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Judgment underscores hospitals' need to help deaf patients, families

Court says hospital wrong to deny interpreter in Lamaze class, birth

Health care facilities risk serious legal penalties if they do not provide effective means of communication to deaf patients or family members, and a recent court case suggests that hospital risk managers may underestimate the need to provide accommodation. Using interpreters only in the emergency room does not solve the problem; it may be necessary to develop a comprehensive policy on how and when the hospital will provide interpreters or other means of communication.

The need for effective communication with deaf patients comes as no surprise to risk managers, but the practical solutions to that problem may be more difficult than imagined. Mount Sinai Medical Center in New York City recently learned the hard way about legally required accommodations for the deaf. The medical center lost a lawsuit after refusing to provide an interpreter for a deaf father-to-be during Lamaze classes and the birth of his child.

Alan Rich, JD, the New York attorney who represented the plaintiff in that successful suit, handles many complaints against health care providers accused of discriminating against the hearing-impaired. He says he is amazed at how often the providers refuse to make accommodation. In every case, he says, the health care provider does not understand how clearly the law requires such accommodation or does not

Executive Summary

Subject:
A recent court judgment should remind risk managers that health care providers have a legal obligation to accommodate the hearing impaired through any reasonable means. That may include some situations you might not expect.

Essential points:
- ❑ The patient is not the only concern. Relatives and other close associates might need accommodation.
- ❑ Accommodation may be necessary in situations not considered clinical care; one court case involves Lamaze childbirth classes.

understand how to work with deaf people.

"It always shocks me to see how risk managers don't look at this as a serious problem," Rich says. "It's a deadly serious problem. There's a certain arrogance that says, 'We're the hospital, so don't tell us how to run the hospital.'"

Rich became involved with the discrimination against deaf people in health care partly because he has three deaf family members. He has represented deaf plaintiffs in several cases against hospitals, but his most recent victory highlights the way hospitals run into trouble where accommodations are concerned. The problem is that the hospitals may see them as gray, but the court sees them as black or white.

Deaf husband's request denied

The Mount Sinai lawsuit was brought by Jeffrey Bravin, a teacher at the Lexington School for the Deaf in New York, whose wife, Naomi, was pregnant in 1997. Naomi Bravin is not deaf. When Jeffrey Bravin attempted to take part in his wife's Lamaze class at Mount Sinai, the hospital would not provide an interpreter so he could understand the instructions. His wife could communicate with him, of course, but Rich explains that she was unable to translate in sign language while participating in the class.

The Bravins requested an interpreter for the Lamaze class but the hospital refused, saying Naomi Bravin, not her husband, was the patient. Because Naomi Bravin could hear the Lamaze instructions, the hospital claimed it had no obligation to provide an interpreter. The Bravins involved their attorney, who sent the hospital a policy letter from the U.S. Department of Health and Human Services explaining the need for accommodation. That letter states that "if prenatal classes are offered as a service to both husbands and wives, a hearing impaired husband must be provided with auxiliary aids so as to afford him the same opportunity to benefit from the services as non-handicapped husbands."

Despite that seemingly clear interpretation of the law, the Bravins never received an interpreter for the Lamaze class. The hospital continued to deny the aid, according to court documents, by saying Lamaze classes were not offered to both parents. The classes were officially "offered" only to expectant mothers, though fathers were allowed to attend, so accommodation was necessary only for the mother, the hospital contended.

When the child was born Sept. 13, 1997, the Bravins were unable to use Lamaze methods properly because the husband was unable to do his part. In addition, there was no interpreter in the birthing room because the hospital again refused to provide one, Rich says. Naomi Bravin tried to explain the Lamaze procedures to her husband and to interpret what the doctors and nurses were saying, all while she was having the baby. The result, Rich says, was an absurd scene that left the husband bewildered and both parents frustrated to the point of tears.

To make matters worse, the newborn boy remained in the neonatal intensive care unit for a week after the birth, and the hospital still would not provide an interpreter, Rich says.

"My wife is hearing, but she has been so upset at what has been happening to our baby that she can not interpret," Jeffrey Bravin wrote in a Sept. 19, 1997, court affidavit in an effort to obtain an interpreter. "She has been crying. I want to speak directly with those in charge of my baby's case."

