

Hospital Liability & Litigation Alert

Strategies for limiting risk & timely analysis on current hospital litigation

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*Damage Caps***ALASKA FREEZES OUT
DAMAGE CAP FOES**

States across the country are edging toward enacting caps on non-economic and punitive damages. In the vanguard, Alaska put such a law in place in 1997 and, in a bellwether case decided late in August, weathered a challenge to the law's constitutionality.

A broad class of plaintiffs — “all injured parties contemplating tort action” — disputed the constitutionality of legislation that limits non-economic compensatory damages to \$400,000 for each death and \$1 million for each injury. The law bars punitive damages in most cases to three times compensatory damages or \$500,000, whichever is greater. In cases where the defendant knowingly caused the injuries for financial gain, the cap is four times the gain or \$7 million, whichever is greater.

The law also requires that half of all punitive damages be paid to the state, imposes a 10-year statute of repose, allows comparative allocation of fault between parties and non-parties, and gives hospitals partial immunity from vicarious liability for some actions of physicians.

The plaintiffs argued that the caps violate the Alaska constitution on six counts: the right to a jury trial, the right to equal protection, the right to substantive due process, the separation of powers, the right of access to the courts, and the ban on “special legislation.” The suit quickly wound its way up to the **Supreme Court of Alaska**. But the plurality opinion by Chief Justice **Dana Fabe** made short work of each count.

Damage caps do not violate the right to a jury trial, Justice Fabe reasoned, because caps are a “policy decision” applied after the jury performs its fact-finding function.

On the right to equal protection, the plaintiffs argued that two groups of Alaskans are short-changed by damage caps, those who are denied “full” compensation because it's in excess of damage caps and rural Alaskans whose awards are worth less because a dollar doesn't go as far in the bush as it would in the city. But Justice Fabe pooh-poohed these arguments on the grounds that plaintiffs' interests were merely economic, while the state has a legitimate interest in tort reform. The evidence plaintiffs provided on unequal eco-

nomie impact, in Justice Fabe's estimation, was underwhelming.

And because “our substantive due process test is a more deferential version of the equal protection test,” Justice Fabe found no violation of substantive due process. Similarly, because damage caps don't violate equal protection, there was no violation of the Alaska constitution's ban on “special legislation.”

Plaintiffs argued that by placing caps on damages, the legislature usurped powers that should belong to the judiciary, violating separation of powers. But this theory, quipped Justice Fabe, rested on the “weak” and “outlandish” assumption that “damages fall within the exclusive province of the court system.” Damage caps aren't remittitur because they don't alter a jury's finding of fact, Justice Fabe reasoned.

Equal access wasn't violated, said Justice Fabe, because caps neither impede actual access nor are they so drastic as to eliminate tort remedies.

Of particular interest to hospitals, the damage cap law limits hospitals' responsibility to granting and reviewing privileges to practice in the hospital. If the hospital provides notice to patients that physicians are independent contractors, then it's off the hook for civil damages arising from doctors' acts or omissions.

Two justices, **Alexander Bryner** and **Walter Carpeneti**, dissented. Justice Bryner argued that the damage caps violate the right to a jury trial and equal protection clause. Citing precedents in Kansas, Oregon, Washington and Alabama, Justice Bryner stressed that “the jury's function has traditionally included determining the amount of damages” and the damage cap circumvents that function.

But an even split in the Supreme Court of Alaska “results in an affirmance.” The state won its summary judgment. The split, however, also means that the affirmance is only for this case and does not set a precedent. ❖

Evans v. State of Alaska, 2002 Alas. Lexis 135. (Aug. 30, 2002).

*EMTALA***NO SAY, NO MATTER**

After more than five years of litigation, an Oklahoma City hospital is stuck holding the bag on a \$35,000 Emergency Medical Treatment and

Active Labor Act penalty — despite the fact that the facility never had a chance to make its own case before the peer review organization that reviewed the purported offense.

That's the effect of the Aug. 28 10th U.S. Court of Appeal's ruling in *St. Anthony Hospital v. Department of Health and Human Services* (No. 00-9529), a decision centering on a reverse dumping charge — i.e., contention that **St. Anthony Hospital** refused to accept an appropriately transferred patient who needed its specialized capabilities.

