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Risk managers as whistleblowers: Is it ever the right path to take?

Reporting malfeasance to regulators might be only choice after other efforts

Any professional, ethical risk manager knows the right thing to do upon finding evidence of fraud within the healthcare employer. Notifying senior leadership and taking corrective action comes naturally.

But what if senior leadership doesn't act to stop the fraud and make amends? At what point do you, the risk manager, pick up the phone and report the fraud to outside regulators? Can you become a whistleblower?

A risk manager faces a difficult choice when considering whistleblowing ...

You can become a whistleblower, and in some situations you are ethically and professionally obligated to do so, according to experts consulted by *Healthcare Risk Management*. But that step is fraught with tremendous career risks and should be taken only after you are certain all other remedies have been tried, they say.

Whistleblowing is nothing new in healthcare, but a situation in San Diego is bringing attention to the unique aspects of having a risk manager or similar administrator turn in the employer. In that case, a former risk manager at Alvarado Hospital in San Diego has filed a $50 million False Claims Act suit against Prime Healthcare Services and accused it of defrauding Medicare at 14 health centers. The lawsuit alleges that Prime increased Medicare patients by eliminating observation care and refusing to discharge patients to post-acute facilities. This case is believed to be the first one in which a risk manager is the whistleblower. *(See the story on p. 51 for more on that lawsuit. See the story on p. 52 for more on the ethical dilemma for risk managers.)*

Risk managers in unique position

A risk manager faces a difficult choice when considering whistleblowing because he or she is charged with looking out for the interests of the employer, says **Andrew A. Oppenberg**, MPH, CPHRM, DFASHRM, director of risk management and patient safety officer at Dignity Health Glendale Memorial Hospital and Health Center in Glendale, CA.

INSIDE

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Oppenberg also is a former president of the American Society for Healthcare Risk Management (ASHRM). That responsibility, not applicable to most whistleblowers, is what raises ethical questions, he says.

"The answer is yes, you can be a whistleblower," Oppenberg says. "Where the law starts to be broken, the ethical responsibility to protect your employer ends. You have to follow the law as risk managers and from an ethical standpoint, you have to take the high road. At that point, you are obligated to report, not just allowed."

But that advice doesn't entirely address the quandary. Although risk managers can blow the whistle in the worst of circumstances, that answer assumes that all other internal remedies have been exhausted, Oppenberg notes. Determining exactly how much effort is enough and when to declare defeat can be the most difficult part of the process, he says.

"That's where the line gets drawn, when they know it's wrong and the intent is to keep doing something that is wrong," he says. "You can't go along with that because you have a license and a reputation to protect."

Executive Summary

A risk manager's allegations of fraud regarding her former employer are raising questions about the ethics of a risk manager becoming a whistleblower. Experts say the risk manager must exhaust all other remedies before reporting malfeasance to regulators.

- ✦ Under the right circumstances, a risk manager might be obligated to report fraud to outsiders.
- ✦ Reaping financial benefits from participating in a *qui tam* lawsuit might be acceptable.
- ✦ Risk managers face special ethical considerations in becoming a whistleblower because they are largely responsible for preventing and correcting fraudulent behavior.

Oppenberg also notes that failing to report known fraud could expose the risk manager to individual liability in the form of fines or even criminal charges.

Willful fraud changes equation

The breaking point might come when other leaders in the organization make it clear that they are not going to stop the behavior, says **Josh Hyatt**, MHL, CPHRM, senior risk management specialist with NORCAL Mutual Insurance in San Diego. Hyatt also was previously a Medicare fraud investigator with the Centers for Medicare and Medicaid Services (CMS). The risk manager suing Prime alleges that senior leaders acknowledged the fraud and had no intention of stopping. *(See the story on p. 52 for more on that allegation.)*

However, there are rare situations in which the wrongdoing is so horrendous that immediately blowing the whistle could be justified.

"If you have a senior executive who is just off the wall and you're blatantly breaking the law, you might have to go over his

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head and report to the appropriate authority," he says. "You would still go to someone high in the organization and say that this step is necessary, so let's do it together and report to the proper authorities."

The nature of the wrongdoing also can determine the appropriateness of whistleblowing, Hyatt says.

"If it is sloppy compliance or people not being as diligent as they should be in following the rules, that is something that you might be more willing to work with administration to get it right even if it doesn't happen right away," he says. "But if it seems like a willful attempt to defraud the government or break the law, you might have less patience for any delays in fixing it. Then blowing the whistle can be the right step." *(Hyatt once reported his employer for alleged fraud. See the story on p. 52 for details. Monetary rewards also can complicate matters See the story on p. 52 for more on that issue.)*

Don't go it alone

Oppenberg cautions that, if it comes to the point, risk managers should not act alone. This is not the time to be Norma Rae or Erin Brockovich going up against the system, he says. A whistleblower should proceed with the support of an attorney and any senior executives who can support the allegations, he says.

The outcome of the Prime Healthcare case could shape how risk managers address their frustrations over unresolved fraud or illegal activity, Hyatt says. It also might affect how employers look at their risk managers.

"This case gives the perception of risk managers that they could be dangerous because of the unique access they have to data and the internal workings of the organization," Hyatt says. "That could play against risk managers. Information may become more controlled around them, which could be very bad."

Sources

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Risk manager blows whistle on hospital, alleges Medicare fraud

In what is believed to the first case of its kind, a former risk manager has filed a $50 million lawsuit against the health system that employed her and accused it of defrauding Medicare at 14 health centers.

Karin Berntsen, a former risk manager at Alvarado Hospital in San Diego, filed the suit in 2011, but it was only recently unsealed. Among other misdeeds, she alleges that Prime Healthcare Services (PHS) fraudulently increased charges by eliminating observation care and refusing to discharge patients to post-acute facilities.

"Relator estimates that PHS Alvarado's fraudulent short-stay inpatient admission billings to government healthcare programs exceeds $4 million," the complaint says. "Considering Alvarado is a typical hospital within the (Prime) system, the probability that all other (Prime) facilities are falsely billing Medicare in the same manner as Alvarado, and that some of those hospitals have been within the (Prime) system for at least six years, relator conservatively estimates that Prime's false billings just with regard to improper short-stay inpatient admissions alone exceed $50 million."

Prime issued a statement calling the allegations "speculative nonsense." **Troy Schell**, JD, Prime's general counsel, released a statement denying the allegations. "It defies common sense that Alvarado Hospital has been engaged in a false claims scheme when the entire Prime Healthcare system has been under this type of heightened and aggressive regulatory scrutiny for years," he said.

