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IN THIS ISSUE

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Addicted doctors may seek help, but don't always reveal themselves

Some physicians avoid in-house help, stay under the radar

No one doubts that addicted physicians pose a significant liability risk and threat to patient safety, so risk managers are eager to offer help when asked. But what if the doctor doesn't ask you or anyone else in your organization and instead goes outside for help in beating the addiction? Shouldn't you be involved so you can address the risk management concerns?

Ideally, that would be the best scenario, most risk managers agree. But nearly all states have confidential rehabilitation programs that allow doctors to continue practicing while being treated for addiction, an issue that is gaining attention as California moves toward abolishing its confidential program on June 30, 2008. The Medical Board of California announced in 2007 that the program was ineffective and would be closed.

Most impaired physicians come to the risk manager's attention, or at least the attention of someone in the organization who can help, through their own behavior in the workplace or because they self-report, says **Paul English Smith**, JD, FASHRM, CPHRM, vice president and general counsel at Cabell Huntington Hospital in Huntington, WV, and past president of the American Society for Healthcare Risk Management (ASHRM) in

EXECUTIVE SUMMARY

Addicted physicians often avoid seeking help through the health care organizations where they work, which means risk managers may not even know they are impaired and seeking help. Physicians are more likely to make their problem known if you provide an atmosphere that is nonpunitive.
- Addicted physicians often fear social stigma and time lost from work.
- It is best to discover a physician's impairment as early as possible.
- Sometimes it might be acceptable for the risk manager to be uninvolved.

Chicago. Smith has seen several such incidents in his career, and he says the best situation is when the physician is aware he or she has a problem and comes asking for help. "The worst is when they are fooling themselves and trying to fool others into thinking they don't even have a problem," he says. "That is most likely to lead to a situation where you have to eventually sever the relationship to protect patient safety."

Steer toward in-house help

Health care providers usually have a system in place to aid impaired physicians and staff, either internally or through a rehabilitation resource outside the organization. The risk manager may not necessarily be informed or involved in the process because of confidentiality constraints, Smith says, but there is reason to encourage physicians to go that route rather than seeking help on their own and keeping it secret from the provider.

If the rehab goes well, the risk manager may never need to get involved, but if the physician's situation is known within the health organization, the potential risks can be brought to the risk manager's attention when necessary, he says. Even physicians who are ready to seek help can do so without letting anyone at the hospital know, he notes, so the goal for risk managers is to encourage those impaired physicians to seek help inside the system, not outside. "We want you to get help if you have an addiction, so we're not going to discourage getting help anywhere," Smith says. "But we have the resources internally to help, and we'd like to see you take that route. We'd like to be part of the process."

Physicians fear punishment

To encourage physicians to seek help internally, much of the risk management department's work will be at arm's length, helping the physician wellness program or employee assistance program obtain the resources they need, for instance. The risk manager also must help create an atmosphere in which physicians do not fear punishment if they come forward, Smith says.

"The compartmentalization is very important, and physicians have to be assured that if they ask for assistance, that information is not going to be passed all over the organization and the risk manager isn't going to be meeting with them the next day to talk about restricting their privileges and any kind of punishment," Smith says. "They have to be encouraged to seek help, and they won't if they think you're going to come down hard on them right away."

Smith also says you should look for opportunities to offer help early in the person's addiction, rather than waiting until the problem is so severe that it comes to your attention through an adverse event. For instance, if there is ever a concern about a physician's condition and the doctor responds by denying a problem and saying, "Test me right now, if you don't believe me," you should test immediately.

"It sounds like defiance, and too often people

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back down and don't do the drug or alcohol test," Smith says. "But sometimes that is how the person is asking for help. If they challenge you to test them, test them right away. Otherwise, you might be losing an opportunity to help."

Confidentiality is key

Jeffrey Driver, JD, MBA, chief risk officer with Stanford University Medical Center in Palo Alto, CA, and past president of ASHRM, also has experience with impaired physicians and staff. About 10 years ago he "learned the hard way" about how to deal with impaired physicians and staff when a nurse and a resident physician died from drug addictions without seeking help through the in-house resources that were available. He is now actively engaged in encouraging physicians and staff to come forward when they need help.

Driver says the promise of confidentiality is key to getting impaired physicians to come forward. They are always fearful of the damage to their reputation and their careers, not to mention potential criminal charges or civil liabilities, he says. **(See article, right, for more on physicians' concerns.)** Though some of those consequences may be legitimate, it is more productive to create an environment in which the physician sees your organization as an ally, he says. That environment helps keep the physician within your system when seeking help, and Driver says that is always preferable.

"But that doesn't mean I personally have to know," he says. "If my committee knows and I have comfort that my committee is addressing the physician's needs, then I don't have to know the particular physician, who it is, and what the details are. The bigger concern is that the person is getting help, and I know that our system will bring me into the picture if and when that is appropriate."

The risk manager will have a role to play when patient safety is threatened, and in that case direct intervention may be required. Driver recalls an incident in which staff reported that a surgeon was in the operating room in an impaired condition, unable to proceed, and so Driver had the surgeon pulled out of the room for an immediate sit down with him and a physician leader. But once the surgeon entered the hospital's diversion program, Driver's direct involvement ceased.

"That surgeon came back completely rehabilitated, a real success story, so the process works if the risk manager understands that it is rehabilitative and not punitive," Driver says. "But still, I was in the loop, and so if something had gone wrong in that physician's rehabilitation program, I would have known and would have been able to act." ■

Impaired doctors fear impact on careers

Addicted physicians must overcome significant fears about the impact on their careers and personal lives before they are willing to ask for help, so risk managers can help by assuring them the process will be about rehabilitation and not punishment, according to two experts in the field.