In New York, a sign language interpreter charges about $70 for a two-hour session.

Throughout the pregnancy and after the childbirth, the hospital maintained that it had no obligation to provide an interpreter because the patient was hearing, Rich says. The implication was that the hospital would have provided an interpreter if the mother had been deaf.

Judge Robert Sweet of the U.S. District Court in New York disagreed, ruling April 16 the hospital violated state and federal laws requiring accommodations for the disabled. The lawsuit focused on the Lamaze classes, though Rich contends the hospital also was obligated to provide an interpreter during the birth. Sweet granted summary judgment after reviewing the case, saying the hospital had violated the Americans with Disabilities Act (ADA) and the Rehabilitation Act. He will conduct another hearing to award damages.

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The attorney handling the case for the hospital, **Ricki Roer**, JD, says hospital officials were gratified that the judge denied the efforts of a group representing the deaf community to join the case. The hospital has filed an appeal of the summary judgment, she says. Roer declined to comment further on the case.

While some risk managers may see the Lamaze demand as an unnecessary accommodation, those who work closely with the deaf say the need is clear. At Southwest Washington Medical Center in Vancouver, WA, **Marcia Maynard**, interpreter and accessibility coordinator for the hospital, says, "Absolutely we would provide an interpreter in that situation. We wouldn't even question it."

Accommodating loved ones

At her facility, Maynard says, staff provide necessary accommodation to any family member or significant friend. "That's pretty much anyone who is close enough to the patient that they are a significant part of the patient's support system," she says. "In a Lamaze class, the husband certainly is a significant person. We don't provide interpreters for just someone visiting the patient, but you are not providing good care if you leave the patient unable to communicate with the important people in her life."

The plaintiff's attorney says the case is a good illustration of how hospitals and other providers can suffer legal liability by not adequately understanding the needs of the hearing impaired. Mount Sinai administrators tried to minimize the needs of the deaf husband, Rich says, taking an oversimplified view of what it means to accommodate the deaf. Many administrators would say it is necessary to provide interpreters or other aids for the direct communication between patient and physician, but Rich says the Mount Sinai case illustrates that the law requires much more.

Risk managers may balk at the idea of providing an interpreter for family members, and the Bravins' attorney notes that such an accommodation would not be necessary in all cases. In this particular case, the father was seen as an integral participant in the Lamaze class and childbirth rather than, for instance, just a relative who stopped by to see how the patient was recovering.

Another question is why the parents did not provide their own interpreter. Surely they had access to one because the father teaches at a school for the deaf, and some would argue that it was their responsibility to provide the interpreter

Don't just depend on written notes for deaf patients

Exchanging notes is prohibitively slow

The recent ruling against Mount Sinai Medical Center in New York City does not mean you have to provide sign language interpreters for every situation involving a deaf person or relative, says **Alan Rich**, JD, the New York attorney who represented the plaintiff in the case. For some routine matters such as taking blood, it may be acceptable to communicate in writing, especially if the patient is familiar with the routine. But Rich does caution that you should not depend too much on using written notes with deaf patients — a common mistake that can have deadly consequences.

"Writing notes back and forth is going to be 25 times slower than conversation," he says. "If you want to discuss a patient's heart condition, the diagnosis, treatment opportunities, and informed consent, that 20-minute conversation is going to take 25 times longer if you write notes. Think any doctor is going to stand around for eight hours writing notes back and forth?"

Information exchange suffers

The result often is that patients are ill-informed and the doctor does not receive adequate information about the patient's condition. Consider the typical, rapid-fire conversation between doctor and patient: "Where does it hurt? More here or less there? Is it a sharp pain or a dull pain?" That long give-and-take may be boiled down to a couple of notes asking where the pain is, amounting to an incomplete assessment.

And a poor assessment can lead to malpractice claims, Rich notes. "It seems to me that hospitals should want to provide effective communication, if only to avoid the malpractice lawsuits that will follow when the staff does not communicate," he says.

