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In a settlement, seeing change may be what a plaintiff wants instead of money

Trend presents challenges but can be good opportunity for settlement

The bottom line for settling malpractice lawsuits long has been what numbers to put after the dollar sign. But that is changing fast.

Where plaintiffs once focused entirely on the settlement amount, even when they had heartfelt grievances, today's plaintiffs are much more likely to demand that you change whatever they think led to their tragedies.

In some cases, promising to change policies and procedures isn't enough. Plaintiffs sometimes demand to be directly involved in the improvement process by sitting on a review board or speaking with physicians and staff about their experiences.

If you haven't yet encountered these demands for a noneconomic settlement, you soon will, says **Martin J. Hatlie**, JD, president of the Partnership for Patient Safety in Chicago and a frequent mediator for medical malpractice cases. Your response can determine whether the dispute escalates or is resolved in a way that leaves everyone satisfied. These plaintiff demands can be an opportunity if the risk manager responds appropriately, he says.

"I think we're seeing more of it, and it's just beginning," Hatlie says. "There is so much dissatisfaction with how the legal system works in handling malpractice claims that I think we're going to see much more."

Plaintiff wanted to prevent more errors

Noneconomic settlements are an opportunity for the health care provider to address the issues that most concern plaintiffs, says **Susan Sheridan**, who lives in Eagle, ID, and has been the plaintiff in two malpractice cases involving more than money. **(See p. 28 for more on Sheridan's experience.)**

Sheridan's pursuit of noneconomic settlements was spurred partly by her experience in suing one hospital for brain damage suffered by her child.

"The experience showed me that litigation is a dishonorable process. I found that it had nothing to do with the truth or patient safety," she says.

"It had nothing to do with compensating the people who really deserve it. It had to do with lawyers trying to out-lawyer each other and expert witnesses paid huge sums of money with no oversight."

Sheridan's advice for risk managers: Look at requests for noneconomic settlements as the plaintiff offering to be a partner in improving patient safety.

"They want to work with the institution. They're not just out for money or revenge," she says. "You can establish a much less adversarial relationship with the plaintiff if you agree to sit down and discuss this up front. Risk managers may find that plaintiffs are more likely to settle if you offer some type of policy change or institutional change. It may reduce the payment because the plaintiffs will be fulfilled in areas they think are more important."

The focus on noneconomic damages is a by-product of mediation, Hatlie says. When plaintiffs request something other than money, they usually want the health care provider to change policy or implement a training program, he says.

Research shows that plaintiffs want acknowledgment that something went wrong, an apology, and changes to ensure that the same tragedy doesn't happen to another family, Hatlie says. Those are the feelings that lead to request for noneconomic settlements.

They want more than just a general promise that you will look into the situation and address whatever deficiencies you find. They want specific requirements written into the settlement.

Most of the requests are reasonable, Hatlie says, and the defendant often is already making the changes requested.

"We often see it as part of the defense, when they claim that they've done something to remedy this situation," he says. "But sometimes they're reluctant to discuss it because it can look like an admission that they were negligent in the first place. A lot of times, it just amounts to putting it in the settlement document for the plaintiff and not necessarily doing something you didn't want to do just because the plaintiff said to."

Good news if handled well

Though noneconomic settlements may seem like a challenge to risk managers and attorneys used to hammering out deals solely based on a dollar figure, Hatlie says they represent a good opportunity.

"I think it's a good development for hospitals because it is a new way for hospitals to negotiate. If they discuss some of these requests they might be able to settle the case for less than they would otherwise," he says. "There are some great settlement opportunities here; but if you just refuse to even mediate these requests, you may end up making the plaintiff even more angry than before and going to trial."

One risk manager who uses noneconomic settlements is **Sheila Stieritz**, RN, BSN, director of patient safety at Abington (PA) Memorial Hospital. Stieritz says she often discusses noneconomic issues with plaintiffs and finds them a way to make the negotiation more constructive.

"Often, it takes the form of education classes

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conducted within the hospital, or some other sort of effort that addresses whatever the plaintiff thinks went wrong," she says. "We've had experiences in which this worked well to bring about a more cooperative feeling and helped everyone feel that they achieved something positive in the end."

Hatlie and Stieritz advise risk managers to be receptive when plaintiffs bring up the idea of noneconomic settlements. Don't be defensive and react as if the plaintiff is stepping on toes and trying to run your hospital.

"Be open to it and evaluate it to determine if it is an opportunity to make a case go away faster and for less money," Hatlie says. "It's new territory and not a lot of precedent yet; but if you can give plaintiffs an explanation and show them the change they want, you may be able to chase away a lot of lawsuits."

The most impact might be felt in cases where the patient has died and the family wants to see something positive come from the loss, he says. When the patient is alive and there is an enduring economic burden for ongoing care or lost wages, there will be less opportunity to negotiate noneconomic damages as an alternative to cash payouts. However, the family still may want noneconomic concessions in addition to the money.

Lawyers not likely to offer

Ideas for noneconomic settlements almost always originate with the plaintiffs, not their attorneys. Even when plaintiffs are eager for such an agreement, their own attorneys may resist the idea and discourage its pursuit.

That's what happened with one of Sheridan's cases that Hatlie mediated. Hatlie says Sheridan's attorneys kept saying, "You're going to blow the settlement. The money is most important."

Sheridan had to speak up herself to say the money was not her top concern.

"The plaintiff's attorneys want the money. They want to see the biggest possible award so they can get the biggest possible percentage," Hatlie says.

If the plaintiff's attorneys don't suggest anything, bring it up yourself, Stieritz suggests. She often does. Hatlie notes that in mediation, it usually is possible for the risk manager and plaintiff to have a direct dialogue; that is the time to ask if there is anything you can do besides the financial settlement.