Clare Waismann, executive director of the Waismann Method, an opiate dependency treatment center in Beverly Hills, CA, that often treats physicians, says it is important to remember that what sounds like help to risk managers can sound like punishment to a physician. For example, she says, a requirement that impaired physicians complete a 30-day rehab program before seeing patients again can sound extremely punitive to a physician who would have to leave a busy practice and financial obligations.

"If you make it very hard for the physician to seek help, requiring 30-day rehab and being away from their practice for a long time, you are harming not just the physicians but also the patients they will continue to treat," she says. "The punishment can be so bad that they will wait until their condition is very, very severe before they get help. They want help, but they can't handle the punishment."

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That type of fear means that rehab for physicians may need to be more creative and more flexible than the typical scenarios that can work for nonprofessionals, she says.

Similar advice comes from **Betsy White Williams**, MBA, PhD, clinical director at Professional Renewal Center in Lawrence, KS, which also treats impaired physicians. She points out that physicians often do not know what resources are available through the health care provider. Risk managers should ensure that the hospital's wellness committee or similar program is actively promoting itself to physicians, she says.

Physicians also can be very uncertain about exactly how to ask for help, because they don't know what happens next, Williams says. "They may want help, but they fear what happens once they trigger that sequence of events," she says. They need to know that asking for help doesn't immediately create a legal problem, and that asking for help does not mean "volunteering to be punished," Williams says. "Educating them about this is critical to getting them to come forward," she says. ■

Patient brochure must be worded carefully

Nearly every health care facility has a patient safety brochure these days, and they almost always come out of some department other than risk management. So do you really know what is in your organization's patient safety brochure? Do you know what you are telling patients, or worse, what you might be promising them?

There is little research available on the impact of patient safety brochures, according to statements from the Institute for Safe Medication Practices (ISMP) in Huntingdon Valley, PA. But at least one study has suggested that patient safety brochures have the potential to cause unintended consequences that actually can degrade patient safety.[1] In that study, the researchers noted that patient safety brochures often encourage patients to get involved in preventing errors without giving them any practical advice for doing so.

"Some messages suggest an inappropriate shifting of responsibility onto patients. Advice that involves checking on or challenging health professionals' actions appears to be particularly problematic for patients," wrote the researchers from the University of Aberdeen, Foresterhill, in Aberdeen, Scotland. "Such behaviors conflict with the expectations many people have — and think health professionals have — of patients' roles."

Group aims for clear advice

Those issues were considered when the Committee to Reduce Infection Deaths (RID), a New York City-based, not-for-profit educational campaign, designed its patient safety brochure, says **Betsy McCaughey**, PhD, chairman of the committee and former lieutenant governor of New York. *(Editor's note: To view the brochure, go to the group's web site at www.hospitalinfection.org and choose "RID's 15 Steps" from the menu on the left.)*

"I've seen so many patient safety brochures that are mind-numbingly vague and old-fashioned," she says. "They're preventing patients from taking part in improving patient safety, even when they very much want to."

McCaughey says the most important goal was to convey to patients the latest, most effective research on preventing infections. She pulled the latest research from medical journals, information

EXECUTIVE SUMMARY

Patient safety brochures must be written carefully, and the risk manager should pay close attention to the content. Failure to do so could introduce liabilities or minimize the effectiveness of the brochure.

- Be involved in the approval of patient safety patient brochures.
- Watch for wording that implies a guarantee.
- Present the latest research from the patient's perspective.

that usually is not shared with patients, and put it in the brochure from the patient's point of view. McCaughey, who wrote the brochure herself, drew from numerous sources to compile the 15 recommendations for patients, and she always emphasized the most current research.

"These aren't just common-sense things or old wives' tales. This is the very best, most up-to-date research that is available to health care professionals, presented to patients in a way that helps them actually use it," she says. "That can be done with a brochure in any area of patient safety. Take the new research and transfer it into the patient's point of view."

McCaughey worked with critical care nurses and other health providers to ensure that the information in the brochure was accurate and substantive. She wanted the brochure to be accurate and patient-friendly. "But *not* dumbed down," she notes. "There's a difference between writing something so that people can understand it and talking down to them.

The RID brochure is revised at least yearly, or more often if necessary because of new research. McCaughey advises risk managers to make sure their own patient safety brochures are updated in a similar fashion.

Brochure can raise legal issues

Risk managers also should be involved in the approval process for patient safety brochures to make sure they don't create potential legal liability, says **Richard King**, JD, an attorney with the law firm of Montgomery McCracken in Philadelphia and previously in-house counsel for a hospital system. In particular, he says, the brochure must avoid anything that sounds like a guarantee of clinical outcomes or claims that the facility has a perfect safety record.

"It's normal to want to tout your commitment to safety and your safety record, but overpromising can be construed as a guarantee or promise of a specific outcome," he says. "When an adverse outcome then occurs, that type of language in a patient safety brochure plays right into the hands of a plaintiff's lawyer."

The best policy is to "underpromise and overperform," King says. You don't ever want a plaintiff to tell a jury that your organization promised everything would be fine and the patient relied on that promise to his or her detriment, he says.

King has helped health care providers edit patient safety brochures to downplay claims of a superior safety record, which he admits can be difficult sometimes when hospital leaders are proud of their accomplishments. Even if your organization has an excellent safety record, you still must be careful what words you use in relating that accomplishment. In general, King says, you should avoid using extreme words such as "never" or "always" or phrases such as "can't happen" or "won't happen." Even though you may word the phrase carefully so that it is technically accurate, the patient may infer more.

