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Impostors could be targeting hospitals to gain information for terrorist attacks

Beware of anyone posing as JCAHO surveyors, other visitors

By **Greg Freeman**
Healthcare Risk Management Editor

Healthcare Risk Management has learned that terrorists may be behind a recent spate of incidents in which people pose as JCAHO surveyors, doctors, or government officials to gain access to hospitals. Experts in hospital security and terrorism say the most likely explanation for these impostors' attempts to gain access is they are collecting information for future attacks on health care facilities.

Word of these impostors has spread quietly through the health care community in the past year, but the problem gained more attention recently when JCAHO issued warnings about people posing as surveyors to gain access to facilities. The Joint Commission has received three reports in the past four months about such impostors. (Read the Joint Commission's warning at www.jcaho.org/accredited+organizations/security.htm.) In all three cases, the impostors fled after being asked for proper identification.

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The problem is larger than just the incidents reported by the Joint Commission. The law enforcement community is concerned enough to issue special bulletins warning of the danger. The number of incidents and their similarity suggest a terrorist connection, says **James M. Roberts**, CHPA, CAS, director of safety and security for Mercy Medical Center in Baltimore. He says impostors have been reported in New Jersey, California, Massachusetts, North Carolina, Virginia, and Ohio. Before working in health care, he spent decades working in counterterrorism efforts for the Army and is a certified anti-terrorism specialist. Roberts has been tracking the reports of impostors.

"Too many hospitals have been contacted" for it to be a coincidence, he says. "They're all asking pretty much the same general questions; and in

some cases, they seem to be very scripted in what they ask."

The impostors are not part of any sort of spot test of hospital security, confirms Joint Commission spokesman **Mark Forstneger**. No other agency is authorized to use the Joint Commission's name in that way, and such use would not be tolerated, he says. **(See p. 64 for more from the Joint Commission.)**

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Joint Commission officials say they do not know the motivation behind the attempts, but experts in hospital security and terrorism say the circumstances point to a frightening conclusion. Health care facilities have long been known as a secondary target of terrorists, officials say, because an attack at the local hospital would hamper any efforts to respond to a larger attack in the community. And as other primary targets, such as government buildings, are hardened against attack, hospitals may become increasingly attractive as a soft target.

Risk managers must be on the alert for these impostors and ensure that hospital staff know how to respond, the experts warn.

Unlikely to be common criminals

While no one can be certain of why the impostors are trying to gain access, their methods suggest they are more than just petty criminals looking to steal laptops, drugs, or financial information, says **Fred Roll**, CHPA-F, CPP, president of the International Association for Healthcare Security and Safety (IAHSS) in Glendale Heights, IL. The average person does not even know about the Joint Commission or that surveyors could access the hospital, he says, so the impostors must be sophisticated enough — and motivated enough — to have identified that method through research.

In addition to his work in health care security overall, Roll is an expert on the terrorist threat to health care facilities. He says the impostors are a growing threat that demands immediate attention.

"I've warned about the threat to health care facilities since 9/11, but we haven't heard too much about these impostors until the recent months," Roll explains. "We have to at least consider that these are terrorists looking for the weak points in our system because this is an unusual, very calculated way to try to get in and get information."

If the impostors are terrorists, he adds, they are seeking information such as what resources you have, the access control points, what doors are kept open, your visiting hours, and other information that might help them get someone or something into your facility at a later date.

They also may ask where you keep radiological materials or where other sensitive areas are located, Roll says. He notes that the impostors sometimes visit during off-hours when it is less

likely a senior administrator will be readily available and more likely to realize that something is amiss than a night clerk.

"They depend on confronting someone who may not know everything about how the Joint Commission operates but knows enough to be intimidated and dazzled by someone who says they are surveyors," he explains. "They're hoping that person is impressed enough to comply before someone with more authority can step in."

Impostors showing up nationwide

Stephen Gaunt, CHCHPA, a past board member of the IAHSS and director of security at a large metropolitan hospital on the East Coast, says the impostors have turned up nationwide. Gaunt has been following the imposter reports and the related warnings from law enforcement agencies, and he says they all suggest a terrorist connection.

"You put a small device in a hospital or school and you've got instant worldwide attention," he says.

Gaunt notes that there is no hard proof of a terrorist connection, but when asked what other purpose might motivate people to pose as Joint Commission surveyors and seek information about access points, he pauses for a long moment and then says, "There isn't any."

It is not unheard of for people to try to gain access to a hospital for illicit reasons, he notes, such as when a gang member tries to find out if a rival gang member is being treated there.

"But those people would not know enough about the Joint Commission to use that as their cover," Gaunt says.

Other explanations possible?

Dan Hodges, a retired FBI agent and currently a consultant with OpSec Consultants in Nashville, TN, also agrees that terrorism is at least one explanation for the impostors. There may be other explanations, he says.

"It's either terrorist activity or to steal something. It's hard to say," he explains. "It all goes back to access control. Many of our hospitals are wide-open societies in which people can go wherever they want."

If the impostors are not terrorists, Hodges says they are probably seeking access to patient information for some reason. A rogue private detective, for instance, could use a ruse to gain access to the hospital's database. Any time someone tries to gain access to the hospital under a ruse, Hodges says, the most likely explanation (other than simple theft) is that the person is seeking information on a particular patient or personal financial information to exploit, he says. But Hodges acknowledges that the nationwide pattern of these impostors also must be considered in determining their motive.

What are they looking for?