Stieritz suggests it is best to wait until you get a sense for whether the plaintiff might be receptive to noneconomic settlement provisions before making any offer. You usually can tell right away if the plaintiff is interested in such changes or just wants money, she says, and don't wait too long to bring up the subject.

"Our experience has been that the sooner you make this kind of offer, the better it will be received and the more good you can do with it," she says. "If you wait until later when the negotiations are getting tough, it can be perceived differently, as if you don't really want to offer it in good faith but you're just doing using it as a tactic."

Stieritz says Abington looks at noneconomic settlements as something that should at least be considered in every negotiation with a plaintiff. In most cases in which they are used, she says they generate a feeling that some good came out of the situation.

"These are plaintiffs who really do want to do something positive. They have a real altruistic side," Stieritz says. "It's something we want to encourage and it fits with our efforts to constantly improve."

Sheridan urges risk managers to see noneconomic settlements as an opportunity for everyone to walk away satisfied. More than merely going along with the request, she says risk managers should actively work with the plaintiff to arrange a settlement of more than money.

This strategy isn't a way for the hospital to avoid paying what you reasonably owe the plaintiff, but it is a way to keep that claim from escalating into something unreasonable.

"Seize this opportunity with both arms, because this is a plaintiff who wants to be constructive and not destructive," she says. "If no one will listen to that plaintiff except their own attorney, the case can explode. If the hospital and risk manager will communicate and turn that error into something positive, I guarantee you it will be a much less adversarial experience and everyone will be more satisfied." ■

A plaintiff who wanted more than just money

When two medical tragedies struck **Susan Sheridan's** family in Eagle, ID, one of her responses was typical and, most would say, entirely justified. She contacted an attorney and sued the health care providers for malpractice. But Sheridan took a different path from most plaintiffs by focusing more on quality improvement than the amount of money in the settlements.

Eight years ago, her son was born healthy but suffered kernicterus, brain damage from untreated jaundice, at 5 days old. Despite the concerns expressed by Sheridan's husband and herself, the medical staff insisted that the jaundice would clear up on its own. By the time the severity of the jaundice was realized, the baby had suffered irreversible brain damage.

"Because of cost-cutting efforts and relaxed guidelines, they had stopped testing babies for their level of jaundice. Everybody told us that kernicterus didn't happen anymore in this country and they didn't need to do anything," she says. "They called him 'the canary baby' and joked about how yellow he was."

Now her son has severe cerebral palsy, can't walk, is hearing-impaired, and has crossed eyes and malformed teeth. Sheridan sued for monetary damages to cover the cost of caring for her child and received a multimillion-dollar settlement. But she also wanted to ensure that the same tragedy would not happen to other families for wont of an inexpensive test.

"We asked our attorney to seek that and we were told that wasn't what attorneys did," she says.

Sheridan had to push her own attorney, but eventually the hospital agreed to a financial settlement and her request that she be able to meet with the hospital CEO to discuss the need for kernicterus testing. They met, and Sheridan recently learned that the hospital significantly revamped its testing policies. Sheridan's settlement did not include any ironclad commitment to test babies with jaundice, but she says she is reasonably satisfied with the outcome.

Meanwhile, her husband developed a pain in his neck and physicians found a mass in his spine. The tumor was removed, and he was told it was benign. Six months later, a surgeon found another mass in the spinal canal the size of his fist. This time, the mass was cancerous and had grown into his spinal cord.

The Sheridans were led to believe that the benign tumor had become cancerous, but the experience with their son left Susan skeptical, so she checked her husband's medical records for the first procedure. "Lo and behold, the pathology report made it to his medical record but not to his neurosurgeon or to us. The medical record for the first surgery said he had malignant sarcoma," she recalls. "So the pathology got lost, and somehow it was never communicated to me and my husband that he had cancer. He went untreated for six months."

After nine months of surgery, seven major surgeries, and other extensive treatment, Sheridan's husband died from the cancer.

Sheridan sued the hospital, but she refused to settle without the opportunity to meet with the hospital's CEO to address the failing that led to her husband's death. After two trials and mediation, the hospital agreed to work with Sheridan to establish a best-practice model for how to communicate malignant pathology findings to patients. That effort is ongoing, with the intention of creating guidelines that can be implemented on a nationwide basis.

"Initially, they wondered what I was up to and why I would be asking for something like that instead of just taking the financial settlement," she says. "The majority of people asking for something like this just want to make sure it will never happen again, because the pain we go through is huge. And we want to play a role in preventing that for somebody else." ■

HIPAA compliance requires strong focus on documents

Nearly every document that makes any mention of a patient in your facility can be considered protected health information (PHI) under the

Health Insurance Portability and Accountability Act (HIPAA), says **Veronica A. Marsich**, JD, a shareholder with the law firm of Smith Haughey in East Lansing, MI, specializing in health care issues.

Even the slightest identifiers or reference to an individual's health can make a document PHI, she says, and that creates a lot of work for a risk manager trying to assure compliance.

"You really have to consciously expand your concept of your notion of what we're trying to protect," Marsich says. "The federal government has told America that they have a federal right of privacy to respect to their health information, and their health information is more than just their medical records. It's bigger than that. That is a sense that has to be embraced within your organization if you want to be in compliance."

She addressed HIPAA compliance at the recent meeting of the American Society for Healthcare Risk Management (ASHRM) in Nashville, TN. "The bottom line is you have to take this seriously," Marsich notes. "This is a big change. If you want to get hyped up about HIPAA, get hyped up about the definition of PHI because that's the biggest change conceptually from what we did before."

Everything else regulated by HIPAA, such as the particulars of what information can be exchanged with whom, and when, doesn't change a great deal from pre-HIPAA days, Marsich says. But the definition of PHI is so broad that risk managers must protect far more information than before, she says.

Marsich also notes that efforts to "de-identify" patient information by removing all identifiers are usually not worth the effort. In most cases, she says, researchers or analysts find the data useless if they can't be connected to individual patients.

