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IN THIS ISSUE

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Katrina murder allegations put spotlight on dire situations

Risk manager can learn from extreme example, response to charges

(Editor's note: This month's Healthcare Risk Management *includes a special report on the allegations that a doctor and two nurses committed second-degree murder while caring for patients in the aftermath of Hurricane Katrina. On* ***page 100****, the attorney representing the accused doctor says she is innocent.* ***Page 100*** *has an article discussing what risk managers can learn from the case. On* ***page 101****, see the statement released by Tenet Healthcare Corp. in which the parent company distances itself from the hospital incident and the accused clinicians. And on* ***page 102****, a medical ethicist discusses what may have happened at the hospital.)*

Special Report: Katrina Deaths

Murder allegations against a physician and two nurses at a New Orleans hospital have stirred up the health care industry, especially the hospitals and other providers that suffered through the dire conditions after Hurricane Katrina hit in August 2005. Louisiana Attorney General **Charles C. Foti**, JD, accuses the three clinicians of murdering four critically ill patients in the flooded Memorial Medical Center and has had them arrested on charges of being

EXECUTIVE SUMMARY

A doctor and two nurses are accused of using lethal injections to intentionally kill patients at a New Orleans hospital in the days after Hurricane Katrina. Risk managers say that though the case may be extreme, there are lessons to learn from the tragedy.

- Assume your clinicians made valid medical decisions until you learn otherwise.
- Stand by your staff during the investigation.
- Plan how you would respond to other, less extreme circumstances.

"principals to second-degree murder." Formal murder charges are being considered.

The decision whether to file criminal charges will be made by the New Orleans district attorney, but Foti made it clear that he believes the three intentionally killed the patients. He also made the distinction that the alleged killings were not "mercy killings."

In a press conference, the attorney general accused **Anna Pou**, MD, and two nurses, **Cheri Landry** and **Lori Budo**, of committing second-degree murder and recommended that the New Orleans district attorney file criminal charges.

"This is homicide, not euthanasia," Foti said. He went on to say that the clinicians injected the four patients with a "lethal cocktail that guaranteed they would die." He did not offer a motive for the alleged killings.

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Desperate situation after storm

According to the affidavit released by the state attorney general's office, an investigation after Katrina revealed that four of the patients who died at Memorial Medical Center had morphine and the sedative Versed (midazolam hydrochloride), drugs that those patients were not supposed to have, in their systems. The criminal affidavit filed by the state attorney general alleges that Pou and the nurses went from room to room with a set of syringes and vials, injecting at least four patients with a combination of drugs intended to kill those who could not easily be evacuated from the hospital.

Pou's attorney, **Richard T. Simmons**, JD, with the firm Hailey McNamara in Metairie, LA, says the doctor did not commit murder but he will not comment on the specific allegations made by the attorney general. The allegations are similar to stories told by other health care providers after Katrina, featured on CNN and in other media outlets. They alleged that some clinicians at Memorial Medical Center debated whether to euthanize seriously ill patients — for the patients' own good but also so that the hospital staff could evacuate without leaving patients behind.

Until the waters receded, the only means of escape were by inflatable boat and helicopter. But not all patients could be removed by those methods. Simmons explains the sickest patients could not be moved by boat, and getting patients to the rooftop helicopter pad required carrying them up to the roof and squeezing them through a 3-foot by 3-foot hole knocked in a wall. The affidavit notes that one of the patients allegedly killed by Pou was 61 years old, weighed 380 pounds, and was paralyzed. Another was 89, with dementia and gangrene.

Some patients already had died while being transported under those conditions, Simmons says. **(See p. 100 for more from Pou's attorney.)**

ASHRM president stresses context

Risk managers must be careful not to jump to conclusions about the Memorial Medical Center deaths, says the president of the American Society for Healthcare Risk Management (ASHRM), **Peggy B. Martin**, ARM, MEd, CPHRM, DFASHRM, senior risk management coordinator at Lifespan Risk

Services in Providence, RI.

Whatever happened with the patients who died, their deaths and actions by clinicians must be considered in context, she says.

"Who knows how terrible it was, except the people who were there?" Martin says. "We do know that it was unbelievable situation. This was not a normal day at the hospital, and we can't judge their actions as if it were."

Martin compares the situation to a battlefield. Clinicians may do things in that situation that they would never do in a safe environment, she says.

Martin says risk managers should monitor this case closely because there are potential lessons for risk managers. It would be a mistake to just write off the Memorial Medical Center incident as a wild aberration, a case so extreme that there is nothing to be learned, she says. The incident can be a lesson about the difficult decisions that clinicians face in triage situations, she says.

"We don't usually do well with the idea of rationing health care or how to triage health care when the resources are limited. It's just not something health care providers like to talk about," she says. "This is an example of how those issues can really come to a head, and it's the clinicians who are forced to make decisions in the heat of the moment."

The New Orleans ordeal should make risk managers reassess how their own organizations are prepared to deal with natural disasters or any other incident that could threaten the hospital or force evacuations. **(For more on how hospitals were affected by Hurricane Katrina, see *HRM*, October 2005, pp. 121-129.)** Hurricane Katrina may have been an extreme situation, but the same issues could arise from disasters on a smaller scale, she says. A flu pandemic could produce a similar crisis in hospitals, for example.

Evacuation plans should be a key focus, Martin says. The best way to avoid the ethical and legal dilemmas faced by clinicians who are stranded with patients at the hospital is to make sure they don't get stranded in the first place, she points out.

Give clinicians benefit of doubt

Martin stresses that almost no one knows the facts of what happened at Memorial Medical Center, but she says if the clinicians administered drugs that killed the patients, the questions of liability and criminality may come down to intent. The law has made a distinction in recent years between palliative care that inadvertently hastens death and murder, she notes.