Prime is no stranger to fraud allegations. Federal investigators in 2011 found that Prime hospitals in California, including Alvarado Hospital, systematically billed Medicare for rare medical conditions much more frequently than other hospitals in the United States. After billing Medicare for treating more than 1,100 cases of kwashiorkor, a dangerous nutritional disorder usually seen among children during famines in developing countries, a Prime hospital in Redding abruptly stopped after the investigation began. The hospital had billed Medicare for kwashiorkor at 70 times the average rate of other California hospitals, according to state health department records.

In 2012, state regulators fined Prime $95,000 for breaching patient confidentiality. In response to allegations of upcoding by a patient in the *Los Angeles Times*, Shasta Regional Medical Center CEO Randall Hempling and Chief Medical Officer Marcia McCampbell emailed the records of that patient to almost 800 employees and two newspapers.

The federal government has not yet joined in the False Claims Act case against Prime, but Thom Mrozek, a spokesperson for the U.S. Attorney's Office in Los Angeles, says it might.

"Our decision not to intervene at this time should not be construed as a statement about the merits of the case," he says. "The government retains the right to intervene at a later date upon a showing of good cause" ✦

Risk manager claims top execs endorsed Medicare fraud

In her lawsuit against Prime Health System (PHS), risk manager **Karin Berntsen** claims that she witnessed leaders at Alvarado Hospital in San Diego encouraging Medicare fraud.

This is an excerpt from her lawsuit in which she makes that claim:

"In January 2011, more than 250 employees, including most of Alvarado Hospital's Quality and Risk Management Department staff, were dismissed by PHS. At about the same time, [Prime founder and chairman **Prem Reddy**, MD] implemented a monthly Hospitalist Meeting attended by the senior and high-volume admitting physicians as well as key administrators. The first such meeting was convened on February 1, 2011, at which time Dr. Reddy startled those present by stating, 'We don't do observation. All patients should be inpatient. You can always find a reason to make the patient an inpatient.'

"Dr. Reddy reiterated his instructions concerning patient admissions at subsequent Hospitalist meetings attended by Relator, including a meeting on May 3, 2011, at which he also encouraged those present to upcode by adding complications or comorbidities such as encephalopathy and fecal impaction to a diagnosis in order to increase the DRG reimbursement rate. For example, he stated:

• 'If the patient is elderly, you should add encephalopathy for a higher payment. You are missing some of these elderly patients. But be careful … I don't want to go to jail, ha, ha, ha.'

• 'If you code fecal impaction in GI bleed diagnoses, I can get $3,000 more per case.'

• 'If the patient leaves against medical advice, you are free to document whatever conditions you want.'" ✦

No choice but to report fraud, then resign

There are some instances in which healthcare managers must protect themselves, even if means blowing the whistle on your employer, says **Josh Hyatt**, MHL, CPHRM, senior risk management specialist with NORCAL Mutual Insurance in San Diego. Hyatt also was previously a Medicare fraud investigator with the Centers for Medicare and Medicaid Services (CMS).

Hyatt says he has reported a past employer for intentionally committing fraud. In that instance, he says, he was upfront about his intention to report the alleged fraud because the institution was making no effort to correct it. "I told them that I had to report it because if I didn't I could be prosecuted," he says. "I suggested they get their books in order, and then I provided my notice."

Hyatt did not file a *qui tam* lawsuit when he reported his former employer; he choose instead to just move on after reporting. He suggests that the more public, more aggressive action of a *qui tam* lawsuit would have a more detrimental effect on a career than simply reporting fraud and receiving no reward. ✦

Monetary reward can cloud ethical decisions

Another complicating factor when a risk manager considers blowing the whistle is the possibility of the risk manager being rewarded for turning in the employer, such as receiving 10% or 25% of the damages in a *qui tam* case.

Is that unethical? After all, the risk manager is supposed to keep the organization on the straight and narrow, and a fraud investigation could be seen as a failure of sorts.

It should not be the motivation, but the potential windfall should not deter the whistleblower either, says **Andrew A. Oppenberg**, MPH, CPHRM, DFASHRM, director of risk management and patient safety officer at Dignity Health Glendale Memorial Hospital and Health Center in Glendale, CA. Oppenberg also is a former president of the American Society for Healthcare Risk Management (ASHRM).

"Regardless of the money, doing the right thing is still the right thing to do," Oppenberg says.

And besides, the money could be necessary, Oppenberg says, because a risk manager might be effectively ending his or her career by blowing the whistle. There are legal prohibitions on retaliation by the employer, but in reality the act of whistleblowing will be a red flag to every future employer, Oppenberg says. In an ideal world, other employers would see the person as highly ethical and willing to make the hard decisions, but in the real world employers will worry that the risk manager will cause trouble for them, too.

"If the *qui tam* is successfully prosecuted, my guess is that risk manager is not going to work again for the rest of his life," Oppenberg says "If I were in that position of considering whistleblowing, I would move heaven and earth to do everything possible to avoid filing a *qui tam*." ✦

Whistleblowing signals failure of the system

Risk managers might find themselves in difficult situations if they think fraud is not being corrected, particularly if they are also the compliance officers at their facilities, notes **John Banja**, PhD, medical ethicist at the Center for Ethics at Emory University in Atlanta.

Unlike some other hospital employees, however, the risk manager has to meet a higher ethical standard when it comes to whistleblowing, he says. Because the risk manager is at least partly responsible for preventing and detecting fraud, he or she cannot look the other way and and say solving the problem is someone else's job, Banja says.

"Assuming he or she has done due diligence and has genuine reason to be concerned about a problematic billing behavior, an absolutely fundamental ethical obligation of a patient-centered hospital is to take the next step in addressing that problem, which could mean reporting it to authorities," Banja says. "Virtually every code of ethics says that when a healthcare professional notices something that violates practice standards or the law, they have to do something about it."

Having an employee resort to whistleblowing is a failure of the system for an employer, Banja says. A hospital's leaders should have a culture that encourages employees to report their concerns internally and a determination to follow through on investigating the issue and taking any necessary remedial actions, he says. If an employee's concerns are handled so ineffectively that they are taken public and proven to have merit, the employers have no one to blame but themselves, he says.