Business associates still a thorny issue

Marsich admits that she "hates" HIPAA because it is overly restrictive and amounts to a bureaucratic exercise with little benefit to the patient. Nevertheless, she says, risk managers must be careful to comply fully, and the ASHRM attendees expressed their own frustration with how to follow the law. The concept of "business associates" prompted many questions from perplexed risk managers, and Marsich says she is not surprised.

"A lot of providers have just given up and called everyone a business associate, but that doesn't work because most people won't sign the agreements if they know they're not one. And some won't sign it even if they are," she notes. "Business associate agreements are one of the most difficult parts of complying with HIPAA."

Marsich says she often is asked if attorneys working with a health care provider are business associates, and the answer is yes. A business associate is anyone you hire to do something for you, so Marsich says that covers a wide range of contacts. But that does not include every contract or person you do business with. Your landlord, for instance, is not doing anything on your behalf. So the landlord is not a business associate even though you are doing business with him or her.

"It's anyone you hire to do something for you instead of you doing it yourself. You need business associate agreements with your legal counsel, billing agents, collection agencies, with anyone who provides business services on your behalf," she says. "But you don't have to get business associate agreement with anyone who provides treatment. And the definition of treatment is hugely broad."

Insurers probably not business associates

Another frequent question involves liability insurance companies. Are they business associates of the health care provider? Marsich says government guidance on HIPAA suggests they are not, with the reasoning that the insurers are working for themselves and not for the health care provider.

"That's an interpretation that I think most risk managers won't disagree with," Marsich says. "It's a cynical way of looking at the relationship, but it means you don't need a business associate agreement with your insurer."

Some risk managers also have wondered if it is a HIPAA violation to provide PHI to insurers when shopping for insurance. It is almost impossible not to, they say, because the insurers demand data about the health care provider's history and patients. Marsich says that practice is safe and does not require a business associate agreement.

"You're using the data for a health care function, the acquisition of insurance coverage you have to have. The use of that data is permitted without a business associate agreement because until you have a contract you don't have anyone working on your behalf, and even then the government says the insurer isn't really working on your behalf," she says. "But if you have a broker shopping for you, you need a business associate agreement with the broker because you're not doing your own work anymore. You hired someone else to do it for you, and that's the definition of a business associate."

There is ample opportunity to run afoul of

HIPAA during a provider's daily operations, Marsich says. Medical staff not following policies or misusing access represents a major risk, but she also warns about unnecessary and inappropriate conversations of employees. Unauthorized conversations with family and friends are another big risk.

Marsich notes that HIPAA also can supersede some state laws regarding confidentiality. "HIPAA probably supersedes state law provisions that enable co-defendants to simply share records as part of a pre-suit discovery process, as well as state statutes that provide a patient has waived the physician-patient privilege with respect to any medical information relevant to a damage claim in a legal action," she says. "HIPAA is probably not impacted by waiver of a privilege, because HIPAA protects information that is not even covered by a privilege."

Marsich points out that though HIPAA establishes a standard of care in terms of what is necessary to protect health information, it is only a minimum and health care providers are free to be more restrictive if they want. That overly cautious approach often is based on a poor understanding of the law and can frustrate health care providers who are trying to engage in a legitimate and necessary exchange of information. But she says you can't really fight them.

"When you run into those health care providers who are doing more, doing something that HIPAA doesn't require and it frustrates you, their response can be, 'So what? I can if I want to.' That is for the most part true," Marsich says. "HIPAA is a floor, a minimum for what we must do."

She notes that HIPAA allows PHI to be disclosed for law enforcement purposes. An example would be providing information as required by laws that require reporting of certain types of physical injuries or events. HIPAA also is not an issue if you are providing PHI in compliance with a court order or court-ordered warrant, pursuant to grand jury subpoena, an administrative subpoena, or summons.

However, Marsich explains that, when releasing PHI for law enforcement purposes, the information must be relevant and material to a legitimate inquiry. The request must be specific and limited in scope to the extent reasonably practicable. HIPAA also requires satisfactory assurance from the requesting party that reasonable efforts have been made to give notice to the patient.

"Alternatively, they have to make reasonable efforts to secure a qualified protective order," she says. "If neither of those things happen, it's still OK to disclose the information if the covered entity itself makes the same reasonable efforts." ■

Tips for ensuring you're in compliance with HIPAA

These tips for complying with the Health Insurance Portability and Accountability Act (HIPAA) are offered by **Veronica A. Marsich**, JD, a shareholder with the law firm of Smith Haughey in East Lansing, MI:

- **Review your HIPAA authorization form to see that it contains a list of elements for a valid authorization, and allows for revocation.** Is it a time specific/situation specific document? It must not condition treatment on the individual providing authorization. Be sure organization policy requires use of the HIPAA-approved form.
- **Check the content of your HIPAA notice.** If a covered entity plans to engage in any of the following activities, specific descriptions must be provided in the notice: contact about appointment reminders or treatment alternatives, fundraising by the covered entity, or health plan disclosure of information to the plan sponsor.

  The notice also must contain, at a minimum, a list of the following obligations of the covered entity: obligation to protect individual privacy; obligation to abide by terms of the notice; and obligation to provide a revised notice before changing its privacy practices. You must post the notice and have copies available for individuals to take at all times.
- **Ensure that staff seek acknowledgment from patients.** Covered entities are required to make a good-faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices at the first date of service. If the covered entity can't get the acknowledgment, the staff should document why.
- **Scan your daily operations for HIPAA pitfalls.** Look for physical safeguards that prevent disclosure of PHI, such as how patient charts are stored. Are conversations and telephone calls overheard by patients? Also consider how faxes and letters are protected, computer security, and the proper disposal of medical records.
- **Make sure you have all the necessary HIPAA policies in place.** You should have policies regarding patients' right to an accounting of disclosures and access and amend their own PHI,

their complaints, incidental disclosures, and proper storage and destruction of medical records.