"Unless you know there was an intent to murder, you have to go with the clinical decision that physicians make at the time," she says.

Once criminal charges are brought against health care providers, the risk manager will play a key role for the organization, she says. Issues such as insurance coverage and interpreting policy restrictions will fall on the risk manager, she says. Martin cautions that criminal charges can force risk managers beyond their comfort zone, and cases such as Memorial Medical Center are a good chance to study the issues that will arise.

Use case to teach providers

The New Orleans case may make clinicians worry about their own criminal liability in a crisis, says the immediate past president of ASHRM, **Pamela L. Popp**, JD, MA, DFASHRM, CPHRM, senior director of claims and litigation at Stanford Hospital and Clinics/Lucile Packard Children's Hospital (SHC/LPCH) Insurance Co., part of the Stanford (CA) Medical Center & Clinics. Popp suggests that the case can be an opportunity to educate clinicians about many legal issues involved in medical care.

"It's a good opportunity to teach them about what criminal allegations mean for the facility, for them personally, for their licensure," she says. "Doing a session on 'what my insurance covers' is not going to get many people's attention unless

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you can point to something happening in the news and use that to explain these issues."

Popp also suggests using the Memorial Medical Center case to illustrate to providers what serving in a disaster can really be like. Health care providers often are eager to volunteer for service in disaster areas, but Popp says they often have a shallow understanding of what situations they may face. These situations may create not only physical and emotional stress, but also potential legal consequences. Providers should be warned about some of the ethical quandaries they may face, Popp says. **(See p. 102 for more on the ethical questions surrounding the New Orleans incident.)** "It could be a good idea to bring in an ethicist to discuss what they may face," she says.

It's not just an unprecedented disaster such as Hurricane Katrina that may create ethical issues, Popp says. "The same issues could come up with a flu pandemic or a big earthquake that knocks out all the hospitals," she says. "We should make sure our people are prepared for what they might face." ■

Doctor's lawyer says she was hero, not murderer

The attorney representing **Anna Pou,** MD, accused of murdering patients in the aftermath of Hurricane Katrina, says the doctor should be lauded for her work in the flooded hospital, not charged with any crime.

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Richard T. Simmons, JD, with the firm Hailey McNamara in Metairie, LA, tells *Healthcare Risk Management* that the doctor is innocent and will vigorously defend herself if criminal charges are brought. Simmons says the four patients who died were unfortunate victims of the storm and that Pou did everything she could for those left in the hospital.

"She is absolutely innocent of the charges," Simmons says. "What occurred was a media circus by the attorney general to get credit for the investigation. How it was handled was totally inappropriate. He could have just forwarded this to the district attorney and allowed him to convene a grand jury to determine if there was justification for formal charges."

Simmons says the state attorney general was grandstanding by making such a show of having Pou arrested at her home, in scrubs, after having been in surgery that morning. He says she had been told that she could self-surrender in the next few days.

"It was totally outrageous to do it this way," he says. "One defense is going to be the character of these women. People are offering to speak to their character, and we will show that these are people who spent all their lives caring for patients, who volunteered to go to the hospital in a crisis, who stayed there when others didn't, and stayed to the end. That's not a person who suddenly becomes a murderer."

He notes that Pou did not have to be in the hospital at all. She had volunteered to stay with the patients who could not be evacuated and found herself in desperate conditions, with seriously ill patients, a flooded hospital, extreme temperatures, no food for staff, looters threatening to overrun the hospital, and virtually no outside help. Medications were running low, there was no electricity, and the batteries for some life support systems were dying. Pou and the two accused nurses, Lori Budo and Cheri Landry, scrambled to keep patients alive and provide whatever palliative care might be possible, Simmons says.

The attorney says flatly that Pou and the rest of the staff deserve accolades for their work after Katrina and that they are being made scapegoats for some of the tragic outcomes of the crisis. He notes that at least seven families of patients who died at Memorial Medical Center have filed civil suits against the hospital, and Pou will find out shortly whether she also will be named in those lawsuits. The lawsuits include allegations that the hospital's parent company, Tenet Healthcare Corp. in Dallas, did not have an adequate evacuation plan. ■

Policy can't cover all situations, can backfire

The president of the American Society for Healthcare Risk Management (ASHRM), **Peggy B. Martin**, ARM, MEd, CPHRM, DFASHRM, senior risk management coordinator at Lifespan Risk Services in Providence, RI, notes how the Tenet Healthcare Corp., the parent company of Memorial

Medical Center, seems to be distancing itself from the accused clinicians. **(See article, right, for more on Tenet's position.)**

Martin says that is not what she would recommend to her corporate executives in the same situation, at least not until there is more information about what happened or criminal charges are filed.

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No matter how scandalous the allegations, Martin says risk managers usually should stand behind their clinicians until there is sufficient evidence to think they have committed an egregious act. Based on the information released so far, she is not yet convinced that Pou and the nurses accused in this incident committed a crime.

"Unless I had reason to think they were totally inappropriate — and that would take a lot of investigation — I would stand by them. No way I would abandon them just because the headlines are so salacious," Martin says. "But I would make sure my institution understood what happened, as far as we know, and I would make sure we had good criminal attorneys consulting us."

Use a general policy

Martin does caution risk managers that it is not realistic to try developing a policy or procedure that would apply in such dire circumstances. A key point is that the situation at Memorial Medical Center was so bad that the clinicians had to do whatever they thought best for the patient, she says, and they could not be expected to follow any specific procedures.

"I would rather have a general policy that says we count on the provider's clinical judgment in every circumstance to do what is best for the patient," she says. "After you've credentialed them properly and make sure you have the best people, we have to count on them to do whatever is best in any circumstance."