Avoid semantic argument

Finding the line can be difficult, King says. For example, it may be acceptable to say your organization "strives" for zero errors but it might be

ISMP offers tips on good brochures

The Institute for Safe Medication Practices (ISMP) in Huntingdon Valley, PA, recently developed this list of questions that can help you determine if your patient safety brochure is effective:[1]

- Is the safety information well defined?
- Is the basis for the safety tips provided?
- Are the safety tips prioritized?
- Does the safety brochure specify what the organization is doing to enhance safety?
- Are patients advised how to report hazards and errors?
- Is the patient safety brochure written from the patient's perspective?
- Do the safety tips require patients to check or challenge health care providers? (Include some tips that do not require challenging health care providers. Also, encourage an atmosphere in which the patient feels confident enough to speak up.)
- Does the brochure shift responsibility from the provider to the patient? (Be clear about how the organization is working to improve safety, to avoid the impression that you are simply making it the patient's responsibility.)
- Do staff reinforce the safety tips and offer patients support in carrying them out?

Reference

1. What does your patient safety brochure *really* say about patient safety? *Nurse Advise-ERR* 2007; 5:1-2. ■

risky to say you have zero tolerance for errors. A fine distinction? Yes, but the latter may imply that you never expect to have an error, while the former only implies that you do make your best effort to avoid them.

Err on the side of caution. Remember that patients will never read something with the same level of scrutiny and diligence that you used when writing it, King says.

"The plaintiff's lawyer will come back and say 'Right in your brochure you say that none of these errors will occur,' he explains. "The best you can do then is try to argue the semantics and exactly what the words mean, and you'll never come off looking good if you do that with a jury. It's a nightmare in terms of litigation."

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Lawsuit says hospital 'dumped' homeless man

Civil rights attorneys are suing Hollywood (CA) Presbyterian Medical Center in connection with the "dumping" of a paraplegic man on Skid Row in 2006 that sparked nationwide outrage after media reports of the man falling out of a van and then crawling in the gutter.

The hospital acknowledged early on that the man was not properly discharged and promised to improve how homeless patients are treated. The case caused some risk managers to reassess their own procedures for discharging the homeless. Now the lawsuit is reigniting fears that callous discharge, or what others may perceive as insensitive treatment, could result in litigation.

The suit was filed in Los Angeles County Superior Court on behalf of the paraplegic man, 42-year-old Gabino Olvera of Los Angeles. It also seeks unspecified punitive and compensatory damages against the hospital for elder abuse, negligence, and infliction of emotional distress. The lawsuit asks the court for an injunction that would bar the hospital and the van company, Empire Transportation of Hollywood, from engaging in future cases of "homeless dumping."

"When you tell the average person this, they are completely shocked that a hospital would treat a human being in this way," says **Hernan D. Vera**, JD, an attorney at Public Counsel, a nonprofit group in Los Angeles that helps plaintiffs find pro bono attorneys to take their cases. Vera is one of the plaintiff's lawyers. Olvera was taken to Hollywood Presbyterian after an automobile accident, according to the complaint. The lawsuit also claims that hospital officials failed to diagnose and treat him for a urinary tract infection or take into account apparent signs of mental illness.

Shelter initially refused man

After several hours at the hospital, Olvera was taken by ambulance about 12:30 a.m. to the Midnight Mission in the Skid Row area of downtown Los Angeles, according to court papers. The mission staff noted that Olvera did not have a wheelchair, and they did not have the facilities to deal with someone in his condition, so they refused to accept him, the suit alleges. Olvera was brought back to Hollywood Presbyterian and placed in a wheelchair in a corner of the waiting room, where he sat unattended for eight hours with no food or water, according to the suit.

Vera says Olvera continued to show signs of mental illness but that the hospital staff did not respond. The next morning, Olvera was driven to Skid Row. Once there, the driver of the van allegedly told Olvera to get out, and he had to drag himself toward the curb with his possessions clenched in his teeth, the suit alleges. When a crowd began to gather demanding help for the man, the driver cursed him, saying he had soiled her van, according to police and witness accounts of the incident cited in court documents. According to the witnesses, the van driver applied makeup and perfume before speeding off.

EXECUTIVE SUMMARY

A California hospital is being sued by civil rights activists who say the health provider dumped a homeless, paraplegic man on Skid Row after treatment. The hospital acknowledges that the man was not properly discharged.

- Another hospital in the community has settled related charges.
- The lawsuit may hinge on suitability for discharge.
- Any monetary settlement probably will be accompanied by procedural changes.

After the lawsuit was filed, Hollywood Presbyterian issued a statement saying that it remained optimistic that a settlement could be reached and that the hospital had taken steps to ensure that such incidents did not happen again.

Kaiser Permanente already settled

Los Angeles health care providers are especially sensitive to the issue because providers there have been the subject of several media reports about how the homeless are discharged. These reports include one in April 2006 that showed footage of a homeless woman who had been treated at a Kaiser Permanente facility and then dropped off at a shelter on Skid Row. Once she was dropped off, she wandered aimlessly on the sidewalk in a hospital gown and socks. Kaiser Permanente confirmed at that time that staff put a 63-year-old woman into a taxi and had her dropped off.

After the local city attorney filed charges of misdemeanor imprisonment and threatened to pursue the case further, Kaiser Permanente, based in Oakland, CA, vowed to create new protocols for discharging homeless patients. As part of the settlement, Kaiser paid $5,000 in civil penalties, $50,000 in investigative costs to the city attorney's office, and contributed $500,000 to a charitable foundation benefitting local homeless programs. **(For more on the settlement and the changes promised by Kaiser Permanente, see *Healthcare Risk Management*, July 2007, pp. 73-76.)**

Linda Stimmel, JD, partner and co-founder of Stewart & Stimmel in Dallas, says the current lawsuit may be more complicated than the charge against Kaiser Permanente, and more difficult to settle. "I would imagine this case will take some time to resolve because the issues will not simply be the inflammatory nature of the alleged dumping of a patient curbside," she says. "The lawsuit will most likely need to address his medical condition to see if he was stable enough for discharge."