The attorney also cautions that health care facilities must be careful in setting up "language banks," which usually are lists of hospital employees, volunteers, and professional interpreters who can be called to interpret different languages, including sign language. Rich notes that most facilities do not require certification in sign language skills, just accepting volunteers' claims that they are proficient enough to interpret in a clinical situation. That, he says, is a mistake. "Would it be OK to have a hospital administrator just say, 'By the way, I also can perform orthopedic surgery?' " ■

Source

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in a non-emergency. The ADA says otherwise.

"The ADA says people with disabilities are not second-class citizens," Rich says. "It makes [a person] a second-class citizen to say [he or she] can't participate in the same activities you and I do. They should be able to participate, and you have to make reasonable accommodations."

Southwest Washington Medical Center decided to improve its accommodations for the deaf nearly 10 years ago, and now the administrator in charge of the program says any health care provider would be well advised to do the same. When the hospital wanted to address the problem, it began by meeting with representatives of the local deaf community, Maynard says. The hospital and the community representatives decided a consultant should be hired to help the hospital improve its services, and the deaf representatives selected the consultant.

"The committee also determined that it would be best to have someone full time on staff whose sole focus is accessibility and nondiscrimination for the patients and families we served, as well as in our own workplace," she says. "They wanted to have a full-time interpreter on staff, also, so they hired me to fulfill both needs."

Maynard is available for interpreting as a main function of her job, but she also contracts with several interpreters in the community. The committee helped the hospital set up an overall set of policies and procedures regarding accommodation for the deaf, and then the committee disbanded. Maynard still works with the consultant occasionally when she encounters difficult cases.

One recent example involved a 16-year-old deaf girl delivering a baby at the hospital. The hospital offered interpreting services to the girl at no cost, but the girl's mother refused, saying she would interpret instead. "Her language and interpreting skills were not at a level we were comfortable with, plus there were some anger issues, so we felt there would not be effective communication," she says. "The patient herself was too frightened to insist on the assistance she needed."

After consulting with some experts in civil rights and disabilities, Maynard determined that the clinicians needed an interpreter as much as the patient so that they could properly do their jobs. She was ready to insist that the mother allow a professional interpreter, but the situation was resolved without a confrontation.

"A nurse with deaf children took the mom aside and, mother to mother, convinced her that it was best to have a qualified interpreter come in," she says. "Even with an extensive program in place, there still are these moments when we don't quite know what to do and have to work hard to find the right solution."

The program apparently works so well at Southwest Washington Medical Center that deaf patients treated there at one time occasionally call Maynard from their hospital beds in another facility, in another state, seeking her help when they can't get help where they are admitted. ■

Consult local groups on hearing impairment

Most health care facilities need a more comprehensive policy on accommodating the hearing impaired, say some experts who deal with related discrimination claims.

A formal policy will help health care providers overcome some ingrained assumptions about the hearing impaired, says **Jackie Roth,** a consultant in New York City who works with hospitals and other companies to develop such policies. She says many people are well-intentioned when working with the hearing

(Continued on page 70)

Executive Summary

Subject:
A comprehensive policy may be the best way to ensure your facility provides effective communication to the hearing impaired.

Essential points:
- ❑ You will need to learn more about the different needs of deaf people.
- ❑ Sign language interpreters are not the only solution and may not be useful for some patients.
- ❑ Accommodating the deaf will require some time and money but is within reach of all providers.

Auxiliary Aids Currently Available at SWMC

Updated Aug. 1, 1998

ASSISTIVE DEVICES AVAILABLE THROUGHOUT FACILITY:

- ❒ Pay telephone amplified for people with hearing loss
  — All pay telephones located in SWMC service areas have the amplification feature.
- ❒ Pay telephone: TTY/Text Telephone/TDD, for people with profound hearing loss
  — SWMC has two pay-telephone TTYs available for public use 24 hours a day.
  — Locations: medical center main lobby and emergency department waiting area
- ❒ Television with built-in closed caption decoder for patients with hearing loss
  — All televisions in waiting areas and about 50% of televisions on nursing units have the closed-caption-decoder feature built in. The set will have either a "caption" button on the front or a menu feature. Activate captioning by choosing CCI.