Any attempt at a policy that defines what can and can't be done in a crisis situation can backfire, Martin warns. "We get in trouble if we try to make a too restrictive policy because it doesn't allow for clinical judgment," she says. "We're hanging ourselves with a policy that may not apply in every circumstance. Sometimes we have an incident and then have a knee-jerk reaction to make our policies stricter and more prescriptive, even though we know the clinicians can't follow them." ■

Tenet distances itself from hospital, accused clinicians

The murder accusations against clinicians at Memorial Medical Center in New Orleans are another blow to the troubled Tenet Healthcare Corp., based in Dallas. The company immediately issued a statement that attempted to distance itself from the controversy.

"If proven true, these allegations are very disturbing. Euthanasia is repugnant to everything we believe as ethical health care providers, and it violates every precept of ethical behavior and the law. It is never permissible under any circumstances," the statement says. "We strongly believe that the judicial process must run its course before any judgments can be made about what did or did not happen in the harrowing days after Hurricane Katrina struck New Orleans. We have assisted the Louisiana attorney general in all aspects of his investigation. If the allegations are proven true, the doctor and nurses named by the attorney general made these decisions without the knowledge, approval, or acquiescence of the hospital or their key physician leaders."

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The statement goes on to say, "We will never forget the courageous actions of many, many physicians and caregivers at Memorial Medical Center, who worked under incredibly difficult circumstances to care for and evacuate patients in the aftermath of Hurricane Katrina, with little or no help from local, state, or federal authorities. More than 2,000 people, including nearly 300 patients, survived the natural disaster thanks to their bravery and dedication, and the assistance of people throughout Tenet."

The company does not need another crisis that could damage its reputation as a health care provider. In June 2006, Tenet agreed to pay $725 million to settle charges that it had duped the Medicare system to collect excessive reimbursement amounts. In the wake of Hurricane Katrina, Tenet announced that it had agreed to sell Memorial Medical Center, which has been closed since the hurricane, and two other New Orleans Hospitals to Ochsner Health System of New Orleans.

The New Orleans facility was among 11 that the company said it would divest as part of a plan to fund the government settlement and improve Tenet's future profitability. ■

Ethicist sees difficult situation in Katrina charges

The evidence released so far concerning the suspicious deaths at Memorial Medical Center in New Orleans has **John Banja**, PhD, assistant director for health sciences and clinical ethics at Emory University in Atlanta, thinking that the clinicians may have stepped over the line separating medical care from murder.

While he acknowledges that the facts are not all known yet, what he has seen so far makes him worry that the clinicians may have gone too far.

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"If that doctor and those two nurses injected that morphine with the intention — and that's the important word — with the intention of ending those patients' lives, that seems like homicide to me," he says. "Neither the risk manager or the ethicist is going to condone that."

But Banja also has sympathy for the clinicians involved, even if they did what the attorney general alleges. He suggests that risk managers think about how extreme conditions can affect a person's thinking. The incident could be a good lesson in how the decision-making process is very different under high stress.

"Health care workers normally would be loathe to load up a syringe and inject a lethal dose in someone, so if it happened, it must have taken some incredible conditions to get them to that point," he says. "It would be like the Pope taking the Lord's name in vain or a leopard changing his spots. It's hard to imagine what could bring that on, but we have to try."

The dire situation may explain what happened, even if it doesn't justify it, Banja says. That can be a lesson for patient safety overall. "Catastrophes happen when you encounter a situation that exploits the cognitive weaknesses of a professional. It's not that people just get dumb or homicidal all of a sudden," he says. "That could be what happened here, and it happens every day in hospitals all over. There's a high-stress situation, with lots of demands on an individual, and something in the mind gives way at a critical moment."

While Banja finds it hard to accept the idea of actively killing a patient for any reason, he acknowledges that the clinicians at Memorial Medical Center could have realized they were in an untenable situation. If they thought the patients were going to die no matter what, and that their own lives were in danger if they stayed longer to care for them, euthanizing them may have seemed reasonable at the time, he says.

"From an ethical standpoint, it's hard to justify. You're killing your patients," he says. "I suspect they did what they did, whatever we learn that was, because that was what they thought best at the time. We have to learn from this how people think in these situations, how risk managers can anticipate that and help people prepare for it." ■

SOURCE

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SBAR checklist can cut risk at patient handoff

Patient handoff now is known to be a high-risk time, with the transfer of responsibilities opening up the potential for misunderstandings, incomplete information, and other failures of communication that can threaten patient safety. Some risk managers and clinicians are embracing a new strategy that they say can significantly reduce the risk.

The new method is known as the SBAR checklist. SBAR stands for the key elements to be communicated in the patient handoff process: situation, background, assessment, and recommendation. Co-creator **Douglas Bonacum**, MBA, vice president of safety management with Kaiser Permanente in Oakland, CA, says the SBAR method provides clinicians a framework for communicating effectively about a patient's condition and needs.

"SBAR is an easy-to-remember mechanism that people can find useful for any conversation really, but especially this critical moment at patient handoff," he says. "It focuses on the critical elements

EXECUTIVE SUMMARY

A special checklist of topics to cover at patient handoff can improve communication at this critical juncture in patient care. Patient handoff has been proven to be a high-risk time.

- The SBAR (Situation, Background, Assessment, and Recommendation) checklist covers the key information that can reduce errors.
- A framework such as SBAR can help overcome the innate differences in how some people communicate.
- Introducing SBAR requires changing the culture of communication in your organization.

that are needed to make this handoff effective and to reduce the chance that important information will be overlooked or misunderstood."

Bonacum created the checklist along with Suzanne Graham, PhD, RN, director of patient safety for Kaiser Permanente, and Michael Leonard, MD, physician leader for patient safety. Bonacum notes that the SBAR method was inspired by the 1999 Institute of Medicine report on medical errors and patient safety, which pointed out that patient handoff can be particularly risky. Improving communication at patient handoff is part of the 2007 Joint Commission on Accreditation of Healthcare Organizations (JCAHO) National Patient Safety Goals.