"If the ethics concerns don't grab you, then what should grab you is the fact that the people who conduct the investigations for the feds are depending on your guilt for their livelihood," Banja says. "The monies they recover in these fraud lawsuits, and the penalties that are imposed, that's what funds these federal offices and what makes these people successful in their careers."

Source

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EMTALA deficiencies rise, but why?

Violations of the Emergency Medical Treatment and Labor Act (EMTALA) have increased recently, and there could be several explanations, according to **Sara H. Shanti**, JD, an attorney with the law firm of Drinker Biddle & Reath in Chicago who frequently advises healthcare clients on EMTALA compliance.

The November 2013 EMTALA deficiency report from the Centers for Medicare and Medicaid Services (CMS) shows a dramatic increase in violations, from 696 in March 2013 to 1,140 in November 2013.

The sharp increase might be due to increased involvement in EMTALA enforcement by the Office of the Inspector General (OIG), Shanti says.

"In the past they were involved, but they left much of the work to CMS, which in turn relied on surveys by state inspectors. There was a lot of downstream delegation," she says. "In 2011 OIG took a renewed interest in overseeing CMS and also at looking more directly at deficiencies. There has been so much talk about healthcare in general for the past few years, in addition to the talk about Obamacare, and so issues like EMTALA compliance are getting more attention from all directions."

EMTALA investigations have been complaint-driven for the most part, Shanti notes, and consumers are becoming more aware of their rights as patients. That increased awareness could account for some increase in deficiencies, she suggests. *(Some states have also enacted laws that broaden the reach of EMTALA. See the story on p. 54 for more details.)*

"It's one thing for the surveyors to come on site and look at the books and the numbers, where everything might look pretty much OK," Shanti says. "But those numbers may not capture the individual who was sitting in the waiting room for hours and finally got up and left, or the people who left after speaking with someone. Those incidents aren't captured in the hospital's books, but if there is some reason people are more willing to complain now, that is data the OIG and CMS would rely on."

That supposition is supported by the recent increase in civil suits, which Shanti says also might be attributed to the public being more aware of their rights and what constitutes malpractice. "The government does watch those headlines, and they will jump in if they want to either join the

Executive Summary

Recent data from the Centers for Medicare and Medicaid Services (CMS) indicate that violations of the Emergency Medical Treatment and Labor Act (EMTALA) are on the rise. An EMTALA expert suggests there are several reasons:
✦ The Office of the Inspector General (OIG) has become more involved in enforcing EMTALA.
✦ Consumers might be more aware of the law and their rights.
✦ Auditors looking at other issues might be stumbling on EMTALA violations.

complaint or investigate the matter for conditions of participation or other government requirements," she says. "Some of the things that end up in the newspaper or civil court come to the government's attention that way."

Auditing also is becoming more common in healthcare for several reasons, such as quality issues and patient privacy. When auditors are in the hospital poking around for one reason, they might come across evidence of a completely different matter such as an EMTALA violation, she says. So the general increase in auditing can lead to a rise in completely unrelated violations.

The increase in violations is particularly the case when there is any kind of complaint against the emergency department (ED), Shanti says. The patient might not have complained about EMTALA but an EMTALA deficiency might be the end result.

"We see this a lot with discrimination allegations in the ED," Shanti says. "The patient may complain about being treated differently than another person, and when the investigators go in to look around, they could find evidence that triggers an EMTALA investigation."

... the general increase in auditing can lead to a rise in completely unrelated violations.

Another factor is the regulators' being more strict with healthcare providers, Shanti says. Now that the rule has been around for 10 years, the government is taking a stronger approach to violations and is much less willing to accept pleas of misunderstanding the rule.

"The ante has been raised with EMTALA compliance," Shanti says. "Hospitals have to pay more attention to EMTALA compliance more than they ever did before."

Source

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States say EMTALA doesn't stop with admission

Complying with the Emergency Treatment and Labor Act (EMTALA) can be hard enough before court rulings give the rule a longer reach. Courts in Kentucky, Ohio, Michigan, and Tennessee have passed laws that make EMTALA applicable even after admission.

The EMTLA rule usually has been interpreted as being in effect only up to admission, explains **Sara H. Shanti**, JD, an attorney with the law firm of Drinker Biddle & Reath in Chicago.

"Courts in those states found that inpatient admission does not terminate your EMTALA obligation, so hospitals still have to either stabilize or transfer the patient according to EMTALA," she says. "That means hospitals in those states have to meet all the inpatient requirements but also the EMTALA requirements for these inpatients. That may sound like the same thing, but it's not."

For example, stabilization under EMTALA has a different meaning than stabilization for an inpatient, Shanti explains. Under EMTALA, stabilization means the patients can be discharged and leave on their own, and there is no threat of an emergency medical condition. Transfer also meets the definition of stabilization.

"It can get confusing for people on the frontlines who think that if they are providing good, quality care then they must be in compliance with EMTALA," she says. "There are pitfalls, especially in these states." ✦

Patient sitters found effective in reducing falls

Patient sitters are a somewhat controversial strategy for reducing patient falls, with many administrators arguing that the cost of paying someone to sit in a room and watch a patient all day cannot be justified. A recent study, however, suggests that patient sitters can be cost effective and significantly reduce falls.

The cost savings achieved in decreasing rates of falls with harm, both in terms of money saved and decreased severity of injury, might justify the costs associated with implementing and maintaining a sitter program, says lead author **Michelle Feil**, MSN, RN, senior patient safety analyst with the Pennsylvania Patient Safety Authority in Harrisburg. Feil and her co-author both have risk management backgrounds.

They analyzed data from 75 hospitals participating in the Hospital and Health System Association of Pennsylvania Hospital Engagement Network Falls Reduction and Prevention Collaboration.[1] *(The full study is available online at http://tinyurl.com/lyfw9tn.)*

Their analysis revealed a statistically significant correlation between low rates of falls with harm and the use of sitter programs. A statistically significant cor-

relation also was identified between low rates of falls with harm and three specific sitter program design elements: defining criteria for sitter qualifications, providing a training program for sitters, and establishing a pool of sitters.

Analysis of falls suggests that the use of sitters might be associated with a higher percentage of assisted falls and a lower rate of falls with harm, Feil explains. "The key is to have a pool of sitters and a process in place to make sure you are utilizing sitters appropriately," Feil says. "There has been research in the past that suggested sitters did not effectively reduce falls, but what they did not account for was who was in the role and whether they had specialized training. It takes time, money, and effort to implement these programs and to do it correctly."