Those issues require medical expert testimony, she notes, so there probably will be a lengthy discovery process to attempt to learn if this incident was part of a pattern or a singular incident. The outcome of the case is difficult to predict, Stimmel says, but it almost certainly will involve more than a monetary award. **(See article, right, for more on the possible fallout from this case.)**

"I would suspect that possibly some type of resolution may involve a commitment to a different style of discharge," similar to the pledge by Kaiser Permanente, she says. **(For the initial report on the incident that led to the lawsuit against Hollywood Presbyterian, see *Healthcare Risk Management*, April 2006, pp. 45-46. For more on the difficulties in discharging homeless patients, see *Healthcare Risk Management*, June 2006, pp. 61-65.)** ■

CA lawsuit could have wide effects

The lawsuit filed against Hollywood (CA) Presbyterian Medical Center could affect how hospitals nationwide discharge the homeless, say some legal observers.

Some impact already is being felt from the lawsuit and the numerous allegations of callous discharge of the homeless, says **Linda Stimmel**, JD, partner and co-founder of Stewart & Stimmel in Dallas. Stimmel cautions that risk managers should not overreact to the risk from discharging the homeless and says that in many cases, the provider is doing the very best job possible in trying to discharge sometimes uncooperative patients who have no good option after leaving the hospital. But at the same time, she says, providers must avoid scenes that look callous at best and may amount to abuse.

Dennis Diaz, JD, an attorney with the law firm of Davis Wright in Los Angeles, says the lawsuit came as a surprise because he was under the impression that the parties had been making progress in settlement discussions for quite some time. He says the case could lead to similar lawsuits across the country. "It's not unlikely that plaintiff's counsel and advocacy groups will want to try to advance their perspectives on public policy and make examples of other hospitals for the problems experienced by a swelling homeless population, many of whom who use hospital emergency rooms for help and shelter," he says.

Diaz says risk managers should develop hospital policies and procedures specifically for homeless patients: Identify them upon arrival at the hospital, provide proper treatment, and get social workers and discharge planners on board quickly to coordinate an appropriate discharge.

Hospitals have little or no control over problems that homeless people experience in our society, Diaz notes, yet they are unfairly expected to provide care that goes far beyond what hospitals are capable of doing. "The hospital here did the

best it could for this particular patient and broke no laws in the treatment and discharge of this patient," he says. "What ultimately happened to the patient after the hospital treated and discharged the patient was unfortunate, but not of the hospital's doing. This is an example of no good deed going unpunished."

Review contractors, discharge procedures

The lawsuit should prompt risk managers to review the procedures of transportation contractors, suggests **David Donnersberger**, MD, JD, a practicing attorney with Winger and Associates in Chicago and a clinical instructor at the Northwestern University Feinberg School of Medicine in Chicago.

"From a risk management perspective going forward, hospitals should review quality control with their transportation carriers and provide education and standards for drivers," he says. "If there is evidence of a *pattern* of misbehavior by a driver or a carrier, contracts should be severed."

Secondly, Donnersberger says, no hospital should discharge any patient who does not provide the *exact* address of their destination. This is especially true if the hospital is providing the transportation to that destination upon discharge, he says.

As for the situation that led to the current lawsuit, Donnersberger says an ounce of prevention would have helped. A social worker, nurse, doctor, resident, chaplain, medical student, or discharge planner could easily have called nearby shelters or community agencies to arrange adequate supervision for the patient, he says. "This lesson should have been learned when the first shelter wasn't equipped for this patient's needs, and he was sent back to the ER for eight additional hours," he says. "Some level of discharge planning occurs with every discharge to a nursing home or transfer to another facility, and it should have occurred for this homeless patient as well."

Watch for EMTALA risks

Henry Fader, JD, a partner with the law firm Pepper Hamilton in Philadelphia, points out that providers also risk violating the Emergency Medical Treatment and Labor Act (EMTALA) when discharging the homeless. Fader says the actions of Hollywood Presbyterian may have violated EMTALA.

"EMTALA requires that all patients who present themselves to an emergency room be evaluated and treated, and this is especially true for mental health patients, who should receive a separate mental health evaluation if they show signs of mental instability," he says. "Additionally, Medicare and most Medicaid programs feature a required commitment by providers under conditions of participation. The conditions of participation require providers to treat patients appropriately under a patient bill of rights."

Fader advises that risk managers take these steps to minimize the risk in treating and discharging homeless patients:

- Monitor compliance with EMTALA in the emergency department, of course, but monitor the psychiatry requirement especially closely.
- When possible, beef up staffing in the emergency department to reduce wait times.
- Provide training to personnel, including outside vendors, on the conditions of participation and patient rights.
- Review vendor selection policies and monitor outside vendors for compliance with hospital policies.
- Review charity care policies and how they are used in the emergency department.
- If the hospital is nonprofit, reconcile the actions taken with the mission statement of the hospital and provide appropriate training to personnel. ■

SOURCES

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Hospital's sepsis program initiative boosts safety

An initiative aimed at standardizing interventions related to the rapid diagnosis and treatment of severe sepsis has significantly improved

EXECUTIVE SUMMARY

A patient safety initiative led by the pharmacy staff has helped a Missouri hospital reduce sepsis and improve outcomes. The multidisciplinary team attributes much of the success to standardization of treatment protocols.

- The protocols are based on clinical best practices.
- New treatment pathways help guide ED patients to the protocol.
- Patients treated with the new protocol received statistically more intravenous, were more likely to be treated with an appropriate initial antimicrobial regimen, had a shorter hospital length of stay, and had a lower risk for 28-day mortality.

patient safety at Barnes-Jewish Hospital in St. Louis.

The multidisciplinary team, led by pharmacy staff, recently received the 2007 American Society of Health-System Pharmacists (ASHP) Award for Excellence in Medication-Use Safety. The award recognizes on a national level pharmacy professionals who have assumed a leadership role in promoting safety in the medication-use process.

The award signaled success not only in improving safety, but also in showing that patient safety leaders can come from all departments, says **Scott Micek**, PharmD, clinical pharmacist for critical care at the hospital and the pharmacist who led the Barnes-Jewish multidisciplinary team in its medication safety initiatives.