• **Business associate agreements should clarify permitted uses and disclosures by your attorneys.** This includes any use or disclosure needed to carry out their legal obligations, functions or services, including but not limited to disclosures to potential expert witnesses, independent medical examiners, mock juries, courts, co-counsel, opposing counsel, and consultants. It also should include incidental disclosures to vendors such as photocopiers and others who may participate in preparing trial exhibits or other materials. ■

Reducing restraint by 99% brings less staff turnover

Health care providers have been working to reduce the use of restraint for years, and risk managers have looked to the possibility of fewer injuries and lawsuits as a result. A behavioral health care center in Mississippi is proving that a concentrated effort to reduce restraint can yield great improvements not only for the patients but also for the bottom line of the health care facility.

Millcreek Behavioral Health Services in Magee has reduced its use of restraints by more than 99%, from 1,025 episodes in 1999 to only four episodes in 2003. The organization credits this clinical and cultural change to increased physician and leadership involvement and a treatment planning process that facilitates a response to each child's unique needs. Millcreek's efforts made it a 2003 winner of the Ernest A. Codman Award from the Joint Commission on Accreditation of Healthcare Organizations.

Restraint use has been almost eliminated at Millcreek, says **Margaret F. Tedford,** MEd, administrator and CEO. Mechanical restraints are a thing of the past and other restraint is used sparingly. The facility removed all its restraint beds from the premises.

In 1999, Tedford had just joined Millcreek, a psychiatric residential treatment facility and an intermediate care facility for the mentally retarded that provides services to approximately 300 children each year through its residential programs, group homes, community-based programs, and special education schools. Millcreek Behavioral Health Services is owned and operated by Youth and Family-Centered Services, an Austin, TX-based corporation that provides health care and educational services exclusively for children and adolescents.

In 1999, Youth and Family-Centered Services mandated a systemwide culture change to reduce the use of restraint. As a result, a performance improvement initiative was started with the Millcreek facility and reduction of restraint was deemed a resource priority.

"When you reduce restraint and seclusion, you totally change the environment you're working in. You change the attitude toward the children," she says. "You have less injury to staff and a less stressful working environment."

Liability concerns

To get the ball rolling, the leaders at Millcreek gathered data to measure performance related to the use of "special procedures," such a physical restraints and seclusion, and staffing effectiveness.

After studying the data, the administration determined that the current method of crisis intervention was inadequate and a new plan was needed. Not only was the old approach harmful to the children, but it also exposed Millcreek to great liability, Tedford says. "We were motivated, partly, by our fears about risk," she says. "Every restraint increases your risk."

The new plan focused on enhanced communication of treatment needs through the interdisciplinary treatment planning process. Policies and procedures were changed across the board and were revised as the effort went on and the viability of the new strategies was tested.

"We always reviewed our experiences not only to see what went right, but what went wrong," Tedford says. "We talked to staff and looked for what could have been done better, what might have prevented the use of restraint in this case."

Millcreek adopted a new model for responding to potentially violent patients, the Therapeutic Crisis Intervention strategy developed at Cornell University in Ithaca, NY. That strategy emphasizes verbal de-escalation of the situation, but allows for seclusion if necessary. Physically restraining the patient is a last resort, but even then it is done without mechanical means.

Also, each patient now has a specific behavior management plan that staff can consult whenever necessary. As opposed to broad recommendations for how to deal with disruptive or violent behavior, the staff now have guidelines drawn up

for each individual.

The results have been significant. In the first year, there was an 89% reduction in restraint, from 1,025 episodes to 112. In the second year, there was a 96% reduction to 41 episodes; and in the third year, there was a 98% reduction to 18 episodes. In 2003, the fourth year, the cumulative reduction in restraint use rose past 99%, amounting to only four episodes in the entire year.

The primary benefits have been to the patients, but Millcreek also is reaping financial rewards from the improvement. Workers' compensation claims related to patient/staff interactions decreased from 109 claims in 2000 to 45 claims in 2002, a reduction of 45%.

That adds up to a significant savings at Millcreek, Tedford says. The reduction in workers' compensation claims comes not just from reducing restraint but also from the bigger goal of minimizing the power struggles between patients and staff, she adds.

"We have injuries from children hitting the staff, or biting, or throwing a chair at someone because they got in a power struggle," she says. "Reducing those injuries clearly is a part of the therapeutic approach we're taking and teaching the staff to stay out of a power struggle."

Similarly, employee turnover has fallen sharply in the same period. Physically restraining children was a terribly stressful and sometimes dangerous job for staff and Millcreek, and they weren't willing to stay on the job when they had to do it more than 1,000 times a year. With the sharp reduction in restraint, job satisfaction has soared, Tedford says.

Millcreek had 44% employee turnover in 1999, but that figure fell to 17% in 2000 when the new strategies were introduced. That figure has held steady ever since.

"That drop has let us go to 50% fewer orientations of new staff, and an orientation here takes two weeks," Tedford reports. "Plus there is on-the-job training. So all of that, and the workers' comp, adds up to a real financial benefit. It's substantial."

More physician, nurse involvement

Millcreek took the approach that physical restraint and other special procedures had to be the absolute last resort for dealing with behavior problems. But that philosophy is the easy part. So how did Millcreek do it? The basic answer is that it took a collaborative, interdisciplinary approach to resolving the issues that previously would have prompted restraint, seeking to identify the individual patient's needs before they reach a crisis point. These were some of the strategies Millcreek employed:

- The physicians initiated more in-depth questioning and discussion with the nurses related to interventions attempted prior to the initiation of restraint, ultimately enhancing nursing accountability and the number of intervention attempts.

Tedford and physicians are on call 24 hours a day for help with disruptive patients. But when they are called, they expect the nurses to know not just what is going on with the patient at that moment but what happened all day long, so that they can determine what might be prompting the behavior and what might stop it.