Patient sitters also are sometimes called patient safety assistants, companions, and one-to-one or constant observers. In any case, they are staff members or volunteers assigned to provide direct observation of patients at risk to harm themselves or others.

One-on-one observation and assistance might seem like a surefire, if expensive, way to prevent falls. But Feil says research into the clinical effectiveness of sitter programs has produced inconsistent results. The cost-effectiveness of these programs is always in question, she says.

Feil's research, however, found a statistically significant correlation between lower rates of falls with harm and the use of sitter programs, as well as specific sitter program design elements. The study also identified specific sitter program design elements that should be used to structure sitter programs. *(See the story below for details on those elements.)*

Executive Summary

Patient sitters can be effective in reducing falls, and the savings can exceed the cost of the sitters. Hospitals should follow specific guidelines for a sitter program.

- ✦ Sitters must be properly selected and trained.
- ✦ Patient sitters are not a perfect solution, and falls still might occur.
- ✦ Even when patients fall, sitters can help minimize injuries.

> *"It takes time, money, and effort to implement these programs and to do it correctly."*

The data came from a state survey that was designed to evaluate the current structure and content of hospital falls prevention programs compared with evidence-based, best-practice guidelines. Hospitals were asked to report the level of implementation (no implementation, partial implementation, or full implementation) for individual falls prevention practices and falls prevention program elements across 17 categories of falls prevention practices.

The use of patient sitters was the third lowest scoring category of practices. Forty-eight of the 75 hospitals surveyed reported having sitter programs, of which 21 reported full implementation of six specific design elements of sitter programs.

"I think if cost were not an issue, more hospitals would have sitter programs, but cost is clearly an issue," Feil says. "But we can see that though it takes money to find these sitters, train them, and to pay them for their hours, a hospital also can suffer huge costs if there is a fall because a patient needed constant observation and you weren't able to provide it."

Reference

1. Feil M, Wallace SC. The use of patient sitters to reduce falls: best practices. *Pa Patient Saf Advis* 2014; 11(1):8-14. ✦

Six elements key to patient sitter program

Falls research led by **Michelle Feil**, MSN, RN, senior patient safety analyst with the Pennsylvania Patient Safety Authority in Harrisburg, found that these six program design elements were associated with successful patient sitter programs:

- a process for requesting and discontinuing sitters;
- patient eligibility criteria;
- a pool of sitters;
- criteria for sitter qualifications;
- a sitter job description with expectations for sitter behavior and responsibilities;
- a training program for sitters.

In addition, she found that facilities might be able to decrease patient sitter use while helping to reduce rates of falls with harm by incorporating these elements:

- Designate staff responsible for overseeing the sitter program and/or assessing patients prior to initiating one-to-one observation (psychiatric liaison nurse, geriatric clinical nurse specialist).
- Outline a process for requesting and discontinuing sitters.
- Define patient eligibility criteria.
- Designate a pool of sitters.
- Outline criteria for sitter qualifications.
- Outline expectations for sitter behavior and responsibilities that include the

following:

♦ reviewing pertinent clinical information, the reason for observation, and the plan of care with the nurse assigned to the patient and communicating regularly throughout the shift to report observed behaviors indicating either continued need for, or ability to discontinue, use of one-to-one observation;

♦ documenting observed behaviors and interventions provided in the course of performing one-to-one observation;

♦ maintaining toileting schedules for patients able to use the toilet or bedside commode;

♦ remaining with patients while in the bathroom;

♦ staying within arm's reach of patients whenever appropriate (the nurse and the patient sitter will need to assess when remaining within close proximity to the patient might be inappropriate because it might increase agitation in some patients);

♦ ensuring a safe environment (remove clutter, keep items within patient's reach);

♦ providing a proper handoff to another staff member, completed in the presence of the patient, when patient sitters must leave the patient;

♦ focusing on observation of the patient and avoiding non-work-related activities that might distract from care of the patient (personal calls, cell phone use, reading).

• Design a training program for sitters that provides education on the following:

♦ safe patient handling techniques;

♦ behavior management strategies for de-escalating agitated patients;

♦ diversional activities (e.g., activity aprons, crafts, magazine reading) to engage patients, particularly those with cognitive impairment. ✦

Sitter inattention still can let falls happen

Even well-designed patient sitter programs cannot prevent every patient fall, but the research by **Michelle Feil**, MSN, RN, senior patient safety analyst with the Pennsylvania Patient Safety Authority in Harrisburg identified particular shortcomings that are most likely to allow falls:

• The sitter was not within reach of the patient when the patient fell off a chair, wheelchair, or side of the bed.

• The patient tripped on an item in the path of walking to the bathroom.

• The sitter left the patient's room with no designated backup staff, and the patient later was found on the floor.

• The patient's legs became weak while ambulating, and the sitter was in the patient room or in the hallway.

• The patient was reaching for an item unassisted while sitting in a chair or wheelchair.

• The patient was found on the floor after being left unattended in the bathroom while toileting or showering.

• The patient slid to the floor while sitting on the edge of the bed. ✦

ACA might raise cost of med mal insurance

The expansion of health insurance accomplished under the Affordable Care Act (ACA) might raise the cost medical malpractice coverage as much as 5%, according to a new report from the RAND Corp., a prominent non-profit think tank based in Santa Monica, CA.

Automobile, workers' compensation and general business liability insurance costs might fall under the ACA, the study found, while costs for medical malpractice coverage could be higher. Researchers say the changes could be as much as 5% of costs in some states, but they caution there is considerable uncertainty surrounding such estimates. The findings are from one of the first systematic studies of how the ACA could influence costs for liability and related lines of insurance, says **David Auerbach**, the study's lead author and a policy researcher at RAND.

"The ACA is unlikely to dramatically affect liability costs, but it may influence small and moderate changes in costs over the next several years," he says. "For example, auto insurers may spend less for treating injuries, while it may cost a bit more to provide physicians with medical malpractice coverage."

Researchers at the RAND Corp. examined how the ACA might operate across different liability lines and how the impacts might vary across states given existing laws, population demographics, and other factors. *(The full RAND Corp. report is free, and it can be found online at http://tinyurl.com/costincrease. .)*

"There are many ways that the ACA might affect the cost of malpractice insurance, and the increase in the number of insured people seeking care is only one of them," Auerbach says. "The increased number of patients in the system increases the amount of care, and that increases the number of things that can go wrong."