The SBAR checklist helps overcome a key cause of errors at patient handoff: the big difference in how doctors and nurses communicate, Bonacum explains. Whereas nurses tend to frame their comments in relation to a nursing plan, physicians are more interested in whatever might be a problem at the moment and what they need to do to fix it.

The structured method of communication helps overcome those innate differences, Bonacum says. The SBAR checklist is used throughout the Kaiser Permanente system and is spreading quickly to other providers. **(See p. 104 for more on how the checklist works and how to get tools for implementing it.)**

SBAR gives formal structure

One of the systems adopting the SBAR checklist is OSF Healthcare in Peoria, IL, which operates hospitals and medical groups in Illinois and Michigan. **John Whittington**, MD, patient safety officer and director of knowledge management at OSF, says his organization has phased in SBAR since 2002. OSF leaders were looking for a solution after recognizing that physicians and nurses often did not communicate well.

"Before that, there was no common mental model of how we would share information between disciplines or within disciplines," he says. "There was no formal structure for communicating, so it was left up to people to do it in whatever they thought worked. It was typical communication between people, which means sometimes it was effective and sometimes information was lost in the process."

Physicians and staff were introduced to the SBAR method and encouraged to use it in many scenarios. Whittington notes that the checklist can be used for much more than just actual patient handoffs. The topics in SBAR can be useful in many circumstances in which clear communication is important, he explains, and staff were urged to think in SBAR terms when conveying any information to a physician or colleague. At actual handoffs, such as at a shift change, staff members were encouraged to use the SBAR checklist in more detail.

Not needed for every discussion

In 2002, OSF also was introducing the concept of "crew resource management," which encourages clear and communication among team members, so SBAR fit well as a tool to use. To train staff and physicians on SBAR, OSF used several methods. SBAR education was incorporated into team resource management training and general orientation. Practical help included SBAR pocket cards for clinicians and laminated SBAR "cheat sheets" posted at each phone. One of the best examples of when SBAR can be useful is when a nurse is calling a physician at home.

Education sessions also included role-playing scenarios in which clinicians were given a hypothetical patient situation and encouraged to use SBAR in discussing it. **(See p. 104 for more on how OSF introduced the SBAR checklist.)**

Whittington notes that staff adapted quickly to the use of SBAR, although there was some hesitancy in providing the "recommendation" to physicians. Physicians were encouraged to listen for the SBAR components and encourage staff to share their recommendation if it was not initially provided.

SOURCES

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OSF leaders also found that they needed to acknowledge when SBAR is unnecessary. Some brief, straightforward communication does not require SBAR, he says. If a physician has requested that a nurse call when a specific lab result comes in, for example, it's not necessary to go through the entire SBAR list for that conversation when she calls an hour later, Whittington says.

"Physicians and staff need to know that you're not expecting them to run down unnecessary information every time they have a conversation," he says. ■

SBAR checklist outlines what to say at handoff

This is the basic framework of the SBAR (Situation, Background, Assessment, and Recommendation) checklist developed by Kaiser Permanente in Oakland, CA, to improve patient safety when handing off a patient from clinician to another. (It can be used in other situations as well.) The clinicians are expected to communicate this key information and use the checklist as the basis for their conversation about the patient:

• **(S) Situation.** What is the situation you are calling about? Identify self, unit, patient, room number. Briefly state the problem, what is it, when it happened or started, and how severe it is.

• **(B) Background.** Pertinent background information related to the situation could include the following:

— the admitting diagnosis and date of admission;

— list of current medications, allergies, intravenous fluids, and lab results;

— most recent vital signs;

— lab results, including the date and time test was done and results of previous tests for comparison;

— other clinical information;

— code status.

• **(A) Assessment.** What is the nurse's assessment of the situation?

• **(R) Recommendation.** What is the nurse's recommendation, or what does he or she want? Examples could be recommending that the patient be seen immediately or that orders be changed.

(Editor's note: Tools for implementing the SBAR checklist can be downloaded free at the web site of the Institute for Healthcare Improvement in Cambridge, MA. You must register at the site to access the resources, but the registration is free. Go to www.ihi.org. After registering, choose "topics" on the left of the home page, then "patient safety" and then "safety: general." Then choose "tools," and on that page find the tool called "SBAR Technique for Communication: A Situational Briefing Model." Click on that file and then "download file" at the top of the page.) ■

Seems simple, but culture change can be difficult

While SBAR (Situation, Background, Assessment, and Recommendation) technique is a fairly straightforward concept, implementing the methodology can be more difficult than you might expect, says **John Whittington**, MD, patient safety officer and director of knowledge management at OSF Healthcare in Peoria, IL, which operates hospitals and medical groups in Illinois and Michigan.

"It's not enough to just explain the components of SBAR and then tell people to start doing it," he says. "It may look like just a checklist that people go down and convey certain information, but some of that involves changing the way people interact with each other, and that can be very ingrained. That's why we saw some hesitation when it came to nurses making a specific recommendation to the physician."

Overcoming that hesitation required time, Whittington says. The nurses had to see that the organization would support them speaking up and making suggestions. Plus, supervisors and other hospital leaders would periodically check on how nurses were using SBAR and would pay special attention to that step.

Measuring the success of SBAR can be a challenge, Whittington says, because no one measure of outcomes can be tied directly to the communication method. To see how well SBAR was being introduced in the OSF culture, Whittington and a colleague made spot checks by calling all the departments in every facility and asking to speak with a nurse. They would ask the nurse what SBAR stands for, and at first, many had no idea.

Over time, the recognition of SBAR improved. Whittington asked the nurses how much they used it. Early on, the nurses sometimes said they only used SBAR with physicians they liked. They felt uncomfortable using it with others.