"This award demonstrates that research can be translated into clinical practice on a local level through teamwork, organization, and standardization of care, all key components to improving quality of care, safety, and patient outcomes," he says.

Sending signal to community

The team's work was significant not just for the measurable improvements in patient safety, but for the signal it sent to the rest of the hospital community, says **Roslyn Corcoran**, RN, BSN, manager of patient safety/risk management at Barnes-Jewish Hospital. **(See p. 34 for more on the results of the team's work.)** "Infection control is at the height of public awareness, so as risk managers, it is imperative that we create a culture of patient safety and transparency for our employees and patients," Corcoran says. "This results in better understanding and compliance, which is the right thing to do for patients."

Sepsis is a serious condition in which infection has spread into the bloodstream, Micek explains. When bacteria or other infectious organisms spread throughout the body and overwhelm the immune system, the infection can be life threatening. Patients with sepsis need immediate medical attention.

The Barnes-Jewish Hospital team instituted and standardized interventions related to the rapid diagnosis and treatment of severe sepsis in patients in the Barnes-Jewish Hospital emergency department. About 1,200 patients diagnosed with severe sepsis are seen at Barnes-Jewish each year, Micek says. The team wanted to incorporate the best clinical research into daily practice at the hospital, Micek says, focusing on the patients who present to the emergency department with a complication that could lead to sepsis. Using clinical literature and benchmarks available in the literature, the team created a process that helps staff identify patients at risk and then make sure they received the appropriate treatment in a standardized fashion.

"It was essentially a quality improvement program," he says. "We wanted to optimize care by using those clinical benchmarks."

A key change was in the nursing triage, Micek says. ED nursing staff and physicians were trained in how to recognize the signs of sepsis and how to put the patient on the proper path for treatment, he says. "In that sense, it is no different from how nurses screen for other symptoms and put the patient in the proper pathway for stroke treatment, for instance," he says. "We introduced the sepsis pathway and had patients steered toward that treatment course. Patients were more rapidly identified, and physicians were more aware of the risk." *(Editor's note: Sepsis pathways are included in their published research. See references on* ***p. 35.)***

Standardized order set helps

The team also developed a standardized order set for managing septic shock. Once the ED staff identified patients at risk, the standardized order set allowed each patient to receive care driven by best practices, Micek explains. **(See article, p. 34, for more on the standardized order set.)**

Prior to the system being introduced in early 2006, there was no standardization for treating these patients, Micek says. The sepsis team, which included members from the pharmacy department along with nurses and physicians, had to devote considerable effort up front to obtaining buy-in from the ED staff, he says.

Having nurse and physician members who could talk to their colleagues about the need for standardization was a big plus, Micek says.

"The education process included group meetings and one-on-one training with individual staff members over a period of months, but it was worth it to get that buy-in from the people who are the key players in actually implementing this program," he says. "It helped that we weren't introducing completely new therapies. Rather, we were standardizing the way we did these things."

Implementing the program, from conception to full use in the ED, took about a year. Micek says. "My advice for other hospitals would be to focus on simple, easy-to-use treatment pathways with triggers that move the patient forward through the process according to best practices," he says. "The other important lesson is that you will get much farther with a multidisciplinary team that can introduce this kind of idea to their colleagues, rather than having it handed down from another department." ■

New protocol yields better outcomes

The standardized hospital order set for the management of septic shock in the emergency department at Barnes-Jewish Hospital in St. Louis, yielded measurable improvements in patient safety. **Scott Micek**, PharmD, clinical pharmacist for critical care at the hospital and the pharmacist who led the Barnes-Jewish team, suggests the team's published report on the clinical criteria could be useful for pharmacy staff or multidisciplinary teams seeking similar improvements.[1]

The team studied a total of 120 patients with septic shock. Sixty patients (50%) were managed before the implementation of the standardized hospital order set for septic shock, constituting the "before group, and 60 (50%) were evaluated after the implementation of the order set, making up the "after group."

Patients in the after group:

- received statistically more intravenous fluids while in the emergency department (3,789 ± 1,730 mL vs. 2,825 ± 1,624 mL);
- were more likely to receive intravenous fluids of more than 20 mL/kg body weight before vasopressor administration (88.3% vs. 58.3%);
- were more likely to be treated with an appropriate initial antimicrobial regimen (86.7% vs. 71.7%) compared with patients in the before group.
- were less likely to require vasopressor administration at the time of transfer to the intensive care unit (71.7% vs. 100%);
- had a shorter hospital length of stay (8.9 ± 7.2 days vs. 12.1 ± 9.2 days);
- had a lower risk for 28-day mortality (30% vs. 48.3%).

The authors concluded that the implementation of a standardized order set for the management of septic shock in the emergency department was associated with statistically more rigorous fluid resuscitation of patients, greater administration of appropriate initial antibiotic treatment, and a lower 28-day mortality. "These data suggest that the use of standardized order sets for the management of septic shock should be routinely employed," they wrote.

Micek also directs risk managers to the research showing the economic benefits of the program.[2] In this analysis, Micek and his colleagues compared patients treated before the protocol with those cared for after the protocol was implemented. They studied 120 patients, evenly divided between those treated before the new protocol and those treated with it. There were more survivors following the protocol's adoption (70% vs. 51.7%). Median total costs were significantly lower with use of the protocol ($16,103 per patient vs. $21,985). The length of stay also was on average five days less among the post-intervention population.

The researchers concluded that the protocol resulted not only in improved mortality but also in substantial savings for institutions and third party payers. "Broader implementation of sepsis treatment protocols represents a potential means for enhancing resource use while containing costs," the authors wrote.

COMING IN FUTURE MONTHS

- Liability for data security breaches
- Creative ways to improve sharps safety
- Hospital tries for zero preventable errors
- Five-item to-do list can save lives

References

1. Micek ST, Roubinian N, Heuring T, et al. Before-after study of a standardized hospital order set for the management of septic shock. *Crit Care Med* 2006; 34:2,707-2,713.