Almost all of the impostors have claimed to be Joint Commission surveyors, but some have claimed to be doctors, and federal law enforcement agents, Roberts says. The questions seem to all relate to the hospital's ability to respond to a mass emergency, he says.

"In all cases in which they were challenged, they left," he says. "They do not seem to want to have anything to do with security."

Witnesses have reported a wide range of appearances for the visitors, including Caucasian, Middle Eastern, and Asian appearances. One incident included a blonde woman as one of the three visitors, he says.

Before 9/11, Roberts says he may have assumed the impostors had a different goal,

such as a well-planned abduction of an infant.

"But after 9/11, to me it appears to be targeting data" for a future attack, he says.

Then why would terrorists target a small hospital like Newton Memorial Hospital in Sussex County, NJ, a 148-bed acute care facility that was recently hit by the impostors?

Actual hospitals may not be the target

Roberts explains that the actual hospitals visited may not be the target. Large metropolitan hospitals are the mostly likely targets for any terrorist attacks in health care, but those also are more likely to have strong security measures in place.

So instead of going to Johns Hopkins Hospital in Baltimore, the terrorists may go to smaller facilities such Newton Memorial where they can gather general information about hospital processes and procedures that may be applied when attacking the larger, more preferred target, says Roberts .

But that doesn't mean that smaller hospitals would not be a target at all, he says. If an attack on a rural hospital put it out of commission, the impact on the surrounding community would be enormous, he says.

"And don't ever forget that the goal of a terrorist attack is not necessarily the actual damage you inflict, but the terror you create in the community," he says. "If they want to send the message that you're not safe in rural communities, that can be one way to do it."

Careful planning a hallmark of terrorists

Roberts notes that, contrary to some commonly held ideas, terrorists are not just wild thugs. They actually are well educated, methodical, and willing to research an attack for years before carrying it out. The carefully orchestrated attacks of 9/11 show that to be particularly true for al-Qaeda, he says.

The 9/11 attacks also show that the terrorist operatives can pass for typical Americans, he notes. Most of the terrorists who hijacked planes on 9/11 could have passed for Joint Commission surveyors, physicians, or government agents if that was their goal, Roberts says.

"This could be an effort to just get a feel for health centers, a way to ask how secure are these places, would they make a good target for us," he says. ■

Here is what to expect from a JCAHO surveyor

Joe Cappiello, vice president for accreditation field operations with the Joint Commission on Accreditation of Healthcare Organizations, urges risk managers to question anyone claiming to be a Joint Commission surveyor at your facility.

Surveyors are well aware of the problem with impostors and will not be offended by a request for identification or even being asked to wait while you confirm that they are who they say they are.

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"I have told my surveyors to expect to be challenged and in fact if they are not challenged they should ask why not," he notes.

Cappiello makes these points:

- *Real* Joint Commission surveyors rarely visit a facility outside of normal working hours, roughly 7 a.m. to 7 p.m.
- They often do not visit on a weekend.
- If they do show up outside of normal working hours, they will go to the main entry point, show their identification, and ask to speak to the senior administrator in house or the administrator on call. They will *not* ask the first person they contact to show them around or to provide information.

The steps to take

At a minimum, Cappiello advises taking these steps:

1. Ask the visitors to show their Joint Commission identification badges.
2. Examine the letter authorizing their visit. If the surveyors are not expected for a scheduled survey, they will have a letter addressed to the head of the organization signed by Russell Massaro, MD, executive vice president of accreditation operations for the Joint Commission. The letter will explain who they are and why they are there.
3. If there is any doubt about the legitimacy of the credentials or other concerns, call Cappiello directly at (630) 792-5757 during business hours, or you can call your local Joint Commission account representative.

"Outside of normal business hours, if there is any doubt, the surveyor will know how to get

hold of me. They have my number and I'll be glad to verify who they are," Cappiello says. ■

Be strict about demanding identification from visitors

Never assume people are who they claim to be, says **Fred Roll**, president of the International Association for Healthcare Security and Safety (IAHSS) in Glendale Heights, IL.

"There is no reason you shouldn't be questioning everyone for valid identification," Roll says. "If they say there are from the FBI or Homeland Security, you should demand identification. If they get hinky about it and make a big deal about being offended or surprised, that should be your No. 1 clue that something is wrong here."

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James M. Roberts, CHPA, CAS, director of safety and security for Mercy Medical Center in Baltimore, says staff should watch for actions by people that are unusual.

"You don't have to profile people," he says, "just what they do." If a staffer notices someone who seems out of place and inquires, for instance, the visitor might ask for directions to another department. Then if the person heads off in a wrong direction after being told which way to go, that should send up a red flag. Call security immediately.

The recent imposter incidents should be cause for hospitals to increase their level of alertness, Roberts says. At his facility, staff have been instructed to call security right away if anyone shows up claiming to be a Joint Commission surveyor, whether their identification seems legitimate or not.

"We would detain that person until we could verify whether they are who they say they are," Roberts says. "The goal is get one of these people and hold them until we can have them interviewed not only by our security but also by the police. Then we might really find out what they're up to."

Roberts also stresses that risk managers should ensure any questionable visitors are reported to federal authorities, such as the FBI and the Department of Homeland Security.

Those agencies may never determine the extent of the imposter visits if hospitals don't report all incidents, he warns. ■

Law enforcement urges vigilance in checking IDs

The Department of Homeland Security (DHS) recently issued a special bulletin that warns of an increase in suspicious activity at hospitals. DHS warns that the impostors may be terrorists and that "U.S. hospitals offer easy public access and would be recognized by terrorist planners as easy, accessible targets. Known targeting of such facilities would instill great panic and fear in the general public."