CONTACT ENGINEERING DEPARTMENT AT EXT. 2087 FOR THE FOLLOWING:

- ❒ Portable amplified telephone for patients with hearing loss
- ❒ Portable TTY/Text Telephone/TDD for patients with profound hearing or speech loss
- ❒ Portable television with built-in closed caption decoder for patients with hearing loss
- ❒ Specialized nurse-call equipment for patients with paralysis or limited physical ability

CONTACT INTERPRETER/ACCESSIBILITY COORDINATOR AT EXT. 2109 FOR THE FOLLOWING:

- ❒ Needs assessment support — cultural diversity/accessibility
- ❒ Interpreter services for patients who are deaf or who do not speak English
- ❒ Point-talk tools for patients who are literate in their native non-English language
- ❒ Large-button audiocassette player for patients with vision loss
- ❒ Communication picture boards for patients with limited use of language
- ❒ Vibrating/visual alarm clock for patients with hearing loss
- ❒ Large-face alarm clock for patients with low vision
- ❒ Portable "pocket talker" voice amplifier for patients with hearing loss
- ❒ FM amplification system for hard-of-hearing participants in group settings
- ❒ Real-time captioning services for deaf/hard-of-hearing participants in group settings
- ❒ Speaker telephone for patients with limited physical ability
- ❒ Large-button telephone for patients with vision loss or limited physical ability
- ❒ Large-dial telephone for patients with low vision
- ❒ Rotary-dial telephone for patients who are blind

CONTACT AUDIOVISUAL MEDIA SPECIALIST AT EXT. 3159 FOR THE FOLLOWING:

- ❒ Infrared amplification system for hard-of-hearing participants in group settings

CONTACT FAMILY BIRTH CENTER AT EXT. 4000 FOR THE FOLLOWING:

- ❒ Visual baby-cry alarm for patients with hearing loss

Please note: This is not an exhaustive list. After an assessment, it may be possible to obtain other auxiliary aids through rental businesses and new purchases. Contact the interpreter/accessibility coordinator at ext. 2109 for more information.

Source: Southwest Washington Medical Center, Vancouver, WA.

impaired, but they do not have the knowledge needed to communicate effectively.

"A lot of people have not known someone with a profound hearing loss, so they are just unfamiliar with what it is like to try to communicate with them," Roth says. "Many deaf people are very uncomfortable being deaf and will not ask for help when they need it. That leads to situations in which the message just does not get across."

"If these patients learn that they can effectively communicate with the physician at your facility, they will come to your facility every time."

People with hearing impairments are reluctant to ask speakers to repeat themselves, for instance. Most will ask no more than three times before giving up, says Roth, who has a hearing impairment herself. After that, they may pretend to understand or to be disinterested.

"A lot of people assume that deaf people are fabulous lip readers," she says. "Some are, but statistics show that they get only about 30% of the words spoken, and the rest comes from context. If the other person is talking about a medical condition that is completely unfamiliar to you, with many words you have never encountered, just imagine how difficult that is to lip-read."

Health care providers also can be misled by a patient or family member's initial understanding at the start of a conversation. A deaf person may understand a simple question like, "Does this hurt?" or "How are you today?" and that leads the doctor or nurse to think effective communication is occurring. But as soon as the conversation moves to more involved matters, there may be no understanding at all.

If hospitals need another reason to enact effective procedures for dealing with the hearing impaired, revenue potential is a good one. Deaf people and their families make up a significant base of potential revenue, says **Alan Rich**, JD, the attorney who represented a deaf man and his wife in a discrimination suit against Mount Sinai Medical Center in New York City.

"If these patients learn that they can effectively communicate with the physician at your facility, they will come to your facility every time," he says. "They will be very loyal because they receive better care. The revenue could more than make up for the cost of an interpreter."

Providing effective communication also can help cut down on unnecessary emergency department visits, Roth says. Many deaf people seek help in the emergency room because they are unable to contact physicians for appointments, for instance. If you provide the means for them to make appropriate contact for your services, they will gladly take advantage of them, she says.

He notes that many of the strategies put in place for helping hearing impaired patients will be of benefit to hospital employees as well. There are about 23 million people in the United States with some degree of hearing loss, according to statistics from the National Institutes of Health.