- Physician involvement in the use of restraints and other special procedures has increased significantly, primarily by helping to guide each patient's treatment plan in such a way that restraints are unnecessary.
- Millcreek sent senior administrators to education and training seminars and observe procedures at similar facilities.
- Compliance was monitored at all levels of patient intervention, resulting in stricter compliance with all policies and procedures.

'Compliance nurse' monitors restraint

- New staff positions were added, including the "compliance monitoring nurse" and "special procedures nurses" to provide additional support and oversight of restraint and other special procedures by well-trained, licensed staff.
- The compliance monitoring nurse distributes aggregated data on a weekly basis that summarize the previous week's episodes of restraint and other special procedures, including an analysis by patient, shift, living unit, duration, and day of the week. Those data allow for early intervention related to potential problem areas.
- The hospital increased knowledge and attention to restraint and other special procedures through discussion in regular meetings at all staff levels. The senior administration stressed to staff that reducing restraint was a major priority.
- A new daily facility report was implemented to record the use of all special procedures in the past 24 hours.
- Debriefing was emphasized as a key process, and its method was continually redesigned. A complete debriefing and written analysis of all

patient-related staff injuries also became mandatory.

The debriefing process focuses on staff's reactions to the episode, which can prompt greater stress in the child having a behavior problem. Debriefing sessions emphasize depersonalization and a positive child-focused perspective. Millcreek provides ongoing training about how to deal with power struggles and negative feedback from patients.

- Millcreek enhanced the treatment planning process to include the analysis of aggregated data related to target problem behaviors identified on individual behavior management plans.
- Performance improvement indicators were reviewed and revised at least monthly to assist in determining the success and sustainability of improvement actions.
- The admissions committee focused on close screening of referrals and admissions in an effort to match admissions to existing populations. The committee also paid special attention to those patients for whom more historical information was needed before admission. ■

Hospital improves error prevention with automation

A California hospital recently saw a 250% improvement in preventing medical errors related to medications after introducing pharmacy automation. Hospital leaders say the use of bar coding and computerized physician order entry (CPOE) has greatly improved patient safety.

The reduction in medical errors was traced to the way automation helped increase clinical interventions — the opportunity for a clinical pharmacist to intervene in the drug ordering process to prevent an adverse error. Those interventions increased 250% between 2002 and 2003, says **Mark Zielazinski**, chief information officer for El Camino (CA) Hospital.

"El Camino Hospital's error rate was already among the lowest in the nation, having been the first hospital in the world to implement a computerized physician order-entry system, which helps to significantly reduce prescribing and transcription errors," he says, and notes that the improvements were seen with no staff increase.

The increase resulted from the implementation of patient safety technologies that include a biometric drug-dispensing system, a bedside drug bar-coding system, and an automated pharmaceutical and supply replenishment system that integrates with the CPOE system. These new technologies not only reduce medical errors and save lives, Zielazinski reports, they also provide considerable savings to the hospital. The interventions resulted in a 500% increase in direct cost avoidance.

Integrating with the CPOE, the new automated dispensing system provides pharmacists with a standard and reliable way to verify a medication order before a patient gets a drug. **Mei Poon**, RPH, director of pharmacy, explains how it works: A physician enters an order electronically. The order goes immediately to the pharmacy, where it is put through clinical checks. The order then goes to the medication-dispensing machine on the appropriate nursing unit.

A profile for the patient for whom the medication is being ordered already is in the system. That information is accessible to all members of the care delivery team so the orders are reviewed before the medication is dispensed, rather than after the medication has been given to the patient at the bedside.

Fingerprints required to dispense

Caregivers, using their fingerprints, access the drawers in the medication-dispensing machine, which open only for drugs listed for that patient and will not give out drugs until a pharmacist verifies the order. Interventions range from a preventing a low-impact event, like missing an aspirin dose, to a high-impact event such as giving a patient an overdose or a wrong dose of medication.

"Automating time-intensive tasks such as pill sorting and counting gives the entire care delivery team more time to spend on patient-focused tasks," Poon says. "There is clear evidence that the more time a pharmacist spends on the care and monitoring of patients, the more errors that are caught and the more harm prevented."

El Camino Hospital plans to continue improving the accuracy and efficiency of drug deliveries further this year with a fixed patient station at the bedside, bar-coded drugs on a unit-dose basis (medications arrive ready for administration in the appropriate quantity) and verified orders, checked and delivered through the front end. All members of the care delivery team will be able to access a single set of patient information, which is updated in real time. ■

Capped malpractice awards lead to lower premiums

Medical malpractice insurance premiums are 17.1% lower in states that have capped court awards, although the lack of such tort reform measures in other states does not fully explain recent jumps in what physicians pay to cover the cost of malpractice suits, says **Kenneth E. Thorpe**, PhD, chairman of the health policy and management department at the Emory University Rollins School of Public Health in Atlanta.

Thorpe analyzes the rise in malpractice costs, and efforts to combat it, in a new analysis by *Health Affairs*, a health policy analysis web site (www.healthaffairs.org). In the study, he examines the effects of recent sharp increases in malpractice premiums in many states and states' efforts to keep malpractice premiums down. Malpractice premiums increased by 23.2% in 2002, although the increases varied by state and specialty.

Awards caps exist in 24 states, and Thorpe notes that they are the only malpractice reform efforts that affected physicians' premiums, reducing them 17.1%. While he says such measures extended to other states or nationally through a federal law "would ultimately result in lower premiums," Thorpe questions whether taking that step would accomplish the goals of the liability system.

"At issue is whether we should adopt short-term, stopgap solutions to slow the growth in premiums, or use the recent experience to more fundamentally evaluate and perhaps reform the liability system," Thorpe says. "The results suggest that capping awards may improve the profitability of malpractice carriers and reduce premiums. Whether this is socially desirable or improves the goals of deterrence and compensation remains an open question."