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The DHS bulletin outlines these recent incidents:

- In October 2004, two hospitals in the Phoenix metropolitan area reported suspicious activity, including photography, requests of building layout, inquiries regarding the location of the pharmacy, and computer fraud.
- Three men inquired as to the location of the pharmacy at St. Joseph's Hospital in Phoenix. These men had previously visited hospitals in Texas and Indiana. All three hospitals are distribution points for the antidote medicines for biological attacks.
- On Feb. 7, 2005, at approximately 10 a.m., two individuals who identified themselves as special agents representing the Department of Defense and the CIA entered the emergency room at Middletown Regional Hospital, NY. The subjects requested to see the charge nurse and presented identification badges. They asked the nurse a series of questions concerning capacity for cardiac care, trauma care, heliport, and private rooms. As the hospital staff's suspicion of the subjects increased, they left the building. The hospital staff did collect a business card from one of the subjects, and it appeared to be fraudulent.

Repeated visits at one hospital

The DHS bulletin notes that on March 27, 2005, a New Jersey hospital experienced its fourth separate incident in a six-week period. "Three male subjects in their 30s and 40s, possibly of Middle Eastern descent, spoke fluent, unaccented English and presented themselves as physicians from" the Joint Commission, the DHS bulletin explains.

In addition to the DHS bulletin, *Healthcare Risk Management* has obtained a special bulletin

disseminated only to law enforcement agencies and select health care provider. The bulletin notes that "counterterrorism analysts remain concerned that terrorist organizations may attempt to target U.S. medical infrastructure in order to cause immediate casualties and disrupt health care and emergency medical services."

The advisory was prepared by the New Jersey Office of Counter-Terrorism and disseminated by the Office of Counter-Terrorism, Office of the Attorney General, Department of Law and Public Safety. This is an excerpt from the bulletin:

On Feb. 26, 2005, at approximately 3 a.m., a Caucasian man and Caucasian woman posing as JCAHO surveyors arrived at a Los Angeles hospital. The man is described as mid-30s, dark hair, approximately 6-feet tall, and dressed professionally. The woman, also in her mid-30s, has dark reddish hair. A security guard at the hospital believed he saw the two individuals wearing badges similar to those used by genuine JCAHO surveyors. The impostors exited after they were stopped by hospital security.

In the second incident, on March 3, 2005, at 3 a.m., a man described as 35-40 years old, of South Asian descent, 6-feet tall, and with a short black beard and mustache, demanded to inspect a medical facility in Boston. The man left the premises after being questioned by hospital staff.

In the third incident, in the morning of March 10, 2005, a Caucasian woman described as mid-40s, 5-feet 7-inches tall, 160 pounds, with blonde hair, entered a Detroit hospital through the maternity ward and began wandering around the facility. When hospital staff questioned her, she stated that she was a JCAHO surveyor. After further questioning, she fled the premises.

Events in New Jersey

Suspicious events have occurred in the past year at New Jersey medical facilities that appear unrelated to the three incidents described in this advisory. These suspicious events have included irregular inquiries, incidents of surveillance, and suspicious employees and patients. In particular, on March 11, 2004, an adult male of Middle Eastern appearance entered the emergency department of Warren Hospital in Phillipsburg Township at approximately 4 a.m. and directed several atypical and evidently prepared questions to the duty nurse relating to the hospital's bed capacity and the means by which care is delivered to patients. ■

JCAHO official suspects terrorists are at work

The impostors visiting hospitals must be taken very seriously, says **Joe Cappiello**, vice president for accreditation field operations with the Joint Commission on Accreditation of Healthcare Organizations.

"It would not surprise me, I would not be stunned, if the FBI found something out and they came back and say it was a terrorist group looking at health care," Cappiello says. "If the intent of terrorism is to undermine the confidence of people in their government to keep them safe, what better place to go than health care?"

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In addition to targeting health care facilities for the effect on the community, Cappiello notes that hospitals contain materials of interest to terrorists.

"There may not be a lot of radiological material, but there's enough for someone interested in making a dirty bomb. And God knows what pathogens are being researched on in some of our university-based medical centers," he says. "So there are a variety of reasons that a group like that might be interested in health care centers."

Like others monitoring the impostors, Cappiello says his assessment would have been different before 9/11. Back then, he would have assumed the visitors were planning a theft of drugs or other valuables, he says. But not now.

"We can't pooh-pooh these kinds of events," he says. "If someone is trying to impersonate Joint Commission surveyors, you need to try to detain them in some way, call the authorities, follow them out and try to get a license number of the car they drive away in. Something we can follow up on." ■

In NJ, impostors attempt hospital access and flee

Officials at two small hospitals in New Jersey say impostors tried to gain access to their facility in scenarios that match the accounts heard from other hospitals across the country.

The impostors went to Newton Memorial Hospital in Sussex County, NJ, on Sunday, March 27, 2005, at approximately 4:45 p.m., says **Brian Grace**, director of marketing and public relations. Three men identified themselves as doctors to an individual in the lobby of the hospital in Sussex County and began asking questions concerning the facility's bed capacity, services, hospital directory, and they requested a tour of the hospital.

"They never presented any credentials and when we started to quiz them they decided to move on," he reports. "There was some reason to believe them at first because we are hiring physicians, but then they started asking about the grounds and some information on security."