The events at issue took place back in 1995. A man injured in a car accident was taken to the emergency room at **Shawnee Regional Hospital**, a small hospital about 35 miles outside Oklahoma City. A Shawnee physician determined that the patient's injuries were too serious to be handled at Shawnee and arranged for a transfer to **University Hospital**.

The patient's condition, however, deteriorated en route, and the ambulance had to return to Shawnee. The doctor tried to arrange helicopter transport back to University, but by that time University already had two emergency surgeries to perform and couldn't take the patient.

According to an administrative law judge who heard the case, the doctor then tried to arrange a transfer to St. Anthony's, was refused, and eventually orchestrated a transfer to yet another hospital.

The **HHS Office of Inspector General** initially eyed Shawnee for an EMTALA violation and referred the case to a PRO. Shawnee had a chance to document its case, and persuaded the PRO that it didn't have the capacity to give the patient the services he needed, and that the benefits of transferring the patient outweighed the risks.

The OIG then sought to impose a \$50,000 EMTALA penalty on St. Anthony based on the PRO's analysis — even though St. Anthony never had a chance to participate in the PRO review by providing information that would explain its actions. The case wound its way through the administrative process, during which the penalty was eventually set at \$35,000.

On appeal, the 10th Circuit acknowledged that the EMTALA statute “unambiguously requires notice of the [PRO] review,” as well as an opportunity for the hospital to discuss the case with the PRO and supply additional information relating to the events. The court also affirmed that St. Anthony

never got such an opportunity. But the court refused to overturn the EMTALA violation, maintaining that the hospital didn't do enough to prove that it was prejudiced by not being able to participate in the PRO review.

“Potential for prejudice in cases such as this does not in and of itself justify setting aside [an] agency's action,” the appellate panel held. ❖

St. Anthony Hospital v. Department of Health and Human Services, 2002 U.S. App. Lexis 17867 (10th Cir. Aug. 28, 2002).

Standard of Care

RADIATION EXPERIMENT FAILS BUT DOC, HOSPITAL GLOW

A pair of wrongful death suits stemming from an experimental radiation treatment for brain cancer had a half-life of over 40 years. And the outcome of the case hinged on a post-mortem of four-decade-old standards of care.

Back in 1961, Dr. **William Sweet** developed what he hoped was a promising treatment for glioblastoma multiforme, cancerous brain tumors. The treatment, Boron Neutron Capture Therapy, entailed injecting patients with boron-10, then bombarding them with thermal neutrons. Sweet believed that boron-10 would be taken up by the tumor tissue but not by normal tissue. When the neutron beam was applied, Sweet thought, “a fission reaction would occur and destroy the surrounding tissue.”

Needless to say, it didn't work.

At the time, Sweet led a team of researchers at **Massachusetts General Hospital** and the **Massachusetts Institute of Technology**. To test BNCT, Sweet and his team enlisted MGH patients who presented with brain tumors.

In the '60s, having a brain tumor was akin to living under a death sentence. The median survival after diagnosis was just 8.3 months.

Several brain cancer victims including **Eileen Sienkewicz** and **George Heinrich**, enrolled in Sweet's study, hoping for a cure or at least a little more time. Both received conventional therapy — surgery to remove their tumors and normal radiation treatments — along with BNCT. Sienkewicz died 16 months after her initial diagnosis. Cancer took Heinrich after seven months.

The estates of each victim sued in 1995, alleging wrongful death and negligence.

To sustain a wrongful death claim in such a case, the plaintiff must show that “the defendant’s actions hastened death ‘even though it would have occurred at no very remote date from other causes,’” *Edwards v. Warwick*, 317 Mass. 573, 59 N.E.2d 194, 196 (1945). And causation — in such a technical case — must be established with the help of expert opinion.

But even Sienkewicz and Heinrich’s expert witness, Dr. **Larry Junck**, couldn’t say that BNCT hastened their deaths. “I think it would be very difficult for me to say what would have happened had they not received the treatment,” he remarked.

The plaintiffs brought up evidence from papers written by Dr. Sweet and his team several years after the trial in which they conclude that BNCT “offered no advantage over standard methods of therapy already available.”

But, according to the opinion by Judge **Sandra Lynch**, the articles “say nothing about BNCT causing the death of the patients earlier than would otherwise be expected.” Without such evidence, Judge Lynch concluded, a wrongful death verdict could not stand.