He says three factors have been the principal drivers of malpractice premiums: growing awards and settlements, increased frequency of lawsuits, and declines in investment income. By 2002, every premium dollar collected resulted in $1.29 in total expenses, awards, and settlements, up from 95 cents of total expenses in 1995, Thorpe wrote.

To view the article, go to http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.20. ■

Reader Question

Let employee health handle falls to help reduce the risk

Question: When employees are injured in falls in our facility, should we send them to the emergency department (ED) or the employee health clinic? Serious injuries go straight to the ED, of course, but we've been playing it safe by sending some relatively minor injuries there, too. We don't want to risk any accusation that we gave an employee lower-quality care.

Answer: Your efforts might be well-intentioned, but they could backfire, says **Mark Hakim**, BS, MA, MBA, risk management consultant with ProAssurance Corp., an insurer in Okemos, MI. As long as your employee health department provides high-quality care, which it should regardless of this particular concern, Hakim says it is a much better policy to send employees injured in falls there routinely instead of the ED.

Life-threatening injuries should receive appropriate care regardless of whether the patient is an employee, of course, so the ED can be the correct

destination in those rare instances. But for most employee slip-and-fall injuries, you put the employer at unnecessary risk by using the ED instead of employee health.

The reason has to do with the "dual-capacity doctrine," Hakim explains. He defines the doctrine as meaning that "an employer who is normally immune from tort action because of workers' compensation laws may be liable for additional damages as a party who has committed a wrongful or negligent act beyond its role as employer."

In other words, if the employee stays in the employee health department, in most cases the hospital is just an employer responsible for workers' compensation claims. If the employee goes to the ED, the employer also could be exposed to malpractice claims or other allegations that any patient might bring.

"If you send this patient to the emergency room, any number of things may come up. Maybe a breach of confidentiality or allegations of medical malpractice," he says. "Normally, the hospital would be shielded from these claims because most workers' comp laws prohibit tort action; but if you treat them outside employee health, you might be opening the door for the claim to go beyond workers' comp."

By treating the injury in the employee health department, the hospital is liable in most cases only for the workers' compensation-related expenses. The workers' compensation laws prevent further tort actions. The dual-capacity concept could allow a workers' compensation case to be treated as a professional liability suit, exposing the employer to far more expense.

A breach of confidentiality is of particular concern with employee cases, Hakim says. The nature of the injury might be embarrassing if it is known to co-workers, for instance; and since those co-workers are right there in the hospital, it is quite possible that they will hear about it from ED staff.

The employee's own knowledge of hospital operations also could lead to an increased risk of malpractice charges. "Maybe the doctor misses a fracture and the employees know they don't do overreads of X-rays," Hakim says. "It's then possible that the employee's inside knowledge could prompt him to go down the malpractice route instead of workers' comp."

He recommends that risk managers enforce a policy stating that all employee injuries must go through the employee health department first, with the exception of those that are clearly serious injuries. They can go straight to the ED.

"It's pretty rare that the dual-capacity doctrine is used, but it's out there and it could result in substantial additional liability," Hakim says. "Why expose yourself to that if the employee can be treated adequately in the employee health department? That's why you have an employee health department." ■

Hospital to pay $9.5 million for Medicare billing issues

A hospital in Greenville, SC, will pay nearly $9.5 million to resolve Medicare billing improprieties from 1997 through 1999 in its home health, hospice, and durable medical equipment programs, the Office of Inspector General (OIG) announced recently. The settlement is the largest reached in such cases. Acting Principal Deputy Inspector General **Dara Corrigan** announced the settlement with St. Francis Hospital, which self-disclosed the improper billing.

When purchasing St. Francis in 2000, Bon Secours Health System discovered billing and documentation problems at St. Francis and then launched an internal investigation that revealed "significant error rates and systematic documentation lapses" in its Medicare billings, Corrigan says.

The hospital brought its findings to OIG under the Self-Disclosure Protocol, which encourages providers to approach the government voluntarily when they uncover evidence of potential fraud and compliance problems in their organizations.

Under the Self-Disclosure Protocol, OIG outlines how providers should investigate and audit compliance problems and works with disclosing providers to resolve the situation. Corrigan says St. Francis was subject to much higher penalties than the settlement amount, but it quickly took corrective steps to remedy the problems. ■

CE objectives

After reading this issue of *Healthcare Risk Management,* the CE participant should be able to:

1. Describe legal, clinical, financial, and managerial issues pertinent to risk managers in health care.
2. Explain how these issues affect nurses, doctors, legal counsel, management, and patients.
3. Identify solutions for hospital personnel to use in overcoming challenges they encounter in daily practice. Challenges include HIPAA and EMTALA compliance, medical errors, malpractice suits, sentinel events, and bioterrorism.
4. Employ programs used by government agencies and other hospitals (such as EMTALA, HIPAA, and medical errors reporting systems) for use in solving day-to-day problems. ■

CE Questions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this activity each semester, you must complete the evaluation form provided and return it in the reply envelope provided in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

9. According to Martin J. Hatlie, JD, president of the Partnership for Patient Safety, what is true of noneconomic settlements?
A. They are on the decline.
B. They are becoming more common.
C. They should be avoided for ethical reasons.
D. They make no difference in how much defendants pay plaintiffs.

10. What is one type of noneconomic settlement sometimes offered by Sheila Stieritz, RN, BSN, director of patient safety at Abington (PA) Memorial Hospital?
A. Education classes
B. Dismissing staff responsible for errors
C. Frequent written reports to the plaintiff on quality improvement
D. Compensation for lost wages

11. According to Veronica A. Marsich, JD, a shareholder with the law firm of Smith Haughey, which of the following would *not* be considered a health care provider's business associate under HIPAA?
A. An attorney
B. A broker used to buy insurance
C. A property landlord
D. A bill collector

12. When Millcreek Behavioral Health Services undertook an effort to reduce restraint, what was one step it took?
A. Employed more "soft restraints" instead of leather
B. Removed all restraint beds
C. Instructed staff to physically restrain patients more
D. Declared that restraint could never be used in any circumstances

Answers: 9-B; 10-A; 11-C; 12-B.