Once the men left, the staff reported the incident to hospital security and the local police. The lobby security camera captured good images of the impostors, which was turned over to the police and federal authorities, Grace says.

Staff at Newton Memorial were on alert for such impostors because they had heard about a similar incident at nearby Warren Hospital in Phillipsburg Township, a year earlier on March 11, 2004. In that incident, an adult male of Middle Eastern appearance entered the emergency department at approximately 4 a.m., says **Kay Shea**, vice president of public relations.

"He addressed the registration clerk and asked about how many doctors the hospital had, how many employees, said he was new in the area, and wanted to know the visiting hours," Shea says. "Then he noticed the security camera and turned around and walked off."

The clerk was very suspicious, partly because such a visit at 4 a.m. is so unusual, and followed the man outside. The imposter drove off in a white van. The FBI took the security tape.

"We were fortunate to get him on tape," Shea says. "And it was a pretty good picture." ■

When a crisis strikes, turn to your bible of crucial info

Sooner or later, some type of crisis will hit you and your organization. It's an inevitable part of your job, so risk managers should plan for that day by preparing contingency plans and putting together a "bible" of crucial information ahead of time, suggest two risk managers who have weathered storms.

The advice comes from **June Leigh**, CPHRM, RN, BSN, MS, FASHRM, ARM, risk control director with CNA HealthPro in Chicago, and **Nancy Lagorio**, RN, MS, CCLA, risk control consultant with the company. They presented their strategies for crisis management at the recent meeting of the American Society of Healthcare Risk Management (ASHRM) in Orlando, FL.

A risk manager's crisis can take many forms, Leigh says, from a tornado hitting your hospital to a medical error that causes the death of a patient. "In health care, a crisis is something that suddenly or unexpectedly has actual or potential adverse effects on the organization or its patient, staff, or community," she says. "That can cover a lot of scenarios."

Leigh notes that not all crises lead to a disaster in which the organization experiences total failure. But some crises that start out relatively small can build to that point if handled poorly, she warns.

"Some organizations may manage to avoid a crisis turning into a disaster through plain old, dumb luck, but more reliably, it's better to prepare and plan," Leigh says. "Like the old saying goes, 'It wasn't raining when Noah built the ark.'"

All industries have to contend with crises, but she notes that health care providers have an added burden because their crises tend to hit the front page of the newspaper, with the biggest headlines, and stay on the front page longer. They also receive both regional and national attention, a result of the public's overall level of distrust regarding health care.

"The longer the bad news stays on the TV news or on the front page, the more damage it is likely to do," Leigh says, "and the more difficult it is to overcome."

Always tell the truth

Risk managers should always keep in mind how the media will portray any action, or inaction, by the health care organization, she says. Leigh and Lagorio offer these key strategies for responding to any crisis:

- **Tell the truth, tell it well, and tell it often.** This is the No. 1 rule for any crisis. Refer to it when in doubt about what to say to anyone.
- **Do the right thing.**
- **Don't delay.** A crisis always requires prompt action. Doing nothing is always the worst response.
- **Don't expect a crisis to go according to plan.** Actual crises rarely are identical to what you

prepared for. The best you can hope for is that you prepared for the general type of crisis you're facing and that your plans are flexible enough to allow you to adapt to the realities unfolding.

Include reps from all major departments

Lagorio says your crisis management plans should start with an identification of potential problems that you could face. These will differ from one organization to the next, depending partly on your geographical location, the size and type of your facility, and the services you offer.

The types of crises range from natural disasters, such as tornadoes, to external emergencies, such as a chemical exposure in the community. There also can be internal crises, such as large-scale infections. And don't forget the internal, nonmedical crises such as an employee strike.

When brainstorming about potential crises and the response plans, be sure to include a representative from every part of the organization, says Lagorio. For each potential crisis, she advises considering each of these points:

- geographic scope and duration;
- impact on operations;
- employee involvement;
- regulatory, accreditation, and law enforcement involvement;
- public concern;
- likely media coverage.

For each scenario you anticipate, carefully establish a formal crisis management and communications team with clearly defined roles and responsibilities. Be sure to consider communications facilities and the heavy demands on space, telephones, web sites, and other resources.

Develop a bible to use in a crisis

Part of your planning should include the development of a bible that can guide you through the tough times, Leigh says. Distribute this handbook of crucial information to leaders throughout the organization so that it is ready to use in a crisis. Leigh and Lagorio recommend including this information in the bible:

- Contact information for core team members, backups, and chain of command.
- Contact information for those others who need to be informed, such as sales representatives, switchboard operators, site security, and contact people at other company sites.
- Information for contacting key people outside the organization, such as experts to whom you can turn for information and external spokespersons.
- A list of local and national media contacts.
- Common questions and answers that may apply in this crisis. For a crisis involving a particular procedure, for instance, the questions might address when the procedure was approved, how many people have the disease, how many procedures are performed nationwide and at your facility each year.

Update the questions and answers frequently, but save the old ones in a separate section in case a reporter asked about information you presented previously. Reporters frequently review archived media stories and may inquire about old statistics or answers, so you need to know where that information came from.

- Any past press releases relating to the issue. Again, you need to know what you have told the press in the past, even if that information no longer is current.
- Procedures that address document management, including e-mail.
- A communication plan that addresses all major constituencies such as patients and families, internal staff, medical staff, board members, and public officials. Be sure to include your policy on who is authorized to communicate with the media or other parties.
- Procedures for media relations, including access to patients, photography, press conferences, message logs, and media inquiry forms.
- Rules for security and confidentiality, including the release of information.
- Policies on training personnel and conducting drills.