Increased numbers, lower pay

Another factor is the changing reimbursement for healthcare, most of it focused on efficiency and meeting quality standards, Auerbach says.

"The federal government is reducing Medicare payments to hospitals, and we expect that to have some influence over

patterns of care and related liability," he says.

Liability insurance companies reimburse tens of billions of dollars each year for medical care related to auto accidents, workplace injuries, and other types of claims, he notes. Consider this example: Auto insurers collectively paid $35 billion for medical costs associated with accidents in 2007, about 2% of all U.S. healthcare costs in that year, Auerbach says.

But some of those costs might be covered by regular health insurance as more Americans become newly covered under the ACA, according to the study. As that happens, the cost of providing automobile insurance, workers compensation and homeowners insurance might decline. Ultimately, any cost changes experienced by insurance companies could be passed on to consumers through changes in premiums and coverage options.

Meanwhile, an increase in the number of people using the healthcare system might trigger a corresponding increase in the number of medical malpractice claims made against physicians and other healthcare providers, according to the study. Such a shift could drive malpractice costs modestly higher, Auerbach explains.

"We do expect that states and areas that have had an increase in insurance coverage will have an increase in claims," he says. "How much it will be we don't know yet, but it could be enough to make a difference for some providers.

Executive Summary

The Affordable Care Act (ACA) might prompt increases in medical malpractice liability insurance. Other types of insurance could become more expensive.

- ✦ The prediction comes from the RAND Corp., a prominent think tank.
- ✦ Price increases are likely, but they might not be large.
- ✦ Costs could drop later if some healthcare reform efforts are successful in improving patient safety.

Cost savings also possible

Researchers say there are many state-level variables that will influence any impacts on liability costs created by the ACA. These variables include items such as whether states require medical costs to be deducted from liability awards or whether states choose to implement the ACA's optional Medicaid expansion.

Ultimately, any cost changes experienced by insurance companies could be passed on to consumers ...

While the study primarily focuses on the short-term impacts of healthcare reform on the cost of liability insurance, RAND researchers also suggest that the ACA could have additional long-run impacts.

Costs of liability insurance could be reduced further if reforms aimed at driving down healthcare costs are successful, for example. Other potential long-run changes include modifications of tort law, shifts in pricing of medical services, changes in the number of practicing physicians and increased efforts by Medicaid to recover a portion of injury payments.

Auerbach also notes that any increase in claims or liability insurance costs could be offset by quality improvements that come as a result of the ACA and other reforms.

"It seems to reasonable that we will see an increase in the use of standardized measures and best practices as providers try to meet the quality and efficiency goals that will be drivers under the ACA," Auerbach says. "If there is an increase there and it has the effect of improving patient care, that may result in savings that can offset other costs." ✦

Health IT, drug shortages lead Top 10 safety concerns

Patient safety is a top priority for every healthcare organization, but knowing where to direct initiatives can be daunting. To help organizations decide where to focus their efforts, ECRI Institute has compiled its first annual list of the Top 10 Patient Safety Concerns for Healthcare Organizations.

With the federal government offering financial incentives for hospitals and physician practices to adopt electronic health records (EHRs), it is no surprise that health IT is the number one item on this year's list. What is surprising, says ECRI Institute, is the specific risk from the integrity of data in health IT systems. While appropriately designed and implemented systems can support patient safety and quality of care, incorrect data can lead to patient harm.

Poor care coordination, drug shortages, and mislabeled specimens made ECRI Institute's list, as well as falls while toileting and foreign objects unintentionally retained after surgery, childbirth, or other interventional procedures. ECRI Institute's analysis

reveals specific contributing factors that can lead to greater occurrences of these events. This awareness enables organizations to spend their patient safety efforts in ways most likely to reduce patient harm and therefore the costs of care, says **Karen P. Zimmer**, MD, MPH, FAAP, medical director of ECRI Institute's patient safety, risk, and quality group and of ECRI Institute Patient Safety Organization (PSO).

"In a time of competing priorities and limited resources in healthcare, we encourage facilities to use the list as a starting point for patient safety discussions and for setting their patient safety priorities," Zimmer says. "ECRI Institute PSO has been collecting and analyzing events since 2009, and there are sufficient data to share recurring themes and associated prevention strategies."

The list is intended to help healthcare organizations identify priorities and aid them in creating corrective action plans. ECRI Institute is providing free access to a number of educational tools at www.ecri.org/PatientSafetyTop10, including the full report, a slideshow that summarizes the Top 10, and a poster.

Included with this report are recommended risk mitigation strategies for these issues. Individuals in risk and quality departments can present this information to their organization's leadership to get the resources they need to improve safety, Zimmer suggests. ✦

All Children's Health System to pay $7M for Stark violations

All Children's Hospital, Pediatric Physician Services (PPS), and All Children's Health System in St. Petersburg, FL, have settled a whistleblower lawsuit brought under the False Claims Act for $7 million.

The James Hoyer Law Firm in St. Petersburg announced the resolution. The defendants have agreed to settle allegations that their compensation agreements with certain employed physicians did not comply with federal law. The lawsuit alleged Pediatric Physician Services, which is wholly owned by All Children's, paid many physicians above market value for their services.

Barbara Schubert, former director of operations at PPS, filed the federal False Claims Act suit in Tampa in July of 2011. Schubert alleged that certain physician compensation agreements between PPS and employed physicians did not comply with the federal Stark statute. To settle the lawsuit's allegations, the defendants will pay the United States approximately $4 million and the state of Florida approximately $3 million. Schubert will receive a 26.5% share of the recovery.

The lawsuit alleged Pediatric Physician Services ... paid many physicians above market value for their services.

According to the lawsuit, in her role as the director of operations, the whistleblower developed a compensation model that would guarantee physicians a base salary between the 25th and 75th percentile nationwide, which was developed from the aggregate of three salary surveys. The board of Pediatric Physician Services approved the compensation model that also stated physicians would not be compensated below the 25th percentile or above the 75th percentile.

However, PPS subsequently hired several physicians and provided them with base salaries above the 90th percentile, which was not supported by any model or survey.

The $7 million settlement will resolve all allegations under the lawsuit, and there has been no liability admitted by any party. ✦

Congressmen aim to reduce med mal abuse

Seeking to lower healthcare costs and improve patient care by reducing medical lawsuit abuse and using evidence-based guidelines developed by doctors, medical liability reform legislation is being sponsored by Reps. **Ami Bera** (D-CA) and Andy Barr (R-KY).