To sustain a negligence claim, the plaintiffs had to show that Dr. Sweet violated his duty of care by failing to provide the applicable standard of care. But “the standard of care for medical doctors is not static or rigid,” reasoned Lynch. And so the court set out to ascertain what standard of care was applicable in 1961.

The court had to determine what Dr. Sweet knew and when he knew it. Again, the plaintiffs relied on articles and reports written by Sweet on the outcomes of his study in which he admitted that the treatment failed. But, observed Lynch, those reports were written with the benefit of hindsight and do not reveal what Sweet knew when they were conducting the trials.

“It was not evidence about what Dr. Sweet knew at the time of the trials,” lectured Lynch, “but about what he learned as a result of the trials.” And it was not an admission of wrongdoing.

Dr. Sweet’s expert witness stated that Sweet’s handling of the patients, though now outdated, was acceptable at that time. The negligence charge failed for lack of evidence.

The take-home message in this world of rapidly changing medical practices: Plaintiffs won’t prevail unless they make sure their evidence on

standards of care is up to date — or purposefully out of date.

MGH also argued that it could not be held liable under Massachusetts’ charitable immunity doctrine. This argument never reached review. ❖

Heinrich & Sienkewicz v. Sweet & Mass. General Hospital, 2002 U.S. App. Lexis 17715 (1st Cir. Aug. 27, 2002).

Charitable Immunity

LOST IN THE SHUFFLE

Charitable immunity isn’t immutable. When a venerable Boston hospital lost medical records demanded under discovery, it also lost its charitable immunity and protection from a statutory cap on damages against charitable corporations.

Dylan Keene was born at **Brigham and Women’s Hospital** in 1986. Tragically, he contracted sepsis.

Hours after his birth, Dylan was transferred to B&W’s nursery with a note reading “watch for [signs and symptoms] of sepsis ... hold antibiotics pending [complete blood count] results and cultures.” What happened then is unknown, but 20 hours later he had full-blown sepsis that caused profound brain damage and a host of other problems.

Nine years later, Dylan’s parents sued B&W on the boy’s behalf for medical malpractice on the ground that the hospital had failed to diagnose or treat the sepsis. Quite naturally, they wanted to depose the treating doctors and nurses.

B&W spent eight months dodging the deposition. The hospital checked its library but could not locate the missing records. In frustration, the Keenes asked that B&W be found in default and that its charitable immunity defense be stricken. They argued that the missing records, which would have identified the treating doctors and nurses, were critical to their proof of claim and without them, their claim would be irreparably prejudiced. No lesser sanction than default would be appropriate, they charged, because the hospital was required by law to maintain the records.

The hospital replied with a three-fold defense: default was inappropriate because it simply didn’t have the records; default deprived B&W of its right to due process; and it was not warranted because the Keenes could establish proof of claim without the missing records.

On appeal, the **Appeals Court of Massachusetts**, in an opinion by Judge **Elizabeth Porada**, bought none of it.

B&W should have had the records, reasoned Porada, and the hospital produced no evidence that the records — “which originated with the defendant and were required by law to be maintained and preserved by the defendant” — were lost due to any circumstances beyond its control.

Due process wasn't dispensed with lightly. Under Mass.R.Civ.P 37(b)(2)(C), judges may not impose the sanction of default unless the inability to comply with a discovery order “is the result of willfulness, bad faith, or fault,” related Porada. But no Massachusetts appellate decisions have defined “fault.”

Looking to the federal courts, Porada noted *Societe Internationale Pour Participations Industrielles et Commerciales, S.A. v. Rogers*, 357 U.S. 197 in which the **U.S. Supreme Court** held that default would not be appropriate where failure to comply with a discovery order was due to circumstances beyond the defendant's control. But B&W was in control, reasoned Porada, so it was at fault.

Due process also would have been violated had the sanction of default been unjust. In determining justness, the lower court judge looked at the degree of prejudice to the Keene's case. Without the records, he concluded, their case was irreparably prejudiced.

Finally, the hospital argued that expert witnesses could substitute for the missing records. But because doctors who never saw Dylan could only offer conjectures as to his condition, “the expert opinions ... would have been subject to attack as unreliable and speculative,” wrote Porada. Moreover, the Keenes needed the records to identify the treating doctors — who were not protected by charitable immunity.

The lower court judge reckoned that the default sanction might deprive the hospital of its day in court but that by losing the records, B&W had essentially deprived the Keenes of theirs. Porada agreed.