Use media to communicate your message

Rely on the bible you prepared before the crisis, but be sure to update it with relevant information during the crisis situation. Add information such as statements issued, supportive statements from third parties, media coverage, and backup information such as published studies and sources for the statistics you will quote.

A major part of your crisis management plan should involve how you communicate internally and to the public. She advises following these key steps for crisis communication:

1. Gather the facts.
2. Determine the size of the crisis.
3. Assemble those involved.

4. Delegate assignments.
5. Relate the facts promptly.
6. Communicate from a high level.
7. Accept responsibility but not blame.
8. Express compassion.
9. Use your positive reputation to your advantage.
10. Follow up with more communications after the crisis to rebuild the image of your organization and restore public trust. ■

In getting your message across, work with media

Risk managers often see the media as enemies trying to show you at your worst, but you're better off looking at reporters as potential allies. That may be hard when they're firing aggressive questions at you, but with the right approach you can use the media to get your message to the public, say **June Leigh**, CPHRM, RN, BSN, MS, FASHRM, ARM, risk control director with CNA HealthPro in Chicago, and **Nancy Lagorio**, RN, MS, CCLA, a risk control consultant with the company.

There are three key factors that will determine how much media coverage your crisis gets: the number of people affected, the severity of the crisis, and the location. When communicating with the media, Leigh and Lagorio advise following these rules:

- Appoint a primary spokesperson. That might be the risk manager, but it often is the director of communications or someone else who is comfortable on camera and familiar with how the media work.
- Respect reporters' deadlines. Schedule announcements and press conferences at times that help them make their deadlines for print publications and the day's newscasts.
- Return calls promptly, even if you can only reply that there is nothing new to relate.
- Don't make off-the-record comments. They can make their way into the news.
- Use third-party allies as support.
- Keep employees informed. Don't let them hear important news from the media.
- Use external resources to train anyone who may be called on to act as a spokesperson.
- Build rapport with the media so they are not strangers during a crisis.
- Draft a news media protocol.
- Draft general media responses.
- Rehearse regularly.

Dos and don'ts for working with media

Lagorio also offers these dos and don'ts for communicating with the media:

- Don't get caught in "good vs. bad" by entertaining questions about who is to blame.
- Don't say, "No comment." Even if you really can't comment, find another way to say it. The phrase "no comment" has come to be seen as a defensive way of stonewalling reporters and implies you have something to hide.
- Don't speculate.
- Don't interview in crisis areas, such as the emergency department, triage area, or the unit where a mistake occurred. Conduct all interviews in a neutral, calm area.
- Don't repeat negative statements in responses.
- Don't mislead or block information. ■

Adverse outcomes: More patient- than error-related

Even though incorrect dosing occurs in about 5% of patients with heart attack who receive a certain blood clot-dissolving therapy, patient-related factors appear to be more responsible for adverse outcomes than the dosing errors, according to a recent study.

The findings could be important in defending malpractice lawsuits related to dosing errors, the authors suggest. Several studies have reported higher death, stroke, and major hemorrhagic event rates in patients who received incorrect doses of fibrinolytic (clot-busting) agents, according to background information in the article. However, several patient factors identified as related to risk of incorrect dosing are also markers of higher risk of death, thereby limiting inference about the cause-and-effect relationship of incorrect dosing and adverse outcomes.

It has been assumed that the adverse outcomes are caused by incorrect dosing. However, it also is possible that the adverse outcomes may be due to confounding factors such that sicker patients with an unstable early clinical course could be more likely to receive incorrect doses, says **Rajendra H. Mehta**, MD, MS, of Duke Clinical

Research Institute and Duke University Medical Center in Durham, NC.

Mehta and colleagues conducted a study to determine how much of the association between incorrect dosing and adverse outcomes is cause and effect (*JAMA* 2005; 293:1,746-1,750). The researchers hypothesized that if the incorrect dose was causing adverse outcomes, the association between incorrect dosing of active fibrinolytic and adverse outcome would be much stronger than the association between incorrect dosing of fibrinolytic placebo.

The study included 16,949 patients with ST-segment elevation heart attack (STEMI; a certain measurement on an electrocardiogram) who were enrolled in the Assessment of the Safety and Efficacy of a New Thrombolytic (ASSENT-2) trial. Patients were assigned to either a bolus (injection of a specified dose) of tenecteplase (clot-dissolving agent; with alteplase [clot-dissolving agent] placebo bolus plus infusion) or a bolus of alteplase (with tenecteplase placebo plus infusion).

The researchers found that incorrect dosing occurred in 4.9% of patients who received active alteplase and in 4.6% of patients who received alteplase placebo. Patients receiving incorrect doses of alteplase or alteplase placebo were more likely to be older, female, black, shorter, have lower body weight and systolic blood pressure, and have a higher Killip class (heart failure measurement) at presentation.

Thirty-day mortality was higher in patients who received an overdose (9.8%) or underdose (19.5%) of alteplase compared with those who received a correct dose (5.4%). The same pattern was present in patients who received an alteplase placebo (10% for overdose, 23.5% for underdose, and 5.4% for correct dose). Similar patterns were seen for in-hospital intracranial hemorrhage and major bleeding. The higher rates of adverse outcomes with incorrect dosing were largely accounted for by adjusting for baseline characteristics.