Healthcare Risk Management's
Legal Review & Commentary™
A Monthly Supplement

Patient dies following peritonsillar surgery, and an $865,000 verdict is returned

By **Jan J. Gorrie**, Esq., and **Blake J. Delaney**, Summer Associate
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News: A young man went to an emergency department (ED) in the afternoon complaining of discomfort in his throat. Surgery was performed to address an abscess. That evening, after his family had gone home, he suffered from cardiac arrhythmia, went into a coma, and died three days later. His wife and two sons brought suit for wrongful death. The jury entered a gross verdict, including punitive damages against the hospital and attending physician for $865,000, which was reduced by the patient's contributory fault. The final award was reduced to $432,500.

Background: The 26-year-old husband and father went to the ED with severe throat discomfort. He was diagnosed by a surgeon as having a peritonsillar abscess in his throat. The patient had arrived in the ED around 4:30 p.m. and was in surgery by 10 p.m.

The procedure lasted just 15 minutes, during which the surgeon incised and drained the abscess, relieving the accumulated pus. Almost immediately, the patient felt better. To relieve pain, the surgeon prescribed a self-administered morphine pump, postoperatively. Assured that the patient was in good shape, his family went home for the night.

The surgeon had ordered that the patient be checked once each shift — three times daily. At 11:35 p.m., the nurses checked on the patient, at which time he appeared stable. When he was seen again at 12:10 a.m., nurses noted that he was near death. The patient had apparently suffered from cardiac arrhythmia and slipped into a coma. He was transferred to another facility, where he remained in a coma and on ventilator support until his death three days later.

The decedent was survived by his wife and two young sons, who were 2 and 5. The estate brought suit against the surgeon and hospital. The plaintiff argued that it was an error to use a morphine pump, as there was significant risk of a closed airway, markedly increased after an emergency tonsil surgery.

Additionally, the plaintiff argued that the use of a morphine pump was compounded by the failure to order and provide adequate monitoring of its use. The plaintiff claimed the surgeon was negligent for choosing the pump in the first place and then relying on the hospital to monitor the patient in the absence of a more detailed order regarding post-surgery observation and care. With the patient highly vulnerable to sedation, the plaintiff's expert said that the surgeon should have ordered observation every 30 minutes.

An autopsy on the decedent linked the cardiac arrhythmia to myocarditis or heart disease, particularly noting the abnormal size of the patient's heart. The surgeon maintained that the monitoring and use of the pump was proper and that the patient's death was due to his underlying heart condition. The hospital also contended that the

death was due to myocarditis, that the nurses not only had followed the doctor's orders but far exceeded the order to check the patient once per shift and had actually checked the decedent four times within a 90-minute period.

The jury initially reported that it was deadlocked. The trial judge gave orders to deliberate again, after which a verdict was reached, holding both the surgeon and the hospital equally to blame in the decedent's death. The jury awarded a total of $865,000. The estate received $100,000 for the death, plus $5,000 for funeral expenses and $10,000 for medical expenses. The joint consortium for the two young sons was valued at $600,000. Compensatory damages thus totaled $715,000, and the panel further imposed $75,000 in punitive damages against the hospital and physician. Comparative fault also was considered in the finding, and so the total award was reduced to $432,500.

What this means to you: Sometimes, the facts just don't add up. Just as bad things happen to good people, bad things can happen to good providers.

"In this case, neither the size of the verdict nor the inclusion of punitive damages makes sense, but bad things happened to a good patient and his good providers. There seems to have been very little, if any, negligence on the part of the surgeon or hospital yet a large verdict was returned against both. And there is no indication that their actions merited punitive damages," says **Stephen Trosty**, JD, MHA, CPHRM, director of CME and senior risk management consultant for American Physicians in East Lansing, MI.

"The hospital nurses provided monitoring of the patient that went well beyond what the surgeon had ordered. In fact, it was as frequent as what the plaintiff's expert said should have been ordered [every 30 minutes], and yet the hospital was found liable. Nurses had checked on the patient at 11:35 p.m., at which time the patient appeared stable, and again at 12:10 a.m., at which time he was near death. Unfortunately for this patient, the 30-minute increments seemed to have not fallen at the precise point in which he began to experience difficulties. The physician's orders to check the patient only once each shift, three times daily, might not have been adequate given the nature of the procedure done on the patient, the possibility of the airway not being completely open, and the use of an anesthetic. Although even though more frequent checking should have been ordered for the night shift, the shift immediately following the surgical procedure, this is actually what was done by the nurses.

"In addition, the physician's order to check the patient could have been more specific regarding monitoring the oxygen saturation level, verifying the sedation level of the patient, checking the position in which the patient was lying in bed (e.g., on his side or on his back), and assessing if use of morphine could be compromising the patient's condition or recovery. The need for a physician to specify in his order that these things be done may be influenced by the existence (or lack thereof) of standing nursing procedure and/or hospital policies and procedures relating to the monitoring of patients. If nursing procedure required that these things regularly be done by nurses who check patients after surgical procedures, and/or if hospital policies and procedures required that nursing perform these specific functions as part of patient monitoring after a surgical procedure, then there might not be a need for the physician to specify these things in his order. If, however, there were no standing nursing orders regarding these issues, and no relevant hospital policies and procedures, then the physician should have specified these activities as part of the patient monitoring. But the facts provided in this case record do not indicate that

the physician and nurses were negligent in their care and treatment of the patient," notes Trosty.

It is possible, given the location of the abscess and the nature of surgical procedure, that the patient could have experienced an airway that was not completely open, "which is why it was important to regularly monitor his oxygen saturation levels," he states.