"In the second year, we sent 'secret shoppers' who went out and had them interact with physicians and nurses, having the kind of conversation in which SBAR should be used," he says. "By then we found that people were using SBAR when it was appropriate, and when there was any shortcoming, it was usually with the recommendation." ■

Rapport with in-house counsel comes in handy

(Editor's note: This is the first of a two-part series on how to get the most from your relationship with both inside and outside counsel. In this article, we look at how to work best with your in-house counsel. Next month's Healthcare Risk Management *will explore how to best work with outside counsel.)*

A good relationship with in-house counsel will help you both to your jobs better, especially if you are employed by a large, complex health care organization, notes **Earl Harcrow**, JD, an attorney with the law firm of Haynes & Boone in Fort Worth, TX. The larger the organization, the more likely that you will be working with in-house counsel on many issues, he says.

Conversely, however, a large organization also can mean that the in-house counsel is in a different office in a different city. Even if you can't go out for lunch every week, risk managers should develop a relationship with in-house counsel so that you can communicate when business arises, Harcrow notes. Developing that relationship means taking steps to meet these people and at least become familiar with them, if not friendly, so that there is some common ground before you call them one day with a problem.

Ask the legal department to keep you informed about any changes in state or federal law that could have an impact on the organization, he says. "The more they can let you know about those changes and help you stay current on the law, the better you'll be able to do your job and the better you can work with them when an issue arises," he says. "Request that the legal department add you to any broadcast e-mails or other regular updates they do for their attorneys and paralegals. Get in the loop as much as you can."

EXECUTIVE SUMMARY

Working well with in-house counsel is important to doing a risk manager's job well, but a good relationship does not come automatically. Good communication up front and a thorough understanding of each other's needs can smooth the way.

- Meet with in-house counsel regularly.
- Determine what the legal department needs from you.
- Know when to call counsel, and have the appropriate facts in front of you first.

Know what legal needs from you

Fred Smith, JD, a partner in the Chicago office of Sedgwick Detert, notes that, as with any relationship, people like it when you make their job easier. When working with in-house counsel, that step might mean getting a clear understanding of what they expect from your department.

"Risk managers should identify and address with in-house counsel the particular internal reporting and other requirements that are important to in-house counsel so that these needs can be met from the very beginning of the relationship," Smith says. "To ensure good communication, the risk manager should coordinate quarterly, or as needed, telephone conferences with in-house counsel to discuss cases, relationship needs, and any other issues."

Smith also suggests that the risk manager should establish a written survey to be sent to in-house counsel on a yearly basis, allowing counsel to comment on the relationship and identify positive elements and problems. The survey also should allow counsel to identify any other needs that have arisen.

Stacy Gulick, JD, an attorney with the law firm of Garfunkel Wild in Great Neck, NY, and a former hospital risk manager, points out that risk

SOURCES

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managers should be prepared before consulting counsel on any issue. Don't fall into the trap of thinking that you can be less prepared when talking with in-house counsel just you're not being charged by the minute.

"I did this myself as a young risk manager, calling for help from the lawyer before I had all the facts in front of me," she says. "The risk manager needs to call counsel early, but not so early that you don't know the basic facts that the attorney is going to ask you. Take a little time to get information before calling, and that will reduce the amount of back and forth work as you try to answer the attorney's questions."

At the same time, however, don't wait too long to call in-house counsel, Gulick says. Remember that the legal department is at your disposal and you're all on the same team. If you have established a good working relationship with the lawyers and paralegals, you will be able to call for assistance with some confidence that you know when and how to involve them, she adds.

Gulick notes that the best way to work with your in-house counsel is to be well educated regarding legal and liability issues. A good risk manager should be able to converse effectively with counsel and know when to let the legal counsel be responsible.

"There is a lot of overlap in abilities and knowledge, especially with a good risk manager, but there is a time when your counsel needs to take over," she says. "It's usually not cut and dried; but once there are other lawyers involved, once you have involvement with outside regulators, once anyone threatens legal action, legal counsel should take a leading role." ■

Settlement means feds looking at charge levels

A recent settlement by a New Jersey hospital chain should alert risk managers that federal investigators are taking a harder look at charge increases and possible violations of Medicare rules, says an attorney who has been following the case.

Saint Barnabas Corp., a hospital chain based in West Orange, NJ, will pay $265 million to settle a pair of whistle-blower lawsuits that accused it of systematically inflating charges to Medicare patients in order to obtain higher reimbursements, according to an announcement by the U.S. Justice Department.

Saint Barnabus is the largest health care system in New Jersey and second largest employer in the New Jersey. The settlement could be followed by more because others are facing similar allegations, says **Mark H. Gallant**, JD, former deputy chief counsel for the Centers for Medicare & Medicaid Services (CMS) and current chair of the health law practice group with the Philadelphia law firm of Cozen O'Connor.

The settlement also might result in large rewards for the three whistle-blowers who prompted the federal investigation. The whistle-blowers claimed Saint Barnabas was abusing a Medicare provision that provides for supplemental payments for unusually expensive cases, known as outliers.

The Justice Department alleged that between October 1995 and August 2003, the nine hospitals operated by Saint Barnabas "purposefully inflated

EXECUTIVE SUMMARY

A large settlement of charges alleging Medicare impropriety could signal trouble for other hospitals that recently have increased charges. What may have seemed allowable at the time now could result in a federal investigation.

- The recent settlement came after threats that the hospitals could be shut out of the Medicare system.
- Federal investigators seem to have changed their interpretation of what charge increases are acceptable.
- Risk managers should consider an internal review to determine risk and a possible response to federal charges.

SOURCE

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charges for inpatient and outpatient care to make these cases appear more costly than they actually were."