"Medical errors due to incorrect dosing of fibrinolytic therapy have been shown to be associated with increased risk of adverse events in STEMI patients and with increased risk of litigation against caregivers," the authors wrote. "When identifying an incorrect dose of a potentially toxic drug associated with an adverse outcome, the reflex and logical conclusion is to assume cause, particularly in malpractice litigation that is principally driven by adverse outcomes."

However, this study raises the possibility that much of the adverse outcomes ascribed to dosing errors, at least in some situations, may be due to confounding rather than a direct effect of the error itself, they wrote.

"Thus, while medication errors need to be minimized, caution should be used in concluding that adverse outcomes associated with errors are primarily caused by the errors," the authors conclude. ■

Insurance costs may rise as soft market hits bottom

Prices in the commercial insurance industry, which declined steadily in 2004 in the first yearlong soft market since 1998, may be showing signs of a rebound, according to a new survey.

The information comes from the Risk and Insurance Management Society (RIMS) in New York. The group's RIMS Benchmark Survey is the industry's only comprehensive survey of current policy renewal prices as reported by corporate risk managers.

In late 2004, RIMS predicted that underlying economic conditions should ensure that insurance capacity remains at levels that would discourage a pricing freefall. Prices in General Liability and Commercial Property lines appear to be fulfilling those forecasts.

Prices in both lines showed signs of firming during the first quarter of 2005 compared to the decreases experienced over the previous several quarters. Property lines saw prices continue to decline at a rate of 3.5%, but that was in sharp contrast to a nearly 10% decline reported in the fourth quarter of 2004. General Liability actually experienced a slight increase in pricing of 1.1%, potentially presaging a return to a period of rising premiums for that line, says **Daniel H. Kugler**, RIMS vice president of membership.

"We have consistently predicted that this soft market would probably be short-lived and relatively shallow, especially compared to the extremely deep and prolonged soft market of the 1990s," Kugler says. "We'll wait to see if we return to the go-go pricing of the last hard market, which we doubt right now, but for the time being, pricing seems to be showing signs of stabilization."

Directors and officers (D&O) liability prices seem to offer a microcosm of a market potentially in transition, he says. The initial reports show that prices declined significantly for the first quarter,

down 8.1%. But anecdotal indications from the market suggest that larger programs, such as programs for Fortune 500 companies, have seen D&O prices either flatten or even increase.

David Bradford, editor-in-chief at Advisen, the New York survey company that conducted the research for RIMS, says most of the major lines seem to be showing some sign of rebounding.

"We have to wonder, however, if this is the bottom, the beginning of the bottom or a brief respite ahead of another round of large decreases," he says. "We doubt it is the latter. Premiums may go a bit lower yet, but it feels like the market is testing its lower bounds." ■

Reader Question

It's best to not reserve capacity, refuse transfers

Question: Can we ever "reserve capacity" for special purposes and refuse transfers even though we technically have beds open? We'd like to save an intensive care unit (ICU) bed for any in-house emergencies, but that might mean refusing to accept a transfer due to "no capacity," and that seems like we're telling a white lie.

Answer: Your motivation is understandable, but reserving capacity for a hypothetical need is a sure way to run afoul of the Emergency Medical Treatment and Labor Act (EMTALA), cautions **Maxine Harrington**, JD, associate professor of law at Texas Wesleyan School of Law in Fort Worth.

Harrington notes, however, that EMTALA does not always require a hospital to accept a transfer. Hospitals must accept the transfer when the patient needs specialized care that is available at that hospital but not found at the transferring hospital, such as neonatal intensive care or burn treatment.

So for the discussion of reserved capacity, consider a situation in which Hospital A is trying to transfer a patient to Hospital B because Hospital B has the type of specialized care needed by the patient. Then the question becomes "Does the second hospital have the capacity to accept that patient?"

"Capacity" can be difficult to define and is not as simple as the term might imply, Harrington says. When investigating a possible EMTALA investigation, the government will look beyond simply how many beds were empty and whether one of them could have been used for the patient in question. Your hospital's history of bed use may play a role, she says, because the government can look at how you responded to requests in the past. Did you move patients around in the hospital, call in additional staff, or borrow equipment from elsewhere? If so, the investigators may want to know why didn't do that in this case.

The government expects you to be truly unable to accommodate the patient before refusing the transfer, Harrington says. So having a bed empty and reserved for some possible need in-house would not meet that standard, she explains.

But there is an important caveat. If that bed is reserved for a particular patient, such as someone in surgery or post-op recovery, that bed is not available. So you can set aside a bed for *an actual patient* who will need it soon, but not for a hypothetical need, Harrington says.

"You also can prioritize beds, and there is nothing wrong with giving priority to patients in your

CE instructions

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.

The semester ends with this issue. 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. ■

COMING IN FUTURE MONTHS

- Perils of increased e-mail communication
- Disruptive physicians: Find them and fix them
- Teamwork lowers risk in labor & delivery
- Liability risks from employed physicians

own hospital if the priority is based on acuity," she says. "If you have one bed open and you have a patient in surgery who will need it in half an hour, you can honestly tell the other hospital that you don't have a bed available right now." ■

CE objectives

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

- **Describe** legal, clinical, financial, and managerial issues pertinent to risk managers in health care.
- **Explain** how these issues affect nurses, doctors, legal counsel, management, and patients.
- **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.
- **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

21. What does Joe Cappiello advise regarding visits by anyone claiming to be a surveyor from his organization?
A. Always verify their credentials and don't hesitate to call his office for confirmation.
B. Assume they are who they say they are if they act like surveyors.
C. Record their names, but no other confirmation is necessary.
D. Never allow entry to someone claiming to be a surveyor if the exact visit time was not scheduled in advance.