They recently introduced H.R. 4106, the Saving Lives, Saving Costs Act. The unlikely allies are not only on different sides of the aisle, but come from what has traditionally been separate sides of the issue — as Bera is a physician and Barr is an attorney.

The Saving Lives, Saving Costs Act will offer physicians who document adherence to certain evidence-based clinical-practice guidelines a safe harbor from medical liability litigation.

"The bipartisan Saving Lives, Saving Costs Act is a practical way to bring down the skyrocketing cost of healthcare, and to make the system work better for patients that people from both

parties can get behind," Bera said in a released statement. "As a doctor, I know that physicians want to do what's best for their patients, and promoting evidence-based medicine will help us do that." ✦

Series of cyber attacks hit Boston Children's Hospital

Boston Children's Hospital was hit with a series of cyber attacks that tried but failed to take down its website, officials told the *The Boston Globe*.

Children's released a statement saying no patient data or its internal systems had been compromised. In a statement soon after the incident, spokesman **Rob Graham** said "Boston Children's Hospital's website has been the target of multiple attacks designed to bring down the site by overwhelming its capacity."

Children's Hospital's leaders contacted law enforcement authorities, and an investigation suggested that the hacking group known as Anonymous targeted the hospital for its role in the controversial custody case surrounding Justina Pelletier. In March, a Massachusetts juvenile court judge gave permanent custody of the teen to the state, agreeing with Children's physicians that the parents were not providing correct medical care. Anonymous also claimed responsibility for an earlier attack on the website of Wayside Youth and Family Support Network, the Framingham, MA, facility where the 15-year-old girl lives. ✦

New York State leads in med mal payouts

Awards in malpractice lawsuits paid out roughly $690 million in New York last year, nearly twice that of second-ranked Pennsylvania, which saw $357 million in payouts, according to government data compiled by Diederich Healthcare, a medical malpractice insurer based in Carbondale, IL.

New York is also the clear leader on per capita payouts, averaging $39 per resident, with Pennsylvania trailing at $25 per resident, the report says.

Payouts overall rose 4.7% between 2012 and 2013 to $3.7 billion, according to the insurer's research. ✦

COMING IN FUTURE MONTHS

- ✦ Social media and employment discrimination
- ✦ Benefits of alternative risk transfer and financing
- ✦ A new defense for medical malpractice cases?
- ✦ Latest data on infant abductions at hospitals

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. Scan the QR code below, or 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 emailed to you instantly. ✦

CNE QUESTIONS

1. **According to Andrew A. Oppenberg, MPH, CPHRM, DFASHRM, director of risk management and patient safety officer at Dignity Health Glendale Memorial Hospital and Health Center, can a risk manager ever become a whistleblower?**

   A. No, not under any circumstances.
   B. No, unless compelled by a court order to reveal information damaging to the employer.
   C. Yes, as soon as the risk manager discovers wrongdoing.
   D. Yes, after taking the appropriate steps to correct the problem within the administrative process of the employer.

2. **What does Sara H. Shanti, JD, with the law firm of Drinker Biddle & Reath say is one reason that EMTALA deficiencies have increased in past months?**

   A. The Office of Inspector General is showing more interest in Emergency Medical Treatment and Labor Act (EMTALA) investigations and getting more directly involved.
   B. Hospitals are decreasing the size of their emergency staffs because of economic challenges.
   C. A lack of obstetrical physicians is causing patients to be turned away.
   D. There are not enough on-call physicians to provide emergency care.

3. **What did Michelle Feil, MSN, RN, senior patient safety analyst with the Pennsylvania Patient Safety Authority, find is a key element for success with a patient sitter program?**

   A. Specific training for the sitters.
   B. Rotating sitters every hour.
   C. Hiring only trained healthcare professionals as sitters.
   D. Using two sitters per patient at all times.

4. **According to a report from the RAND Corp., why might the Affordable Care Act result in increased premiums for liability insurance?**

   A. The act requires an increase in premiums.
   B. Increased utilization will mean more opportunity for errors in healthcare.
   C. Insurers are uncertain of the effect from healthcare reform, and so they are increasing rates as a precaution.
   D. Restrictions on the care available to insured patients will mean lower quality outcomes.

Legal Review & Commentary

Expert analysis of recent lawsuits and their impact on healthcare risk management

Improper medication during outpatient surgery causes brain injury and $5.1 million verdict

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News: The patient, a 44-year-old woman, underwent a routine, outpatient surgical procedure to relieve sinus congestion at a surgical center. The surgeon called for an injection of 1% lidocaine, as well as cotton balls soaked in Afrin to control bleeding in the patient's nose. Due to a miscommunication, the two medications were mixed up, and the surgeon injected the patient with the incorrect medication, which caused the patient's heart rate to drastically drop. Despite finding out this mistake, the surgeon continued, and further improperly used labetalol in an attempt to stabilize the patient's high blood pressure. The patient went into cardiac arrest, was resuscitated, but suffered brain damage. The patient and her husband sued and alleged that the surgeon was negligent and that the surgical center was at fault for knowing that the surgeon failed to follow safety procedures. The surgeon and center denied wrongdoing. The jury found both liable and awarded $5.1 million in damages.

... this injection of 6-7 cc of Afrin was a hundred times more than the amount that typically is recommended.

Background: In this matter, the patient was a 44-year-old woman who underwent a routine, outpatient nasal surgery to relieve sinus congestion. Prior to the procedure, the surgeon called for an injection of 1% lidocaine with epinephrine for local anesthesia, as well as cotton balls soaked in Afrin, a topical vasoconstrictor, to control bleeding in the patient's nose. The circulating nurse poured Afrin into an unlabeled cup and did not relay the preparation to anyone else in the operating room. A second nurse then drew the Afrin, believing it to be the requested lidocaine, into an unmarked syringe, which the surgeon injected into the patient's nasal cavity. After the injection, the patient's heart rate dropped to 36. A nurse anesthetist administered glycopyrrolate, which brought up the patient's heart rate to 80.

The surgeon asked for more 1% lidocaine, but a nurse responded that only 2% lidocaine was available, at which point the surgeon discovered that the original syringe was Afrin rather than lidocaine. Information revealed at trial showed that this injection of 6-7 cc of Afrin was a hundred times more than the amount that typically is recommended. The surgeon decided to continue with the elective surgery, despite finding out this information. Anesthesia still was required, so the surgeon proceeded with injecting the patient with lidocaine, which caused the patient's heart rate to spike to 140 and blood pressure to rise to 260/150. The surgeon responded to this situation by administering the drug labetalol.