2. Shorr A, Micek S, Jackson Jr. W, et al. Economic implications of an evidence-based sepsis protocol: Can we improve outcomes and lower costs. *Crit Care Med* 2007; 35:1,257-1,262. ■

VA official apologizes for substandard care

Nineteen deaths over the past two years at a Department of Veterans Affairs (VA) hospital in southern Illinois may be linked to substandard care, according to a an investigation that prompted an impassioned apology from a VA official.

The hospital performed surgeries that were beyond the capabilities of its staff and physicians, and then they were slow to respond once problems surfaced, according to **Michael Kussman**, MD, U.S. Veterans Affairs undersecretary for health in Washington, DC. Kussman commented publicly after releasing findings of the VA's investigation and summarizing a separate probe from the Office of the Inspector General in the Department of Health and Human Services.

"I can't tell you how angry we all are and how frustrated we all are," Kussman told reporters. "Nothing angers me more than when we don't do the right thing."

Kussman said, however, that the substandard care provided at the Marion Veterans Administration Medical Center was not typical of the VA care found across the nation. He said the VA will help affected families seek compensation, either through claims against the U.S. government or with the VA's disability compensation program.

The VA investigation found that at least nine deaths between October 2006 and March of last year were "directly attributable" to substandard care at the Marion hospital, which serves veterans from southern Illinois, southwestern Indiana, and western Kentucky.

Kussman said inpatient surgeries will remain suspended indefinitely at the Marion hospital. They have not been performed at the facility since problems first became public in August 2007. The next month, the VA installed interim administrators to replace the Marion VA's director, chief of staff, chief of surgery, and an anesthesiologist, Kussman said. The VA moved them to other positions or placed them on leave, he said, and those leaders will not return.

The trouble at the Marion VA caught the attention of Congress in November 2007 and prompted

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CNE instructions/objectives

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 **June** 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.

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 hospitals, for hospital personnel to use in overcoming risk management challenges they encounter in daily practice. ■

lawmakers to call for tighter protocols for hiring doctors and bolster quality control across the nation's VA system. Kussman said the VA has launched an administrative investigatory board to review care issues and matters raised by employee groups.

The investigative report regarding the VA hospital in Marion can be found online at this address: www1.va.gov/health/docs/2007-D-1356Marion.pdf. ■

CNE Questions

9. According to Paul English Smith, JD, FASHRM, CPHRM, should risk managers be involved in helping addicted physicians get treatment?
A. The risk manager may not necessarily be informed or involved directly in the process because of confidentiality constraints, but there is reason to encourage physicians to go that route rather than seeking help on their own and keeping it secret from the provider.
B. The risk manager should not be involved in any way, directly or indirectly, in the physician's treatment for addiction.
C. The risk manager should require that all requests for addiction treatment go through the risk management department, which will refer the physician on to the proper resources.
D. The risk manager must be directly involved and should require weekly reports on the physician's progress.

10. What does Richard King, JD, recommend regarding patient safety brochures?
A. The brochure must avoid anything that sounds like a guarantee of clinical outcomes or claims that the facility has a perfect safety record.
B. It is OK to guarantee a good clinical outcome because the brochure is not legally binding.
C. It is OK to claim a perfect safety record in your brochure but only if you are willing to provide documentation on request.
D. Your brochure must not make any mention of safety goals or strategies for improving patient safety.

11. According to Henry Fader, JD, how does a patient's mental health status affect the risk of violating EMTALA when discharging the homeless?
A. The patient's mental health status has no bearing on the risk of violating EMTALA.
B. The risk can be higher with mental health patients, who should receive a separate mental health evaluation if they show signs of mental instability.
C. The risk is lower with mental health patients because there are built-in exceptions for those patients.
D. There is no risk at all because mentally unstable patients are not covered by EMTALA.

12. According to Scott Micek, PharmD, what was one key reason for the plan's success?
A. The team was multidisciplinary, and the members could promote the plan to their colleagues rather than having it handed down by another department.
B. The team was made up only of pharmacists, which gave the plan credibility.
C. The team was made up only of physicians, which gave the plan credibility.
D. The Joint Commission required implementation of a sepsis plan, so participation was mandatory.

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

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

Failure to timely diagnose tuberculosis leads to death, confidential settlement

By **Jon T. Gatto**, Esq.
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News: A man exhibiting tuberculosis-like symptoms went to a clinic for treatment. Tests were ordered, including an analysis by the state health department, after which it was determined that the man was suffering from a disease related to tuberculosis called *Mycobacterium avium*. Several months later, the man presented to the emergency department with ear pain and an upper respiratory infection. He died two weeks later. An autopsy showed tuberculosis meningitis and myelitis. The patient's family sued his treating providers and the state health department for failing to timely diagnose the man's tuberculosis. The plaintiff reached a confidential settlement during trial with the health department and the clinic physician.

Background: A 34-year-old migrant farm worker went to a clinic and was given a tuberculosis skin test to determine if he had developed an immune response to the bacterium that causes tuberculosis. Based on the positive test results, blood was drawn and a chest X-ray was ordered. The man was given a mask to wear so as to protect others from contracting his potential tuberculosis.

A few weeks later, when the man returned to the clinic, a general practitioner diagnosed the man with possible active tuberculosis and administered a test to determine whether he had an active tuberculosis infection, a related infection, or tuberculosis-like symptoms attributable to another cause. The man was ordered to continue wearing a mask at all times.

The state health department's analysis of the test showed that the man did not have active tuberculosis but rather a related disease called *M. avium* complex. The clinic's physician reviewed the test results with the man and advised him that while it was likely he did not have tuberculosis, it could not be definitively ruled out until he saw a pulmonologist. But the man did not consult with a pulmonologist or follow up with the clinic.