The hospital also argued that when the lower court imposed the sanction of default and struck its charitable immunity — and thereby removed the \$20,000 limitation on damages usually enjoyed by Massachusetts charitable corporations — it usurped a power that usually belongs to the

legislature. But charitable immunity is an affirmative defense, reasoned Porada, “and thus is subject both to being waived and being stricken.”

“We conclude that the limitation of liability flows from proof of the defense of charitable immunity,” wrote Porada, “and that, once that defense is stricken, the limitation on liability is non-existent.” Lacking charitable immunity, B&W must cough up \$4.1 million. ❖

Keene v. Brigham and Women's Hospital, 2002 Mass. App. Lexis 1184 (Sept. 19, 2002).

Contract Law

WE PROMISE IN PROPORTION TO OUR HOPES...

“... And we deliver in proportion to our fears,” warned the **Duc de la Rochefoucauld**.

When a patient's family asked a doctor whether the patient would live out the year, she promised them that she saw no reason why he would not. He died 11 months later. The family sued both the physician and the hospital at which their father was treated, charging breach of contract. And Washington courts were left to decide whether the doctor's promise constituted an enforceable contract.

Kurt Hansen suffered symptoms of neurological dysfunction throughout the 1990s. He turned to Dr. **Lynne Taylor**, a neuro-oncologist at **Virginia Mason Medical Center** in Seattle.

The doctor originally suspected multiple sclerosis and ordered a batch of tests. Over two and a half years, Hansen's condition deteriorated but tests revealed nothing enabling Taylor to make a positive diagnosis.

In January, 1996, Hansen, along with his wife and son, visited Taylor again, and Barbara Hansen expressed her fear that Kurt would die within the year. She remembered Taylor telling them that “he was not terminal within the next year.”

Taylor's recollection of the conversation is a little different. She said that she “assured” the Hansens that Kurt “had no diagnosis of a terminal illness that would lead me to believe that he would die within the next 12 months.” She insisted that she was “not making any promises to the Hansens.”

After Hansen died, an autopsy revealed that he had pilocytic astrocytoma — a tumor — of the brainstem.

The surviving Hansens sued. Besides missed diagnosis, violation of the Consumer Protection Act and negligent infliction of emotional distress, they charged breach of promise. Both the Hansens and Taylor, along with Virginia Mason, moved for summary judgment on the breach of promise.

The Health Care Provider Act, *RCW 7.70.030*, governs recoveries for injuries resulting from health care and allows awards when “a health care provider promised the patient or his representative that the injury suffered would not occur.”

The court had to decide the case *de novo* and — lacking clear guidance from legislative history — turned to common law. One case was particularly pertinent, observed Judge **Ann Schindler** in her opinion for the panel.

In *Carney v. Lydon*, 36 Wn.2d 878, 220 P.2d 894 (1950), a drugless healer promised to cure a patient’s diabetes. There, the Court held that the practitioner “expressed his opinion” that the cure would work, and didn’t make an enforceable promise.

“The existence of a contract will not be inferred where a practitioner merely offers an opinion regarding the effect of a course of treatment,” Schindler wrote.

A promise is a term of art in contract law, concluded Schindler. And while a promise includes an undertaking that something shall, or shall not, happen in the future, this case “is not related to a specific undertaking or a specific result or cure through a course of treatment or a procedure,” she wrote.

Schindler surmised that in writing the HCPA, the Washington legislature intended to incorporate common law. Although the HCPA allows damages for injuries that doctors promise would not occur, common law shows that a promise in the form of a doctor’s opinion does not add up to an enforceable contract. ❖

Hansen v. Virginia Mason Medical Center & Taylor, 2002 Wash. App. Lexis 1995. (Sept. 3, 2002).

Informed Consent

DOCS INFORMED: INFORMED CONSENT THEIRS ALONE

Hospitals can take a breather. Doctors are in the best position to advise patients of the risks of surgery, ruled the **Supreme Court of Pennsyl-**

vania. It would be “unworkable” for a hospital to dictate how doctors obtain informed consent.

Under Pennsylvania law, if a doctor performs an operation without first obtaining informed consent, it’s considered equivalent to a technical assault, a tort. No wonder, then, that the **Albert Einstein Medical Center** in Philadelphia got worried when one of its doctors was accused of implanting a catheter without the requisite consent.