In a press release, Assistant Attorney General **Peter Keisler**, head of the Justice Department's Civil Division, said, "Today's settlement demonstrates the United States' determination to make sure health care providers do not overcharge the Medicare program." Saint Barnabas did not admit to any wrongdoing, but it entered into a "corporate integrity agreement" in which it promised to take steps to ensure compliance with Medicare regulations and policies in the future.

Risk analysis may be wise

Gallant cautions risk managers that it appears Saint Barnabus settled under the threat of having its hospitals shut out of the Medicare system. Furthermore, he isn't sure that the hospital chain did anything wrong.

"It is intriguing that there would be settlement in this case because the charges appear to stem from a loophole in the Medicare program that the government previously admitted existed," Gallant says. "This settlement will fuel the government's fire to go after other hospitals for increases in charges that were perfectly legitimate."

Gallant explains that the government now appears to be heavily and closely scrutinizing hospitals that engaged in aggressive charge level increases with an eye toward ferreting out abuses relating to Medicare outlier payments. Risk managers should be particularly vigilant if their hospitals have been subject to fiscal intermediary audits of charge increases in recent years. Risks are further enhanced for hospitals that may have selectively raised (or lowered) charges in their chargemasters with the goal of enhancing outliers, hospitals that may have done so on the advice of revenue consultants touting revenue maximization, and hospitals that raised their charges — even across the board — in the absence of a defined budgetary need or determination that the hospital's charges were below prevailing area levels.

Another "flash point — and a big problem under any reading of the rules" — would be including higher charges on UB92 billing forms for Medicare beneficiaries than for the equivalent diagnosis related group (DRG) or Current Procedural Terminology (CPT) codes billed to non-Medicare consumers or insurers, Gallant explains. "Hospitals in these situations may want to gird for an inquiry from by the Justice Department or the Office of Inspector General by performing an internal risk analysis," he says.

It is critically important that this review be done under the supervision of legal counsel, Gallant says. Otherwise, the hospitals internal findings will not be protected by legal privilege and will be fair game for a discovery request by federal authorities or private plaintiffs, such as other hospitals claiming that the offending hospital caused less money to be available for their federal outlier adjustments. ■

Tools to stop wandering may not be effective

Wandering occurs in 15%-60% of people with dementia, notes **Louise Robinson**, MD, a researcher at the University of Newcastle upon Tyne in the United Kingdom.

Health care workers have turned increasingly to drug-free ways to prevent wandering. However, "there is no robust evidence so far" to recommend any of these alternatives, Robinson says. She and her colleagues recently published a review of 10 studies of wandering prevention strategies and 27 studies on the acceptability and ethics of the techniques.[1]

Exercise programs and "multisensory environments" of light and sound relaxation sessions can reduce wandering and restlessness, but the single

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studies supporting these techniques are of poor quality, the analysis concludes. The average age of participants was 79 years, from the seven studies that reported age.

Reference

1. Robinson L, Hutchings D, Corner L, et al. A systematic literature review of the effectiveness of non-pharmacological interventions to prevent wandering in dementia and evaluation of the ethical implications and acceptability of their use. *Health Technology Assessment* 2006; 10:1-124. ■

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 management in health care.
- **Explain** how these issues affect nurses, doctors, legal counsel, management, and patients.
- **Identify** solutions, including programs used by government agencies and other hospitals, for hospital personnel to use in overcoming risk management challenges they encounter in daily practice. ■

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 semester's activity with the **December** issue, you must complete the evaluation form provided and return it in the reply envelope provided in that issue in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

9. According to Peggy B. Martin, ARM, MEd, CPHRM, DFASHRM, how should risk managers respond initially to serious allegations against clinicians?
A. Immediately distance the organization from the accused.
B. Assume the charges are true until proven otherwise.
C. Make no comment whatsoever regarding the charges.
D. Stand behind the clinicians until there is sufficient evidence to think they have committed an egregious act.

10. What did John Whittington, MD, teach physicians and staff about when to use to the SBAR checklist?
A. It should be used every time for every communication between clinicians, no matter how brief.
B. It should be used only when the physician requests SBAR.
C. Only situations involving a critically ill patient require SBAR.
D. Though the technique can be used in many situations, some brief, straightforward communication does not require SBAR.

11. Why does Fred Smith, JD, advise risk managers to conduct an annual survey of the organization's in-house legal counsel?
A. To determine the number of hours spent on malpractice cases.
B. To allow counsel to comment on the relationship and identify positive elements and problems.
C. To assess the success of risk management activities.
D. To identify the most common high-risk activities in the organization.

12. According to Mark H. Gallant, JD, how should an organization perform an internal risk analysis regarding higher charges on UB92 billing forms for Medicare beneficiaries than for the equivalent DRG or CPT codes billed to non-Medicare consumers or insurers?
A. It is critically important that this review be done under the supervision of legal counsel. Otherwise, the hospitals internal findings will not be protected by legal privilege.
B. The review should not be done under supervision of legal counsel. The findings will automatically be protected by legal privilege even without counsel.
C. The findings will not be protected by legal privilege even if you involve legal counsel, so there is no need to involve counsel.
D. It does not matter if you use legal counsel or have legal privilege. Other parties will not be interested in the findings.

Answers: 9. D; 10. D; 11. B; 12. A.

Healthcare Risk Management's
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Improper transfer of heart attack victim leads to $800,000 verdict against transferring hospital

By **Blake J. Delaney**, Esq.
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News: A man arrived at the emergency department (ED) with chest pain. While doctors attempted to find the cause of the pain, an inadvertent dislodging of the man's intravenous line (IV) caused swelling in his arm muscle, requiring the need for an emergency fasciotomy. The hospital's subsequent electrocardiogram (EKG) and cardiac enzymes tests were interpreted as normal. Nevertheless, the man's primary care physician determined that his patient should be transferred to a second hospital for additional testing, although the stability of the patient's question was in doubt. Once transferred, the patient sustained a heart attack, and he brought suit against both hospitals and all of the providers. The primary care physician settled for $1 million prior to trial. The jury returned an $800,000 verdict against the first hospital, but it rendered defense verdicts for the second hospital and the ED physicians.