22. According to bulletins issued by law enforcement agencies, which of the following is true of the impostors who tried to gain access to several hospitals by impersonating officials?
A. They all appeared to be of Middle Eastern descent.
B. They were all male.
C. None of them spoke English well.
D. They were of varied appearance and both men and women.

23. According to advice offered by June Leigh, CPHRM, RN, BSN, MS, FASHRM, ARM, and Nancy Lagorio, RN, MS, CCLA, how should risk managers work with media during a crisis?
A. Assume the media will make you look bad and release as little information as possible.
B. Choose one local reporter to release information to and shut out the rest.
C. Communicate only with national media reporters, never the local media.
D. Work as cooperatively with the media as possible and see them as a way to get your message to the public.

24. What does Maxine Harrington, JD, advise about "reserving capacity" without violating EMTALA?
A. Hospitals may reserve beds as they see fit.
B. Hospitals may never reserve beds for any reason.
C. Hospitals can reserve a bed for a specific patient expected to need the bed soon, but not for a hypothetical need.
D. EMTALA allows for a one-hour hold period, after which the bed must be made available for transfers.

Answers: 21. A; 22. D; 23. D; 24. C.

Healthcare Risk Management's
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A Monthly Supplement

Neck fracture not detected: $31.1 million verdict in Texas

By **Jan. J. Gorrie**, Esq.
Buchanan Ingersoll PC
Tampa, FL

News: A professional truck driver was involved in a serious motor vehicle accident. EMS personnel placed him on a backboard, supported his neck with a cervical collar, and transported him to the nearest trauma center. While being triaged and evaluated in the ED, the patient's protective neck collar was removed and he was assisted in walking to a wheelchair. On the way to the wheelchair, he collapsed and has been unable to walk since. The patient and his family brought suit against the trauma center and emergency physicians; they were collectively awarded $31.1 million, which included almost $8 million in punitive damages against the hospital.

Background: The patient, a 41-year-old truck driver, was injured in a brutal rollover motor vehicle accident on a highway near Dallas. EMS placed the driver, who had visible swelling on his head due to a hematoma, on a stabilizing backboard and placed a cervical collar on his neck prior to transporting him to the nearest Level I trauma center.

At the trauma center, his examination included several neck X-rays, which were interpreted by a radiology resident. After receiving the X-ray results, the emergency nurse removed the protective neck collar and had walked the patient about 10 feet toward a wheelchair when he collapsed. He was left without sensation from the chest down and with minimal movement and strength in his arms and hands. The patient ultimately suffered a severe subluxation of the spinal cord, which left him paralyzed.

The patient and his two children — a daughter age 18 and an 11-year-old son — sued the hospital and the two physicians involved. The patient alleged that had his condition been treated conservatively and appropriately, he would have experienced 100% recovery. The plaintiffs claimed that when the patient arrived at the trauma center, he complained of a burning sensation within his fingers and that consideration of his complaints combined with a correct interpretation of his X-rays should have lead the staff and physicians to a more conclusive diagnosis. In addition, the plaintiffs maintained that the nursing staff and physicians ignored the signs and symptoms that the EMS personnel had observed in the field, and that they should have followed EMS' lead in paying more attention to the potential severity of the injury. Specifically, the plaintiffs averred that the medical personnel should have realized that his neck needed to be surgically fused prior to his attempting to walk. Instead, the plaintiffs claimed the staff and physicians failed clinically and radiologically to find the two small fractures along with the torn ligaments in the patient's neck, which made his cervical spine unstable for any movement.

At trial, the emergency physician testified that

he had not completed his examination of the patient at the time of the further aggravation. The ED doctor contended that he did not order the nurse, and had not intended for her, to walk the patient, much less remove the neck collar. The nurse testified to the contrary. She claimed that the physician had explicitly instructed her to remove the stabilizing collar and to discharge him. The plaintiffs successfully maintained that the hospital was negligent, that its policies and procedures were insufficient to address the injuries sustained by the patient and that the nursing staff was not properly trained to work in a Level I trauma center. They further contended the ED was understaffed at the time of the incident, operating with a 9-1 patient-staff ratio instead of the 4-1 ratio standard for a trauma center. The plaintiffs also argued the hospital's malfeasance constituted malice.

The patient claimed damages for past and future medical expenses, pain and suffering, impairment, disfigurement, and mental anguish. His children claimed damages for loss of society and support. The jury found the hospital 65% liable, the radiology resident 27% at fault, and the emergency physician 8% liable. The plaintiffs were collectively awarded $31.1 million. The patient was awarded $30.4 million, including: $190,000 for past medical expenses, $7.5 million for future medical costs, $200,000 for past lost earnings, $800,000 for future lost wages, $1.75 million for past pain and suffering, $3.5 million for future pain and suffering, $300,000 for past disfigurement, $700,000 for future disfigurement, and $7.75 million in punitive damages against the hospital. His daughter will receive $246,500 for loss of consortium, and his son shall receive $492,000 for the same.