"Every hospital wants to provide the best health care service to everyone who walks through the doors, and they should want to do the same for deaf people," Roth says. "The only way they can do that is to overcome the communication barrier. It's not as difficult as a lot of people think."

Solutions often less costly than expected

Marcia Maynard, interpreter and accessibility coordinator for Southwest Washington Medical Center in Vancouver, WA, says her hospital has found that developing policies and procedures is not overly burdensome. She cautions that you should not focus exclusively on the need for sign language interpreters because that is only part of the solution.

A good accommodation program also involves educating staff and providing equipment used to communicate with the deaf, solutions that tend to be less expensive than many people think when they consider hiring a sign language interpreter. (**See p. 69 for a list of auxiliary aids available at Maynard's hospital.** The list is made available to staff and patients.)

Roth, Rich, and Maynard offer this advice for improving communication with the hearing impaired and developing a facility response:

1. Remember that deaf people have different abilities and needs.

Not every deaf person is going to want a sign language interpreter, and many cannot read sign language. Likewise, many cannot read lips.

2. Try to enunciate clearly when speaking to someone with a hearing impairment.

Speaking slowly, loudly, and clearly, which is

Source

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silly when trying to communicate with someone who doesn't speak English, is the best strategy to use with the hearing impaired, who may be trying to read your lips or may be able to hear slightly, Roth says. Also, remember to face the listener and not obstruct the view of your face with a clipboard or anything else.

Heavy accents may be more difficult to understand. People who have strong accents should be especially careful to speak clearly, and it may be better to have someone else do the talking.

3. Use nonverbal cues to your advantage.

Deaf people often look for nonverbal cues when communicating, such as the other person's facial expression, body stance, and hand gestures. Use those to your advantage if you are having difficulty communicating with a deaf person, Roth says.

Also, beware of misunderstandings caused by the way deaf people interpret nonverbal signals. A doctor may have an unpleasant look on his face because of an unrelated matter, such as a message he just received about another case, but a deaf patient straining for context cues may think it means bad news.

4. Consult local groups representing the hearing impaired.

Input from your local community is important because it may provide information about problems encountered in the past or the needs of particular ethnic groups, for instance. Enlist the aid of community groups in designing your policy, Rich says, but do not consider them your "experts" on accommodating the deaf.

"That's like suggesting that just because you're black, you're an expert on how to fix the problems affecting the black community," he says.

5. Make sure your policy conforms to state and federal laws.

Remember that some state laws will be stricter than federal requirements. Some laws will require you to provide an interpreter or other accommodation within a certain amount of time.

6. Understand the different methods of accommodation and communication.

It is not necessary for most staff to learn sign language, but it is important for risk managers and clinicians at least to understand how the hearing impaired communicate. American Sign Language, for instance, is not just the alphabet signed on the hands.

In many cases, a deaf person will need only a minor form of accommodation and not a sign language interpreter. You have to ask what would help the person communicate better.

"You should explain that your goal is to communicate effectively and you want to provide whatever will help make that happen," Maynard says. "When you ask how to help, often the patient will tell you that, 'Yes, I speak sign language, but all I really need right now is a new battery for my hearing aid.'" ■

Billing fraud victory called good omen for doctors

A recent court ruling in Texas is being hailed as a major victory for health care professionals who feel persecuted by federal prosecutors. The action suggests that even a single health care provider can indeed stand up to the government and successfully defend against charges rather than having to make a begrudging settlement.

The case offers important lessons for risk managers, suggests the attorney who successfully defended the doctor. First, the verdict shows that

Executive Summary

Subject:

A Texas doctor recently won a case in which federal prosecutors had accused him of fraudulently billing for medical services. The victory is seen as noteworthy because health care professionals rarely win such battles against the government.

Essential points:

- ❑ The case shows that it sometimes is worthwhile to fight fraud charges in court.
- ❑ Allegations of wrongdoing by an employee of the physician suggest the need for closer oversight of financial matters.
- ❑ Fraud charges can be manufactured against a physician or other provider.

health care providers should not assume a settlement is the best way to respond to federal fraud charges. Second, the case illustrates a risk area that could be overlooked by busy risk managers: fraudulent billing in small physician practices affiliated with your hospital or health system.