Background: A 39-year-old man presented at the hospital's ED for chest pain. The emergency department physician ordered an EKG and cardiac enzymes test, the results of which were interpreted as normal. However, while at the ED, an IV in the man's right arm was inadvertently dislodged, allowing fluid to infiltrate the surrounding tissue. This infiltration of fluid increased the pressure in the patient's arm muscle compartment and decreases the blood supply to the affected muscles, a condition known as compartment syndrome. Due to the surrounding inelastic fascia, the swelling of the man's arm muscles left no room for expansion, and, eventually, his blood supply was cut off. To prevent permanent injury to the soft tissues, doctors were required to perform an open fasciotomy by cutting away the fascia to relieve the pressure.

While surgeons performed the open fasciotomy, the ED staff decided to contact the patient's primary care physician. Although the primary care doctor did not have admitting privileges at the hospital, he came to the hospital to see his patient. He determined that despite the normal results of the EKG and cardiac enzymes, the patient required further observation, additional testing, and supplementary work-up. Accordingly, he and the ED physician arranged to transfer the patient to another hospital.

Shortly after the plaintiff arrived at the second hospital, another EKG was ordered. This EKG was interpreted as strongly suggestive of an acute myocardial infarction (AMI). Consequently, the ED physician reviewed the EKG from the first hospital that had accompanied the patient in the transfer. Realizing that the EKG from the first hospital did not have a patient name on it, the ED doctor asked for another copy to be faxed from the transferring hospital. The faxed copy was received 10 minutes later, and it confirmed that the plaintiff was suffering from an AMI. In an

attempt to break up and dissolve clots in the man's blood, which are the main cause of heart attacks, the doctor at the second hospital ordered thrombolytic therapy. These drugs seek to mimic the function of natural tissue plasminogen activator, which is a clot-dissolving enzyme produced naturally by cells in the walls of blood vessels and which catalyzes the conversion of plasminogen to plasmin. Commencement of the thrombolytic therapy in this case, however, was delayed in order to stabilize the patient's blood pressure drop; the patient did not receive a thrombolytic infusion until 1½ hours after his admission to the second hospital.

The man remained in the ED for 23 hours before being transferred to the intensive care unit. Another hour passed until finally a cardiology consultant visited the patient. The consultant determined that the man had sustained heart damage from the AMI.

The patient brought suit and alleged claims of medical malpractice against both hospitals and his treating physicians for damages relating to his myocardial infarction. When he suffered a stroke 2½ years later, the man included those damages in his lawsuit, claiming that the stroke was related to the myocardial infarction. The primary care physician settled prior to trial for $1 million. Then, while in the pretrial phase against the remaining providers, the plaintiff's attorney dismissed his client's claim against the second hospital. Unbeknownst to his client, the attorney had forged the man's signature on a settlement agreement with the second hospital, purporting to release any claims in exchange for $200,000. The attorney had tried to keep all of the money for himself, but when his client inquired as to why the claim against the second hospital had been voluntarily dismissed, the attorney was forced to confess his fraudulent behavior. When the conduct of the plaintiff's attorney came to light, the court voided the settlement agreement and allowed the plaintiff to pursue a claim against the second hospital. (The attorney initially was suspended from practicing law and then disbarred by the Illinois Supreme Court in 2002.)

At trial, now represented by a new attorney, the plaintiff claimed that the negligent actions of the medical staffs and doctors had permitted clots to develop and travel to the man's brain, which caused him to suffer a massive heart attack and stroke that rendered him completely disabled. As to the first hospital and its ED, the plaintiff pointed to the dislodging of the IV in his right arm and the delay caused by sending his EKG with no name affixed to it. As to the second hospital and its ED physician, the plaintiff averred that his transfer never should have been approved by them given his unstable condition. He further maintained that this transfer actually delayed the initiation of the thrombolytic therapy.

The first hospital argued that the compartment syndrome was the result a subsequent fall unrelated to the hospital visit. The jury ultimately returned a verdict of $800,000 against the first hospital, but found no liability on the part of the second hospital or any of the other doctors.

What this means to you: This case presents a multitude of issues that should trigger risk management involvement. The most notable problem in this case, and the one that seemingly caused many of the problems experienced by the patient, was the policy and procedure and actual practice regarding insertion, anchoring, and monitoring of IVs. "Emergency departments are places where patients are moved for various examinations and tests, providing frequent opportunities for an IV or the rate regulator to become dislodged," says **Leilani Kicklighter**, RN, ARM, MBA, CPRHM, consultant/principal with The Kicklighter Group, Tamarac, FL, and past president of the American Society of Healthcare Risk Management. Such dislodging can allow the fluid to flow freely, which causes an infiltration, extravasation, or even compartment syndrome, as was the case in this scenario. "Practice must follow policy, and policy must reflect actual practice. Both should reflect the accepted standard of practice. In this case, the hospital's policy and actual practice should be revisited," recommends Kicklighter.

The alleged arm injury occurring in the area of the IV-related compartment syndrome raises further concerns. Kicklighter questions the hospital's judgment as to placement of the IV, considering the alleged prior trauma in the area where the IV was placed. "This is yet another aspect of the policy and procedure that should be addressed with the ED staff," she notes.