What this means to you: "This emergency room was a scary place. The narrative provided reflects a group of medical professionals who lacked leadership, team cooperation, and communication. Trauma patient policies appear to be lacking or at a minimum not adhered to. The nurse in question either was unfamiliar with ER policy, was inadequately trained or merely disregarded the ramifications of what she was about to do. The physician was not exercising proper oversight over the patients or his subordinate staff. The unit appeared to be understaffed, a huge liability particularly in such a critical care area where every minute counts and every decision must be made in light of all if known facts," says **Lynn Rosenblatt**, CRRN, LHRM, risk manager at HealthSouth Sea Pines Rehabilitation Hospital in Melbourne, FL. "The ER is not the place for the faint of heart. Quick action is the order of moment. The environment is supercharged and the staff runs on continuous adrenaline high. Given the pace and severity of the patients seen, it is certainly a place where the potential for serious life threatening and life endangering mistakes is magnified a hundredfold.

"The nature of care expected to be provided in a trauma center requires the quick mind of not one but many highly trained professionals each contributing to the whole. Staffing in this setting is an enormous challenge as the volume of patients and the level care required is unpredictable. The ability to accurately triage patients and assign care to appropriate staff requires specialty training in itself, and advanced practice across all participating care givers. Competency of the trauma team should be assessed and reassessed. Hospital personnel who have not been trained in an ER environment and specifically in trauma care should not be assigned there," notes Rosenblatt.

"Trauma patients arrive as total strangers, many are unable to assist in providing essential details as to the nature of the illness or injury. Some are mildly sick and barely injured, while

others are near death. Treatment success depends on a coordinated assessment by all members of the trauma team under the direct leadership of the physician. Each member collects independent data related to a specific clinical specialty and collaborates with the other team members on a plan of care," says Rosenblatt.

"In this case the information gathered at the scene of the accident did not trigger the cautious responses that it should have," says Rosenblatt, "a patient arriving via ambulance following a roll-over trucking accident on a backboard and in a neck collar should have sent a signal that this patient would require very careful handling. The situation spoke loudly to an assumption of potential spinal cord injury — had the staff and physicians been listening. This assumption was even more reasonable given the patient's complaint of burning in his distal extremities, a common diagnostic sign in spinal cord trauma.

"Protocols should be designed that trigger additional diagnostic procedures, should the patient's symptoms merit greater investigation."

"The X-ray department should have received the patient in the same state that he arrived, backboard and collar. This would have provided not only stabilization, but also would have served as an alert to the radiology staff as to the patient's potential for a serious spinal injury. While the narrative failed to identify the actual training level of the radiology resident, anyone less than at a senior level probably should have sought confirmation of the initial impression given the serious nature of the suspected injury and the results of a misdiagnosis," notes Rosenblatt.

"Protocols should be designed that trigger additional diagnostic procedures, should the patient's symptoms merit greater investigation. The same is true in dealing with cardiac patients or strokes. The patient's symptoms should speak to medical professionals in a manner that demands a correct diagnosis. In this case the films appeared negative but the nature of the injury and the patient's burning sensation should have defied the radiology evidence. There appeared to be sufficient rational to look further prior to letting the patient walk," says Rosenblatt.

"In this modern age of medical response, success with many catastrophic emergency situations depends on protocols that are implemented in a time-sensitive and highly coordinated manner. The timing and accuracy of the diagnosis and treatment are essential to the patient's recovery, and the policies and procedures are the dictates by which the response team operates. Just as specific procedures are the cornerstone of the operating room suite and dictate in every respect the outcome of the procedure, the same holds true for specific responses in the ER — particularly one that purports to be a trauma center," adds Rosenblatt.

"The contradictory testimony of the physician and the nurse certainly speaks to a failure of some sort of established leadership and communication channels. It certainly raises several questions. Was the physician too busy with other cases to realize what the nurse was speaking to him about? Alternatively, was this patient confused with another whose injury may not have been so serious? Did the nurse assume that the treating physician had reviewed the radiology findings, completed his assessment of the patient, and signed off on the case? Were there policies to cover all of these potential risk situations and the countless other possibilities that emergency care can generate?" asks Rosenblatt.

"During trial, it is relatively easy and certainly common for both sides to proffer expert testimony as to what should have and should not have been done. The jury will believe the testimony that supports the injury that the patient can prove was sustained, or testimony that allows a reasonable deduction that there was no injury or no blame. In this situation it was impossible for the hospital to dispute the plaintiffs' contention that the hospital was understaffed, as staff records would be readily available and testimony as to general practice damning," says Rosenblatt.

"The dispute between the nurse and the physician was also a critical factor. The physician claims that he never ordered that the patient was to be discharged. Certainly there was no written order to that effect, so the nurse relied on a verbal order, or so she claimed. It also appears that medical evaluation was not complete. A cursory look at the treatment record should have indicated that to the nurse, which raises the question of whether she reviewed the patient's treatment record before removing the collar in preparation for discharge. In fact there is no way to determine what she verified, but it is easy for a jury to assume that she acted on her own as there is no proof otherwise, even though

the physician's statement is self-serving," notes Rosenblatt.

"A case like this is big anytime a jury has to decide how much will it cost to make it right. What was likely described to that jury was the hospital's incompetence. What they saw was a severely injured individual with multiple life-altering situations. They also saw lifelong dependency, two children whose lives were impacted, and major medical expense over his lifetime. Is there any doubt that the award would be huge? And don't for a minute think only in Texas!" concludes Rosenblatt.

Reference

- Dallas District Court, Case No. 01-1793-E. ■

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