that of an OR and tested 15 surgeons with one to 30 years of operating experience. The surgeons' ability to understand and repeat words was tested using the Speech In Noise Test — Revised (SPIN-R) under four listening conditions typical of OR environments. These conditions included quiet, filtered noise through a surgical mask, and background noise both with and without music. Subjects were tested in two situations: engaged in a specific surgical task and task free.

The study showed a significant decrease in speech comprehension with the presence of background noise when the words were unpredictable. In addition, the surgeons demonstrated considerably poorer speech comprehension in the presence of music compared with a quiet environment or one with OR noise present. However, the addition of music became a significant barrier to speech comprehension only when the surgeon was engaged in a task.

The researchers concluded that OR noise can cause a decrease in auditory processing, particularly in the presence of music. Furthermore, the ability to understand what is being said becomes even more difficult when the conversations carry critical information that is unpredictable.

REFERENCE

1. Way TJ, Long A, Weihing J, et al. Effect of noise on auditory processing in the operating Room. *J Ame Coll Surg* 2013; 216:933-938. ■

Same-Day Surgery Manager

Is your staff unsociable? Phones an obsession?

Answers to 3 of your most pressing questions

By **Stephen W. Earnhart,** MS
CEO
Earnhart & Associates
Houston, TX

Question: Is it me, or is surgery just not as much fun anymore? I mean, I have worked at this hospital for 15 years, and it has turned into

a freaking job! I hate it! We use to laugh a lot, tell gross jokes in the operating room, prank the surgeons, haze the new staff, punch each others' timecards if they were running late, all that. It was fun! Now everything is business! If I wanted "business" as a career, I would have become an accountant and not a nurse. Is it me? Am I just getting old? I'm only 40, though! I really don't think I like this anymore.

Answer: Our jobs in the operating room are not different than any other profession. Yet somehow, we are. I don't find the same degree of cohesiveness and sharing that perhaps other industries share. It could be me, but I get the same comments from others as well. Playing together well in the sandbox? Yeah, I think we have that, but that sense of … closeness … between staff seems lacking. I believe that, as our business has become more competitive, hospitals vs. ambulatory surgery centers (ASCs), vs. office-based facilities, and on and on, we have lost a bit of that sparkle of congeniality. I guess in short, many of us are starting to notice staleness about our jobs. While we have great social media with people who are not around us or that we have never met before, we don't have that same feeling with the person sitting or working beside us.

Question: I was sitting in the surgical lounge the other day, waiting for our case to start, and not one person in the lounge was talking. Everyone, I mean everyone, had their hands on their phones doing something other than communicating with each other. I find the same thing with my kids and friends. Is this getting out of control? It is a little scary.

Answer: I was at a restaurant last night, and I did a head count. Of the 87 people dining, more than 70% had phones in the hand texting or doing something other than being with the one they were with. We are becoming a country, no, a global society of rude, insensitive people with the manners of slack-jawed, knuckle dragging, cave dwellers! I personally don't see the end point. I share your concern, as many do. Short of confiscating personal communications devices, I don't have an answer for that type of behavior in our workplace. I think any suggestions from the readers would help us all.

Question: We caught one of our housekeeping staff taking a picture of a female patient in the recovery room with his smartphone. He was fired on the spot, but I am sure that there will be repercussions from many directions. We are considering banning all phones in the entire surgical department, not just beyond the "red line." Any thoughts on what others are doing, and has it worked?"

Answer: It sort of follows some of the other comments above. How is it policed? Clearly patient confidentially takes precedent over personal communications, but still! Check with your HR department, but I am beginning to believe that, just like smoking, we need to have a designed area where people can use or have their communication devices in operating area. Install small lockers at the entrance to the department. Everyone has his or her own box, and all devices go in there when they come to work. During breaks they are free to use them in a designated area, again, just like smoking areas. I plan to enact this at our new ASC coming up. I will let you know how it goes! *[For more on monitoring devices, see "In light of 2 criminal cases, how do you ensure employees don't abuse patients?"* Same-Day Surgery, *January 2006, p. 1. Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Earnhart & Associates' address is 238 S. Egret Bay Blvd., Suite 285, Houston, TX 77573-2682. Phone: (512) 297.7575. Fax: (512) 233.2979. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.]* ■

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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.*
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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.
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COMING IN FUTURE MONTHS

- What medications interfere with surgery?
- Avoid liability with sales reps in the OR
- New outpatient surgery procedure is a hit
- New free resource for pain management

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CNE/CME OBJECTIVES

- **Identify** clinical, managerial, regulatory, or social issues relating to ambulatory surgery care.
- **Describe** how current issues in ambulatory surgery affect clinical and management practices.
- **Incorporate** practical solutions to ambulatory surgery issues and concerns into daily practices.

CNE/CME QUESTIONS

1. Which should physicians do to reduce risks with electronic medical record documentation, according to Kathy Ferris, ARM, CPHRM, a healthcare risk management consultant at Physicians Insurance?
   A. Avoid routinely validating patient history documented by previous providers.
   B. Avoid using free-text entry in addition to system tools.
   C. Confirm, correct, or update data automatically filled by the system.
   D. Never switch the coding engine option "off."

2. After Shands HealthCare agreed to a $26 million settlement with the Justice Department regarding outpatient claims the department said were inappropriately submitted as inpatient claims, what changes were made at Shands?
   A. Improvements to case management protocols and utilization review processes with an improved team approach to accurately assess and code the care provided
   B. Use of improved software
   C. Implementation of new policies and procedures, and supplemental employee training;
   D. Engagement of expert physician advisors who help assess coding and are on staff 24/7.
   E. All of the above.

3. In the case reported in this issue's guest column, in which a female head of anesthesiology reported being treated in a hostile manner by the male chief of surgery, what should the CEO have done when informed of the treatment, according to the columnists?
   A. Initiated a referral to the dean, if appropriate
   B. Initiated a referral to the hospital's human resources (HR) department to initiate a full HR investigation.
   C. Engaged risk management to collaborate with HR in this investigation
   D. Set out a directive to control and intervene so it would not escalate.
   E. All of the above

4. Which of the following ambient background noise is a patient and surgical safety factor that can affect auditory processing among surgeons and the members of the OR team, according to a recent study?
   A. Loud surgical equipment
   B. Talkative team members
   C. Music
   D. All of the above