There is a question of whether the surgeon and nurses were checking the oxygen saturation level of the patient to be sure that the anesthetic was being absorbed and that there was no airway obstruction preventing the patient from inhaling adequate amounts of oxygen.

"If there was a closed airway, or if the oxygen level was low, the morphine pump should not have been used or should have been removed. Nursing staff should have been checking for this and it would have been advisable for the physician to include this in his order," Trosty says.

There is no indication that the patient's position affected the outcome.

"Under the circumstances, the preferred position for this patient was for him to have been on his side as opposed to his back in order to not obstruct the airway. When patients are on their back, especially if they are snoring, the possibility for having an obstructed airway is greater. This would be especially true in the time shortly after the procedure had been performed and the patient was still recovering from the anesthetic used in the procedure," says Trosty.

Nursing staff should have been monitoring the patient's position, and this should have been included in the physician's order.

"In the case of a 26-year-old healthy male who underwent a 15-minute minor procedure for the incision and draining of a peritonsillar abscess, the use of self-administered morphine pump for management of pain is not unusual or a violation of the standard of care. The procedure likely involved the use of a local anesthetic. In these types of situations, particularly given the age and health condition of the patient, as well as the likely type and quantity of anesthetic used, patients will usually absorb/recover from the anesthetic in a reasonably short period of time. It is not likely to result in major sedation.

"In addition, self-administered morphine pumps, if properly set and regulated, will only release a set amount of medication within a given period of time. No matter how often the patient might push the pump, there only will be a set amount of morphine that will be administered in a given period of time as long as the pump is properly set and regulated. If properly set for the age, health status, and health condition of the patient, use of the pump should not be a deviation from the standard of care. It is used in many similar cases, with monitoring of the patient being done by the nursing staff. It also is important that the pump received regular and ongoing preventive maintenance checks, and that there is documentation to verify that this has occurred. While this is the responsibility of the hospital, there is no indication that the pump malfunctioned or was improperly used," states Trosty.

Just as there was little if any indication of negligence, "there was no evidence indicating the existence of gross negligence, or of a willful or wanton disregard for the well-being of the patient, on the part of the surgeon or hospital. This is the usual standard for awarding punitive damages, and in this case it is difficult to see any basis for having awarded punitive damages," adds Trosty.

In a case where the patient/plaintiff is sympathetic, such as presented here — a seemingly otherwise healthy young man with a young family — providers should consider availing themselves of nonjury alternatives if at all possible.

"This case presents facts where mediation, arbitration, or some other form of alternative dispute resolution might have helped the parties to arrive at a fair and equitable resolution of the case. Allowing both sides to present their evidence to individuals who are better able to objectively evaluate the facts and the applicable medical standards, and who are not as likely to be swayed by emotions, often results in a more valid decision. It also can serve as a way to eliminate frivolous or nonmeritorious cases," suggests Trosty.

With regard to the plaintiff/patient, "another baffling aspect was why comparative fault was found against this patient?" queries Trosty. It appears that the award was reduced by approximately one-half due to comparative fault, but based on the facts we are unable to ascertain what the comparative fault might have been. This is interesting, since it is unusual to have malpractice awards reduced as the result of a finding of comparative fault — particularly if the comparative fault is due to an underlying congenital anomaly.

Reference

- Laurel County (KY) Circuit Court, Case No. 98 CI 0321. ■

Failure to monitor airway leads to Maryland death

News: A post-kidney transplant patient was admitted to a hospital with urosepsis and was placed in the intensive care unit. He was intubated; but when his airway became obstructed, efforts to correct the situation were unsuccessful, and he died. The case settled for $800,000.

Background: The 71-year-old male had undergone a successful kidney transplant. However, when he began suffering from urosepsis, a common side effect, he was readmitted to the hospital and placed in the intensive care unit for monitoring. He was intubated with a breathing tube to address respiratory distress and subsequent respiratory failure.

When the nursing staff repositioned the patient to deliver care, his breathing tube became dislodged and blocked his airway. The nursing staff were unable to reposition it in a timely fashion, and the patient suffocated.

The decedent's family brought suit against the hospital for the negligent care and treatment by the staff. In the early stages of the suit, the hospital settled for $800,000.

What this means to you: "This case calls for a root-cause analysis," states **Leilani Kicklighter**, RN, ARM, MBA, CPHRM, director, risk management services, Miami (FL) Jewish Home and Hospital for the Aged and past president of the American Society for Healthcare Risk Management. "There are far too many unresolved issues that if left unresolved could lead to further untoward incidents."

The first line of questioning and focus is directed at the patient's endotrachial tube.

"Was there a mechanical defect or human error in the operation or placement of the tube? This should be the risk manager's initial level of inquiry because such tubes are generally designed to allow for routine and necessary turning and repositioning of the patient. Respiratory patients must be turned to avoid pressure sores among other reasons, and so equipment used to care for such patients must be designed to accommodate the clinical need for repositioning. Nothing indicates that there was a defect in the tube balloon, and so the focus would turn to staff training, education and knowledge of placement and securing of endotrachial tubes as well as turning the patient once the tube is in place would need to be conducted," notes Kicklighter.

Once the tube is addressed, the second level of review is the timing and response of the emergency response team.

"The initial inquiry in this regard would be whether the ICU staff was aware of the patient's respiratory distress and the emergency ramifications. If the ICU staff were not aware of the fact that the patient was distressed, they may not have sounded the alarm. Alternatively, if the emergency response was called, it appears from the outcome in the case that their response time may have been lacking," adds Kicklighter.

"When things happen that should not have happened under normal circumstances and seemingly error upon error occurs, root-cause analysis and early resolution/settlement should be considered," concludes Kicklighter.

Reference

• Jonathan Schochor and Kerry D. Staton with Schochor, Federico, and Staton, Baltimore, attorneys for the plaintiffs. ■