FINANCIAL DISCLOSURE: Author **Greg Freeman**, 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. **Damian Capozzola**, **Jamie Terrence** and **Tim Laquer**, co-authors, have no relevant relationships to disclose.

However, this decision was incorrect: The labetalol bottomed out the patient's blood pressure, which caused cardiac arrest. The patient was transported to a nearby hospital and resuscitated there, but the damage already was done. The patient suffered from brain damage and impaired cognitive abilities, vision, memory, and speech, and these injuries were expected to worsen with age.

The patient and her husband brought suit and alleged that the surgeon was negligent by failing to stop the procedure, particularly after discovering that there was no advantage to continuing this elective procedure. At this time of discovery, the surgeon could have aborted the procedure with no negative consequences, while continuing posed potential unknown consequences. The patient claimed that the medication overdose and error were negligent, but the real damage came from persisting with the surgery while knowing about these medication mistakes.The patient alleged that the physician should have postponed the surgery. Additionally, the patient alleged that, based on the past actions of the surgeon and those in his practice, the hospital leaders knew that safety procedures were not being followed properly and that this incident was just another time that the surgeon failed to abide by proper procedures. The surgeon and center defended on the basis that the judgment decision to continue the procedure was correct, based on information from the nurse anesthetist. Furthermore, the defense attempted to argue that the lidocaine injection was minimal with no meaningful effect on the patient's outcome, and that the damage was caused by an unforeseen reaction to the Afrin. The jury rejected these defenses and found the surgeon and center liable for 38.5% and 61.5% respectively. The total damages were $4.6 million for the patient and $500,000 for the patient's husband for loss of consortium. However, a confidential high-low agreement in place reduced this verdict to an unknown amount, as an attorney stated that the $5.1 million exceeded the high value.

What this means to you: This case serves as an illustration of the need for communication among physicians, nurses, and anyone involved in a surgical procedure. It is almost a guarantee that multiple individuals are involved with any single patient's care, and these parties must be kept informed of what the others are doing. Thus, communication is extremely important to ensuring a patient's proper treatment. Proper communication can also serve to eliminate waste or inefficiency in a hospital setting. It will ensure that preparations and procedures, such as pre-surgery measurements or medication administration, are not repeated unnecessarily or dangerously. When parties do not communicate, these procedures might be repeated, especially because patients might not speak up or even know that this overlap is happening. Hospitals should train physicians, nurses, and staff to emphasize teamwork and foster communication. Such training can help a hospital if litigation arises which alleges that the hospital was negligent, because it shows that the hospital took affirmative steps to properly educate its employees.

Another problem revealed in this case is what can go wrong when medications and containers are not properly labeled. Giving a patient the wrong medication, or wrong dosage, can have serious consequences, as seen in the case here, in which the patient went into cardiac arrest. Hospitals and surgery centers should instruct their surgeons and nurses to make sure to properly label their instruments and containers. In many circumstances unlabeled containers and syringes are prohibited, and unless the physician is immediately going to use a medication he or she draws up into a container or syringe, there should be a label placed on both. In addition, it is critical that when a doctor gives a verbal order for a medication to a nurse, the nurse gives a "read back" or gets a verbal confirmation of the drug and dose ordered.

Training, again, can come into play with hospitals teaching their employees about these marking procedures. Physicians and nurses must make sure to use the correct drug under the circumstances. If it is unknown how one drug will interact with another, caution must be exercised. According to a 2006 statistic from the Institute of Medicine, medication errors injure 1.5 million Americans each year, which costs $3.5 billion in losses. These errors can occur at any step of the process: prescribing, transcribing, dispensing, or administering the medication. Administration errors account for a large portion, 26% to 32%, of total medication errors. Because nurses administer most medications, hospitals must ensure that their nurses and staff are properly trained regarding medication administration procedures. Packaging for many drugs looks similar, so hospitals and providers should make sure that all medications are provided in clearly labeled unit-dose packages. Similarly, many medications sound alike as well and might be confused based on this simple mistake. Reports to the Food and Drug Administration (FDA) about name confusion include the following:

- Celebrex (celecoxib) for arthritis and Celexa (citalopram) for depression;
- Zantac (ranitidine) for heartburn, Zyrtec (cetirizine) for allergies, and Zyprexa (olanzapine) for mental conditions.

The FDA carefully reviews drug names before approval and tracks reports of errors due to drug name confusion, but this area still is a potential hazard for hospitals. Clarification about the correct medication is essential to ensure that the patient doesn't receive a dangerous or superfluous medication.

If something goes wrong, and there is still an opportunity to abort without further harm, then stopping a procedure might be the best idea. Stopping the procedure is especially a good idea for an elective procedure, such as the one here. Hospitals must ensure that procedures are done only when necessary and under the proper circumstances. When

those circumstances change, even last minute, hospitals and surgeons should be prepared to think critically about whether to continue. The surgeon in this case would have done well to consider options before going through with the elective surgery after a medication mistake. Hospitals who allow unnecessary procedures to occur might be found liable if proper supervision and training would dictate that these procedures be delayed or canceled altogether.

Parties involved in medical malpractice suits have several options available to them to limit potentially enormous verdicts that often are widely publicized. "High-low" agreements are one such option that allows parties to agree prior to trial to a minimum and maximum amount of recovery. Plaintiffs are guaranteed the minimum, low, amount regardless of a small verdict or finding for the defense, while the defendants are protected from exorbitant verdicts by the high amount, which sets a cap, limiting the plaintiff's recovery amount. Hospitals and providers should consider discussing such high-low agreements with their counsel and with plaintiffs. These agreements are especially useful when it appears that liability is a possibility, and they can be used to limit damages. High-low agreements have benefits for plaintiffs as well, since they are guaranteed to recovery some money regardless of the jury's determination, thus eliminating some of the gamble of going to trial. This security measure means that discussions can be beneficial to both sides. The high-low agreement here helped the defendant center reduce its overall loss.