Nine months later, the man returned to the clinic experiencing cold symptoms, including fever, cough, and ear pain. Doctors diagnosed an upper respiratory infection and discharged the patient with medication and instructions to go to an emergency department if his fever did not subside within a few hours or if he experienced shortness of breath later that night. A follow-up appointment at the clinic was scheduled for the next day.

Six days later, the man went to an emergency department complaining of persistent vomiting and with signs of electrolyte imbalance. A lumbar tap was performed, but the spinal fluid was equivocal. The man was transferred to two other hospitals before he died. An autopsy showed tuberculosis meningitis and myelitis.

The man's estate sued the patient's treating physician at the clinic, the hospital, the emergency department physicians, and the state health

department. It claimed that they failed to timely diagnose his tuberculosis. The estate's claimed damages were past and future lost earnings, estimated at $460,000, past and future pain and suffering, and loss of support and services. The estate dismissed the emergency physicians shortly after trial began and settled with the health department and the clinic physician for an undisclosed amount.

What this means to you: "What an interesting case!" says **Leilani Kicklighter**, RN, ARM, MBA, CPHRM, LHRM, consultant/principal of The Kicklighter Group in Tamarac, FL, which focuses on risk management consulting services, and past president of the American Society for Health Care Risk Management. "This sequence of events reflects the many health care errors that can result from multiple handoffs and multiple caregivers as a result of lack of communication and lack of knowledge," she says. "One wonders if an accessible, master electronic medical record would have prevented this ultimate, untoward outcome. Because this patient was a migrant farm worker, one wonders whether he had health care benefits and whether or not a lack of health care benefits may have contributed to this unfortunate sequence of events — particularly the failure to follow through with specialist care. What is more, one wonders whether language, cultural, or financial factors had a role in this scenario."

Tuberculosis (TB) is caused by *Mycobacterium tuberculosis,* not *M. avium. M. avium* is an atypical, acid-fast, opportunistic organism that is primarily a pulmonary pathogen.

Diseases and conditions caused by the avium organism are not reportable to the health department. On the contrary, the presence of *M. tuberculosis* must be reported. Tuberculosis is spread through airborne droplets, while the *M. avium* organism is not.

This patient ultimately expired from tuberculosis meningitis and myelitis. Tuberculosis can infect body organs such as the kidneys, bones, and meninges, as it did in this case.

Patients who present to a clinic who are exhibiting signs and symptoms of, or who have a differential diagnosis of tuberculosis, should be referred to the state health department or an infectious disease specialist for definitive diagnosis and appropriate care, says Kicklighter. At the time of this patient's initial visit to the clinic, tests showed the *M. avium*. He also was given a skin test for tuberculosis. However, a tuberculosis skin test [purified protein derivative (PPD)] needs to be "read" in three days. In this case, the patient did not return to the clinic for a few weeks, so the test results may not have been read in a timely manner. The test results from the state health department showed that at the time the tests were done that he did not have active tuberculosis.

It is unclear in this case whether the patient had a positive PPD. If he were in an immunosuppressed state, which does not seem to have been determined, he could have activated dormant tuberculosis as he became more debilitated or become exposed to active tuberculosis, which may have caused the active disease in him that went undetected.

When this patient was seen at the clinic for the second time, by a different physician, he was referred to a pulmonologist for a definitive diagnosis of tuberculosis. The patient never saw the pulmonologist. At this point, it is unclear whether he ever made the appointment or whether the clinic did make the appointment and the patient did not keep it. It may have been that language, culture, or financial issues due to lack of health insurance contributed to this failure to follow up with the pulmonologist.

Nine months later, when the patient presented first to the clinic and shortly thereafter (within six days) to the emergency department with the signs and symptoms that ultimately led to a lumbar puncture, the patient was transferred out. Apparently he was transferred to two hospitals before expiring. Again, the reasons for the multiple transfers are unclear, but the nature of this patient raises speculation that there may have been a violation of the Emergency Medical Treatment and Labor Act..

What this means to risk management departments is that they should work with the medical staff to ensure complete documentation when multiple physicians are involved in clinical patient care. Kicklighter says that, while cost may be an issue, risk managers should work with management to develop a short- and long-term plan for implementing an electronic medical records system. Such a system could improve the quality of information exchanged in connection with handoffs between caregivers and help prevent situations such as this from happening, she says. Meaningful peer review also may assist. More specific to this case, risk management can provide educational sessions for physicians and physician extenders to provide a better understanding of the differences between *Mycobacterium avium* and of *Mycobacterium tuberculosis*. Also, the best practices to use in case of these diagnoses can be explained. Finally,

risk management can work with physicians and physician extenders and the state health department in their area to establish stronger lines of communication and methods to facilitate follow-up with patients who are immigrants or migrant farm workers and who may have language, cultural, or financial issues that interfere with proper care.

Reference

• Highlands County (FL) Circuit Court, Case No. GC02-612. ■

Unresolved gallstones cause bile leakage, death

News: An obese, middle-aged woman suffering from pancreatitis and gallstones underwent gallbladder removal surgery at a hospital. Over the next two weeks, she continued to experience abdominal pain, nausea, and vomiting. Although doctors suspected that the woman might have gallstones floating freely in her bile duct, they were unable to perform the necessary procedures to confirm that suspicion due to the patient's size. The woman subsequently died. An autopsy discovered numerous gallstones throughout the woman's bile ducts caused bile to leak into the patient's abdomen and ultimately kill her. After the woman's estate sued the doctors and the hospital, the parties settled for $545,000.

Background: A 56-year-old woman weighing 425 pounds and suffering from chronic hypertension and renal insufficiency went to the hospital complaining of persistent nausea and abdominal pain. An internist at the hospital diagnosed pancreatitis and gallstones and referred her to a general surgeon, who recommended gallbladder removal to be performed five days later.