The case involved Anthony Valdez, MD, a physician in El Paso, TX, charged with defrauding a number of health care companies by submitting fraudulent bills. An El Paso jury took only 20 minutes to acquit Valdez of the charges. His attorney, **Frederick Robinson**, JD, in Washington, DC, says the victory could signal a new attitude in the way some health care providers react to the now common charges of billing fraud.

Health care providers typically settle such cases because they are unable to risk the financial loss that could come with the decision to take the government all the way to court. Pursuing the case in that manner probably would prompt the government to suspend the provider's participation in Medicare and Medicaid until the case was resolved, and most institutions just cannot afford that kind of financial loss, he explains.

In the Valdez case, however, the government did not charge him with defrauding Medicare or Medicaid, only private insurance companies, so there was no risk of losing participation in the government programs. That freed Valdez to defend himself in court as vigorously as he wished.

"For most providers, suspension of payment is equivalent to a death penalty before you've had a trial, so they're willing to give in to unreasonable demands to avoid even worse outcomes before you can even get to court," Robinson says. "But if you don't have that threat hanging over your head, remember that you have a chance in court. This case shows that a provider can go up against the government and win."

The case against Valdez, a solo practitioner, began when a former employee of the physician's practice reported to federal investigators that the doctor was billing for services not rendered. Federal investigators found no evidence of fraudulent billings in the Medicare or Medicaid programs, but they alleged that there was evidence of fraud in bills submitted to private insurance companies and prosecuted the doctor for those.

Robinson says the doctor's defense hinged on his allegation that the former office manager had been caught embezzling from his office and contacted federal authorities out of revenge, or possibly to cover her tracks. The attorney says the office manager "was able to create money the doctor wouldn't miss by overbilling the insurance companies without the doctor's knowledge." She would submit false claims to the insurance company by slipping them into a stack of documents the doctor was to sign, Robinson says. The allegations against the office manager were made in court as part of the defense, but they are unproven; she has not been charged with a crime.

Doctor determined to prove innocence

Valdez signed the false claims and did not provide the services, so at first glance, it may have seemed that the doctor had committed fraud. That first impression may have convinced some providers to settle the case quickly, but Robinson says Valdez was determined to prove that he had no knowledge of the fraudulent claims. In court, the doctor explained that the claims involved in the fraud case represented less than 1% of his practice.

"The jury may have concluded that the amount of claims at issue were so small that the fraud could have been an oversight by the doctor and not a pattern of fraudulent conduct," Robinson says. He says the case illustrates the need for a corporate compliance program even in a small practice. Valdez did not have such a program. If he had, he probably would have caught the billing irregularities before they came to the government's attention, Robinson says. "This case shows that no matter how large or small your practice, it's beneficial to have some sort of compliance program in place to protect yourself in case you ever come under investigation," he says.

"Even a solo practitioner can pay an outside organization to come in and audit sample billings on a regular basis," Robinson points out. "A solo practitioner doesn't need the same compliance program as a multistate hospital, but there still are things you can do to show you are being careful in how you conduct business with government health care programs." ■

Source

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Reader Question

Risk managers should review contracts

But be careful not to get in over your head

Question: How much should I be reviewing contracts that the hospital enters into? I'm not a lawyer, but as risk manager I think I should have some role in checking contracts for liability exposure. Are there any pointers about what I should be looking for?

Answer: Risk managers should be involved in the review process for some, if not all, contracts involving the health care organization, says **Roy Bossen**, JD, partner with the law firm of Hinshaw & Culbertson in Chicago. He has represented hospital and physician groups in transaction and regulatory matters for more than 20 years.

The degree to which you review contracts can depend on several factors, mainly your background and experience. If you have a legal background, you will feel more comfortable reviewing contracts, Bossen says. But even if you came to risk management from a clinical or business background, you still should have enough familiarity with the issues to review contracts for liability, he says.

If you have in-house legal counsel, your responsibility for reviewing contracts may be minimized, but you still should have a role. Without in-house counsel, your role could be more significant. Either way, you may be only one of several people reviewing the contract for liability.