Reference

Montgomery County Court of Common Pleas, PA. Case No. 2011-09176. Jan.16, 2014. ✦

Fire during surgery on vocal cords results in $30 million for the injured patient

News: The patient, a 55-year-old woman, underwent surgery to have polyps removed from her vocal cords. The procedure took place at a hospital and was supposed to take only about 10 minutes, with the patient able to return home the same day. However, during the procedure, the surgeon's laser came into contact with the tube placed inside the patient's airway. This tube caught fire and began to burn inside the patient's throat, which caused serious injuries including leaving the patient unable to speak. The patient was moved to a different hospital, where she underwent extensive care and numerous surgeries over more than three months. The patient brought suit against the initial hospital, the hospital's healthcare system, surgeon, and anesthesiologist, and argued that multiple oversights and errors caused the fire. The defendants denied any responsibility. The hospital settled for $12 million, and the jury returned a verdict for an additional $18 million.

Background: In this matter, the patient was a 55-year-old woman who underwent laser surgery at a hospital to have polyps removed from her vocal cords. During the procedure, the surgeon's laser came into contact with the breathing tube used to supply the patient with pure oxygen while she was under anesthesia. The laser acted as an ignition source, and combined with the pure oxygen source from the tube, a fire began in the patient's throat. This fire caused the tube itself to burn, which resulted in severe damage to the patient's throat. The patient was quickly flown to a different hospital. She stayed in intensive care and went through multiple surgeries in an attempt to repair the damage. The patient stayed at this second hospital for more than three months on a ventilator recovering from her injuries. The seriousness of the injuries will require long-term care, as the patient still needs assistance breathing.

The patient brought suit against several parties involved in the accident: the initial hospital, the hospital's healthcare system, the surgeon, the anesthesiologist, and the manufacturer of the air tube that caught fire. The patient alleged that all the parties were negligent and at fault for causing the fire and that failures on multiple levels created the catastrophic event. Initially, the surgeon erred when first firing the laser and missed his intended target. The anesthesiologist also was allegedly at fault for using pure oxygen rather than regular air, because pure oxygen is more flammable. The physicians blamed the hospital for providing only single-cuff tubes rather than the typical double-cuff tubes used for these procedures. Furthermore, the physicians and patient alleged that the manufacturer was at fault for failing to provide warning of similar fires and that the single-cuff tube design was faulty. After a seven-week trial, the jury deliberated for a day and a half. It ultimately found that the anesthesiologist was 52.5% at fault, the surgeon 42.5% at fault, and the hospital 5% at fault; it did not find the manufacturer to be negligent. The hospital settled, prior to the verdict, for $12 million, and the jury awarded an additional $18 million in damages.

What this means to you: Patient safety must be a top priority at hospitals. There are innumerable ways in which a patient might be threatened or harmed based on events common or

uncommon. This case shows a possible catastrophic event that might occur and cause serious harm to a patient, given the right, although unlikely, circumstances. Hospitals and providers should have precautions in place in case of emergencies such as the one here. One thing that the individuals did properly in this case was taking extraordinary efforts to help the patient once the damage was done. Quick action is necessary to prevent injuries from becoming worse, which is a possibility in an emergency situation.

Precautions and emergency plans will help hospitals and providers to prepare their employees for situations that might not be expected. Having general strategies in place will help protect patients from injury and the hospital from subsequent liability. Many hospitals have emergency preparedness plans for situations involving mass casualties, natural disasters, chemical emergencies, etc., but hospitals should provide guidelines to their employees regarding smaller-scale emergencies as well, such as those for a single patient. Physicians and nurses need to be prepared for the worst and know what to do if that occurs. Information on who to contact in an emergency is critical, and this information should be widespread throughout a hospital. If an individual does not know what to do, then that individual should, at a minimum, know who he or she should contact in an emergency.

Multiple parties might contribute to a single event's cause, and some or even all might be at fault for any injuries incurred. Causation plays an important role in medical malpractice cases, as the negligent action must be specifically linked to the injury suffered for the actor to be found liable of negligence. If a hospital acts improperly, but the action does not actually, in fact, cause the harm, then it cannot be found guilty of negligence. For a situation that involves multiple parties, any individual party might be partially at fault. A single party's action does not have to be the "but-for" cause of the injury, however, for it to be liable. A situation might occur where two parties act improperly, but the injury is only caused by the compounded action of both parties: The injury would not have been caused by the first party's improper action or the second party's improper action, but the two combined cause the result. In this case, both parties can be found liable, as their actions caused the injury, despite the fact that another actor also was required to cause the harm. Hospitals thus might be liable in cases of negligence even if their action alone would not have caused the injury. If it contributed to the injury, along with another individual's improper action, to cause the harm, liability may be found.

... surgical fires are a constant threat when electrical equipment is used close to a source of high concentrations of O_2

Hospitals should encourage physicians, nurses, and staff to immediately speak up if there is any concern about a patient's safety or quality of care. There need to be processes to report mistakes, no matter how small, to encourage supervision and oversight. The patient's care is the top priority, so this must care be given preference over an individual being concerned with a superior treating them disfavorably for reporting mistakes.

Hospitals encouraging this type of reporting might consider protecting such internal whistleblowers from reprimands by their superiors. Mistakes happen, even at the best hospitals, so this type of reporting is essential everywhere. Internal oversight is an important feature for hospitals, and it offers strong protection when viewed in a subsequent litigation. If a mistake occurs, hospitals can protect themselves by having proper procedures in place for reporting these mistakes and correcting them promptly. A hospital that ignores problems, instead of acknowledging mistakes and taking affirmative efforts to prevent future mistakes, might be more likely to be found negligent.

Working with especially dangerous instruments requires extra caution and training, which hospitals should provide to those working with such devices. Note that surgical fires are a constant threat when electrical equipment is used close to a source of high concentrations of O_2. The humidity of the OR itself must be high enough to ensure an environment that will not promote arcing or sparking. The lowest concentration of O_2 should be used when the electrical equipment will be in very close contact with the oxygen.

As technology becomes increasingly advanced and prevalent in the medical field, so too must education and training. Laser surgery is far from novel, but poses different, potentially more serious, harms than the traditional scalpel counterpart. Robotic surgery is an even more advanced field, and the liability stemming from these raises even more concerns for hospitals, particularly as these robots, such as the da Vinci Surgical System, use proprietary software that may not be modified by surgeons.

Regardless of the specific type of instrument used, hospitals must ensure that their surgeons are properly trained for the intended instrument, to prevent liability. If a hospital allows an untrained physician to use sophisticated medical equipment, this situation might bring rise to a claim of negligence against the hospital for failure to properly oversee its professionals.

Reference

King County Superior Court, WA. Case No. 12-2-17928-0. Dec. 5, 2013. ✦