On the day of the surgery, the woman was feeling better, and her doctors thought she might have passed the gallstone or that it was floating freely in her bile duct. The general surgeon was unable, however, to perform a preoperative endoscopic retrograde cholangiopancreatography (ERCP) because of the patient's weight and the weight limits of the hospital equipment. The surgeon subsequently operated on the patient to remove her gallbladder, but he again was unable to perform an intraoperative cholangiogram to determine if any stone remained in the bile ducts due to the patient's size. The gallbladder removal was uneventful, and the woman's renal insufficiency immediately improved. The patient was discharged two days later.

Four days after discharge, the woman followed up with the internist, who noted that she was doing well. But two days later, the woman was experiencing abdominal pain, and fluid was draining from one of her abdominal incisions. The internist instructed the woman to collect the fluid in an ostomy bag and return in one month.

Two days later, however, the woman went back to the hospital complaining of abdominal pain and tenderness, nausea, and vomiting. The triage nurse and an emergency department physician noted that bile was leaking from the patient's abdominal incision site. A general surgeon who was covering for the first general surgeon diagnosed a biliary cutaneous fistula and admitted the woman to the hospital. Blood tests showed the bilirubin to be within normal limits, but the alkaline phosphatase was twice normal.

The covering surgeon contacted the first surgeon the next morning and told him that the patient had a suspected bile leak. The first surgeon came to the hospital that day, and when he examined the woman, she told him that she was feeling better and was no longer leaking fluid from the incision site. The doctor accordingly declined to perform a work-up, and he instead discharged her with instructions to return to his office in two weeks.

Three days later, however, the woman returned to the emergency department complaining of abdominal pain, nausea, and vomiting. Noting that her abdomen was firm and tender, the same emergency department physician admitted her for a work-up. Within several hours of admission, the woman developed shortness of breath, causing the physician to suspect a pulmonary embolus. The physician called the first general surgeon in the middle of the night to discuss the diagnosis, and the surgeon agreed. The surgeon informed the physician that he would arrive at the hospital in a few hours, at which point he would check on the patient. But the patient unfortunately died before the surgeon arrived.

During the subsequent autopsy, several liters of bile-stained fluid spilled out onto the floor when the pathologist opened the decedent's abdomen. The autopsy was immediately terminated because the floor became so slippery, and no cause of death

was determined until four years later when the body was exhumed for a second autopsy. At that time, 31 gallstones were found throughout the decedent's bile ducts. Although no perforation of a bile duct was found, the pathologist did find evidence of peritonitis and marked ascites, which is excess fluid in the space between the tissues lining the abdomen and abdominal organs. The pathologist determined that the stones left in the bile ducts at the time of surgery caused bile to leak into the patient's abdomen by the process of pressure diffusion through the membranous wall of the duct. The pathologist determined that the patient's death was caused directly by the leaking bile, as it produced an inflammatory response causing the body to produce huge amounts of ascitic fluid. When the fluid could not leak out after the incision healed, the woman suffered respiratory arrest.

The woman's husband and two children sued the general surgeon, the emergency physician, the covering surgeon, and the hospital. The plaintiffs claimed that the defendants failed to meet the applicable standard of care in treating their decedent when they failed to properly diagnose her condition, perform appropriate diagnostic testing, or provide appropriate treatment.

The defendants denied liability, principally claiming that the decedent's weight prevented the performance of certain standard tests to find remaining stones in the bile ducts prior to surgery. The defense also claimed that the clinical presentation was not typical of bile leak because the patient's temperature had not been elevated and because her bilirubin and white blood cell counts were normal. The general surgeon claimed that exploratory surgery was not warranted because the patient was feeling fine when he came to visit her and because there was no further evidence of drainage when she left the hospital after the first emergency department visit. The defense also claimed that the patient died of heart failure as a result of chronic hypertension.

The parties settled prior to trial for $545,000, including $430,000 from the first surgeon, $50,000 from the emergency physician, $25,000 from the covering surgeon, and $40,000 from the hospital.

What this means to you: The patient was extremely obese, says **Ellen L. Barton**, JD, CPCU, a risk management consultant in Phoenix, MD. "Thus, regardless of what else was happening, this was an overriding factor and should have led to some better decision making," she says.

The fact that on the day of surgery the appropriate tests could not be performed before or during surgery because of her weight should have been a red flag to the surgeon. It already was suspected that gallstones might be floating freely in the patient's bile duct. Unfortunately, this proved to be the case.

The patient returned to the internist and complained of fluid draining from the incision; however, instead of referring her to the surgeon immediately, the internist told the patient to collect the fluid and return in a month. "The appropriateness of this action was highly questionable given the suspicion that gallstones might be floating in the bile duct," says Barton.

The first visit to the emergency department resulting in the admission appeared to be appropriate. However, when the first surgeon visited the patient and she "appeared" to be doing better and had no leaking from the incision site, the surgeon declined to perform a work-up. Instead, he discharged the patient with instructions to follow up in his office in two weeks.

The second visit to the emergency department occurred just three days after the patient's discharge from the hospital and, again, the same emergency department physician admitted the patient for a work-up. The covering surgeon contacted the first surgeon, who agreed to come to the hospital in a few hours to perform the "work-up." "Unfortunately for the patient, it was not only several hours but probably several days too late," says Barton.

Although delayed for four years, the autopsy revealed that the cause of death was related to gallstones in the bile duct that had been suspected on the patient's initial hospitalization but not acted on. The failure to refer the patient to a facility that could do the appropriate testing was clearly a breach of the standard of care. "It was this failure to refer for appropriate diagnostic testing that undid the defense's arguments, and not the patient's weight," says Barton.

Finally, according to Barton, the issue of the patient's weight should have been openly discussed as part of the informed consent process. However, this would not have discharged or overridden the duty to refer the patient to an appropriate facility.

Reference

- Jasper County (MO) Circuit Court, Case No. 02CV679159. ■