Keep in mind, however, that risk managers should not take on more responsibility than is reasonable when reviewing contracts. Some contracts will be so complicated, and the potential risk so great, that they should be reviewed carefully by counsel even if that means retaining outside counsel for the job.

"Today, anything to with physician referrals, tax exemptions, Medicare, or Medicaid should involve your in-house counsel, or you should retain counsel to look at it," Bossen says. "The consequences of not picking up something justify the added time and expense. The risk manager still probably should look at it first."

It may not be necessary for you to review every contract involving the hospital, but you should have a set policy on what type of contracts must get your approval. In many cases, a health care organization will establish that contracts over a certain dollar amount must be reviewed and some types of contracts, such as physician group agreements, must be reviewed. When reviewing contracts, the best approach is to look for certain red flags or omissions that could cause trouble, Bossen says.

"You can work with counsel to develop checklists to look for certain things in certain types of contracts," he says.

Remember these three tips

With that in mind, here are three general tips for reviewing contracts:

1. For a service contract with a physician group or corporation, what are the insurance requirements for continuing coverage? Are you required to purchase tail coverage?

2. What services are being provided to you? This sounds basic, but Bossen says many contracts do not adequately specify what it is you are buying or providing. If you do not settle that issue before signing the contract, you may have to deal with disagreements later in which one party is demanding service the other party says is not included in the contract.

3. In entering into a consulting agreement, make sure the contract clearly defines the scope of service and establishes a clear structure for paying the consultant.

"I've seen situations where the final product is delayed or the client believes it was never delivered, yet the contract requires the consultant be paid 100% of the payment on a certain date," Bossen says. "Then you have to sue for breach. It's better to have clear demarcation lines that say the consultant gets paid in increments when certain steps are implemented." ■

Source

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Study shows best doctors may be sued the most

You know that doctor everyone thinks just isn't quite up to speed and isn't really the one you'd choose to take out your gallbladder? He's not the one most likely to be sued for malpractice. It's the doctor who would be your first choice when you go under the knife.

That's the conclusion of a new study that may have been overlooked by risk managers because it was published in a journal devoted to family practice. The study suggests that the highest likelihood of being sued for medical malpractice lies with those physicians who are seen as the most knowledgeable and experienced.

Everyone involved with the research was surprised by the results, says lead author **John Ely**, MD, associate professor of family medicine at the University of Iowa in Iowa City. The research determined that risk factors for malpractice claims included graduation from a U.S. or Canadian medical school, specialty board certification, the American Medical Association's Physician's Recognition Award, and membership in the Alpha Omega Honor Society for physicians.[1] Those are all good traits, so the research counters the common belief that the doctors who are sued the most are the doctors who deserve to be sued the most.

'It doesn't mean they're bad physicians'

"Risk managers might want to reassure physicians that even if they've had some suits, it doesn't mean they're bad physicians," Ely tells *Healthcare Risk Management*. "You also could look at this data and say that being a great physician, in a technical sense, doesn't protect you against malpractice."

Ely and his colleagues studied family physicians who practiced in Florida between 1971 and 1994. The results do not necessarily apply to all other medical specialties, but Ely says there is reason to believe the results would be substantially similar. The researchers collected data from the Florida Department of Insurance, which since 1974 has maintained a database of closed medical malpractice claims. The database was mandated by state law after malpractice claims skyrocketed in the mid-1970s. The state database includes records of more than 52,000 lawsuits against physicians.

The data show that for physicians with 10 or more years in practice, the risk of being sued at least once was 56% among those in a high-risk group, such as board-certified male physicians graduating from a U.S. medical school, whereas the risk was only 17% among physicians in a low-risk group, such as nonboard-certified female physicians from a medical school outside the United States. Physicians with three or more claims were most likely to have characteristics associated with greater knowledge. Also, physicians whose malpractice suits resulted in payment were more likely to be more knowledgeable.

There are several potential explanations for the findings. Ely refers to previous research showing that physicians with poor interpersonal skills are more likely to be sued and suggests there could be a connection. It is possible, he says, that physicians who have achieved great success and acquired great knowledge may tend to have poor interpersonal skills. "I don't know why they would have the worst interpersonal skills, unless you think of the stereotypical student studying all the time, never going out to party," he says. "That student doesn't develop interpersonal skills but develops great technical knowledge that will be recognized within the profession. Just a theory."