Another issue raised in this case is the transfer of the patient from the first hospital to the second hospital. Even though this patient's primary care physician did not have privileges at the first hospital, there are ways for a physician to obtain emergency and one-case privileges. Kicklighter questions why this was not pursued in this case, rather than transferring this patient to another

hospital. In fact, even though this scenario does not go into detail about the risks and benefits of the transfer as compared with remaining at the first hospital or about whether the second hospital actually accepted the patient, risk managers must be aware that such transfers are governed by the rules of the Emergency Medical Treatment and Labor Act (EMTALA). EMTALA imposes various requirements on hospitals before being permitted to participate in the transfer of a patient, including ensuring that the patient suffering from an emergency medical condition is stable and that the transfer is "appropriate." Kicklighter also questions why there seemed to be such a rush to transfer the patient, especially given that he had just undergone a fasciotomy to relieve the compartment syndrome. Although the scenario does not give sufficient information regarding the patient's primary care physician's specialty, Kicklighter questions why a cardiologist was not summoned in light of the signs and symptoms that brought this patient to the ED. After all, an EKG does not always immediately reflect the damage to the heart muscle, as was the case in this scenario.

Kicklighter also is concerned by the fact that the second hospital interpreted the patient's EKG as showing an AMI that had not been diagnosed before the transfer. "One of the ED quality monitoring processes is the rereading of EKGs and radiology films — known as 'wet readings.' Because the literature reflects that missed diagnoses or misdiagnoses of myocardial infarction is a primary cause of lawsuits brought against a hospital's ED, qualified cardiologists should reread EKGs and compare those readings with the readings performed by the ED physician," suggests Kicklighter. She also recommends that X-rays taken by a radiologist be reread and compared to the wet reading done by the ED physician. "Those that do not coincide should be referred back to the emergency room for follow-up, and then the patient should be called or referred to his or her primary care physician," states Kicklighter.

Any readings that do not match also should be tracked as "incidents" by risk management and by medical peer review to determine whether a particular physician or type of missed/misdiagnosis is associated with a pattern or trend. "Had the EKG been appropriately diagnosed at the first hospital, the thrombolytic therapy might have been more timely initiated, and the transfer to the other hospital might not have been undertaken," surmises Kicklighter.

The lack of any identification indicating the patient's name on the first EKG strip faxed to the second hospital is also a significant risk management issue requiring attention. "The process for legibly and consistently labeling all parts of the medical record *concurrently* should be reviewed and emphasized," encourages Kicklighter. "Not labeling records is a practice below the acceptable standard of care." Unlabeled parts of the medical record sometimes do not make it to the medical record, leading to:

- errors in diagnosis and care if, for example, the wrong patient is paired with an unlabeled report or other documentation;
- allegations of spoliation of evidence, if the record is misplaced altogether;
- claims of fraud and abuse, if a record substantiating a charge suddenly cannot be located.

Kicklighter also shares concern with the manner in which the thrombolytic therapy was administered. There are protocols for conducting a thrombolytic infusion, the administration of which should be included in the standard of care for treating a potential cardiac injury such as an AMI. Although the scenario does not discuss the protocols in place for thrombolytic therapy at the either hospital, Kicklighter emphasizes that risk management should review such protocols and verify that all ED physicians are knowledgeable as to the process.

The final area of concern relating to the hospitals highlighted by Kicklighter in this scenario involves the credentialing of physicians. Credentialing of ED physicians is a process of the ED and the hospital's medical staff, with final approval at the board level. "Risk management should have some involvement in the credentialing of all physicians and surgeons. Risk management can provide a different perspective to the process and review with the chief or chair of each service the trends and patterns of the quality monitors, incident report trends by physician, potentially compensable events (PCEs) — whether asserted and unasserted — and other peer review issues by physician.

Finally, Kicklighter points to some of the issues raised by the conduct of the individual professionals involved in this case. First, the fact that a cardiologist did not arrive to consult and examine the patient in the second hospital until after the thrombolytic therapy had begun is an area of risk management concern. Under EMTALA, for example, hospitals are required to maintain

on-call physicians (including specialists and subspecialists) to assist in the screening, examination, or transfer of patients, and hospitals are required to maintain a list of those physicians who are on-call. Once a physician is called in, the physician must show up, and hospitals are required to ensure that an on-call physician responds within a reasonable time. Kicklighter suggests that the standard for an on-call physician to respond is 30 minutes, a benchmark that clearly was not met in this scenario. She also notes that the definition of respond depends on the hospital's definition and the severity of situation, both of which are determined by the ED physician. In some hospitals, respond means only a callback.

If a physician does not respond when summoned, EMTALA requires the hospital to report the physician and, if the patient is then transferred to another hospital, give the physician's name and address to the receiving hospital. The hospital should have policies in place to define a physician's responsibilities and to outline what should happen if an on-call physician cannot respond due to circumstances beyond his or her control. Penalties to the hospital can include a $50,000 fine and loss of Medicare certification. EMTALA, however, does not create a mandate for physicians to serve on-call or to be on-call at all times. In fact, a doctor may even perform surgery while on-call, if there is a suitable backup plan. EMTALA's requirements are mirrored in the laws and regulations of many states. In Florida, for example, the Board of Medicine has the authority to penalize an on-call physician for failing or refusing to respond, conduct that is deemed to be practicing below the standard of care.

Second, the conduct of the plaintiff's attorney in this case was — needless to say — less than honorable. The attorney's forging of his client's signature on a purported settlement and attempt to divert his client's client money reminds Kicklighter that risk managers and insurance carriers should not be too quick to dispose of claim files after a verdict or settlement agreement has been reached/obtained. Statutes can be overturned, people can act in unethical ways, and a many other circumstances could arise that would require a retrial or a dusting off of the claim file. The issues presented in this case span the gamut and go to show that no area of service should be ignored by a risk manager. Risk management's involvement in and correction of the foregoing issues will go a long way in reducing errors, injuries, and claims and in increasing overall patient, staff, and community satisfaction.

Reference

- Cook County (IL) Circuit Court, Case No. 01L-14480. ■