Another possible explanation is that the most knowledgeable physicians care for the sickest and most challenging patients, inevitably leading to some bad outcomes that could prompt lawsuits. Though the exact cause of the association between malpractice suits and medical knowledge may not be clear, Ely says the results clearly show a history of malpractice suits is not proof that the doctor's skills or knowledge are inadequate. "I've gotten feedback from physicians who are glad to hear this. There was one letter from a physician in California who thanked me. He said he had been sued three times, but his board scores were always in the 90th percentile and he couldn't figure out why he was getting sued."

Reference

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Source

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JCAHO issues advice on infant abductions

Eight cases analyzed in sentinel event review

The Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, has completed its analysis of eight infant abduction cases and is now offering the latest advice on how to prevent these devastating crimes.

The Joint Commission began tracking sentinel events three years ago. Infant abductions automatically are considered sentinel events, so each of the eight events was followed by a comprehensive review of the systems and procedures that may have allowed the incident. The Joint Commission's review included the root cause analysis the health care provider completed in each case.

Most at risk: Larger hospitals

Here is some of the information and advice gleaned from those analyses:

- All of the abductions took place in hospitals with more than 400 beds.
- Five of the events occurred in the mother's room, while two were in the newborn nursery, and one took place in the neonatal intensive care unit.
- Seven of the infants later were recovered unharmed, most within a few hours, and there was no evidence of violence to the mother or child. One of the infants is still missing.
- All of the abductors were female. In three of the cases, a woman impersonated a nurse or aide. In the other abductions, a woman pretended to be a volunteer, a physician, or the infant's mother. In one of the cases, the birth mother abducted a child who had been placed in the state's custody from a neonatal intensive care unit.
- Infants were abducted when taken for testing, during return to the nursery, when left unattended in the nursery, or while a mother was napping or showering.
- Three of the eight hospitals reported the discovery of failed abduction attempts shortly before the abduction occurred.
- In four cases, abductions took place during the day shift. Abductions occurred during the evening shift in two cases and during the night shift in two cases.

The Joint Commission's sentinel event investigation requires the provider to determine the root causes of the event. In the infant abduction cases, the root causes were similar. All the hospitals identified unmonitored elevator or stairwell access to the postpartum and nursery areas as a root cause.

Other root causes fell into the following six general areas:

1. security equipment problems, such as security equipment not being available, operational, or used as intended;
2. physical environmental problems, such as no line-of-sight to entry points as well as unmonitored elevator or stairwell access;
3. inadequate patient education;

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4. staff-related problems such as insufficient orientation / training, competency / credentialing issues, and insufficient staffing levels;

5. information-related factors such as birth information published in local newspapers, delay in notifying security when an abduction was suspected, improper communication of relevant information among caregivers, and improper communication between hospital units;

6. organizational culture factors such as reluctance to confront unidentified visitors and providers.

Strategies to prevent abductions

In consideration of those causes, the Joint Commission suggests that hospitals take these preventive steps:

- Develop and implement a proactive infant abduction prevention plan.
- Include information on visitor and provider identification as well as identification of potential abductors / abduction situations during employee orientation and inservice programs.
- Enhance parent education concerning abduction risks and parent responsibility for reducing risk and then assess the parents' level of understanding.
- Attach secure identically numbered bands to the baby (wrist and ankle bands), mother, and father, or significant other immediately after birth.
- Footprint the baby, take a color photograph of the baby, and record the results of the baby's physical examination within two hours of birth.
- Require employees to wear up-to-date, conspicuous, color photograph identification badges.
- Discontinue publication of birth notices in local newspapers.
- Consider options for controlling access to the nursery / postpartum unit such as swipe-card locks, keypad locks, entry point alarms, or video surveillance (any locking systems must comply with fire codes).
- Consider implementing an infant security tag or abduction alarm system.

(Editor's note: For more on strategies to prevent infant abductions in your facility, see Healthcare Risk Management, *July 1998, pp. 77-87.)* ■