Lope Valles was admitted to AEMC for a suspected abdominal aortic aneurysm. He was given an aortogram but the dye used in the procedure damaged his kidneys. He needed extended dialysis and so his doctor proposed placing a catheter.

The doctor might have implanted the catheter in any of several sites on Valles’ body. The doctor chose to put it in Valles’ chest but, during the surgery, Valles suffered an accumulation of air and blood in the chest cavity and cardiac arrest.

His wife, **Esmelinda Valles**, brought a suit, alleging that Valles was not properly informed of the risks associated with the various choices of sites for placement of the catheter. She sued both the doctor and the hospital, arguing that the relationship between AEMC and the doctor was such that the hospital had sufficient control over the doctor so as to render it vicariously liable.

Valles maintained that the hospital is an employer and so responsible for the doctors’ actions under the principles of respondeat superior. AEMC countered that historically, the duty to obtain informed consent rests only with the doctor, and moved for summary judgment.

The court considered a slate of factors to determine whether the doctor was an employee of AEMC, but this case turned on the degree of control a hospital had over the doctor.

Valles argued that the doctor’s “exercise of independent medical judgment was subject to AEMC’s right of control” because he couldn’t delegate work without approval from the hospital, had to report his medical findings in accordance with hospital guidelines, and he had to follow the hospital’s protocols and schedule. The hospital also required the doctor to obtain informed consent for surgery.

Even if the court bought Valles’ argument that the doctor was a hospital employee, she “is still not entitled to relief,” concluded Justice **Ralph Cappy**, writing for the majority. “Informed consent flows from the discussions each patient has

with his physician, based on the facts and circumstances each case presents,” insisted Justice Cappy. “We decline to interject an element of a hospital’s control into this highly individualized and dynamic relationship.”

AEMC won summary judgment. ❖

Valles v. Albert Einstein Medical Center, 2002 Pa. Lexis 1783. (Aug. 28, 2002).

Indigent Care Surtax

PRIVATE HOSPITALS STUCK WITH BILL FOR INDIGENT CARE

Miami-Dade County citizens may have had a rough time of late electing a representative government. But a recent Florida appeals court ruling affirms the power of the county government in the face of state legislators.

In 1991, seeking to compensate public hospitals for the care they provided to indigents, the Florida legislature instituted an indigent care surtax of 0.5 percent. As insurance against declining revenues, the legislature also required that in subsequent years, the counties continue to contribute at least 80 percent of the 1991 appropriation.

Indigents, however, sometimes prefer private hospitals. The legislature, recognizing this fact, in 2000 amended the 1991 law to divert a portion of the appropriation to private hospitals. The amendment stipulated that a governing board, chartered by the county commission, be established to allocate the funds.

Trouble is, the legislature wrote rules for the governing board that only pertain to Miami-Dade County.

The county, not wishing to give up revenues for its public hospital, decided not to abide by the 2000 amendment. Miami-Dade gave notice that it would not comply with the amendment on the ground that it was an unconstitutional “special law” applicable to it alone and no other counties. It also decided to abolish the governing board under its Home Rule Charter.

Private hospitals in Miami-Dade sued, trying to compel compliance with the 2000 amendment. Both parties filed cross-motions for summary judgment. Now the **Court of Appeal of Florida** has weighed in on the county’s side.

“The 2000 Surtax Amendment” wrote Judge **Mario Goderich**, “is applicable only to Mi-

ami-Dade County, and therefore, is an unconstitutional special law.” The judge cited the rules for the governing board which specifically charge the mayor of Miami-Dade County with appointing members to a nominating committee. If only Miami-Dade’s mayor got saddled with that task, then the law must only apply to Miami-Dade.

The private hospitals countered that severing the governing board provisions could save the amendment. Severability would be possible, Judge Goderich reasoned, if the clear purpose of the legislature were preserved.

But the legislature clearly intended the amendment to only apply to Miami-Dade, concluded the judge, or it wouldn’t have tipped him and only him with the a role in rounding up a governing board. Goderich ruled for summary judgment in favor of the county. ❖

Homestead Hospital Inc. v. Miami-Dade County, 2002 Fla. App. Lexis 12780 (Sept. 4, 2002).

Business Practices

DON’T LET NUMBER CRUNCHERS CRUNCH YOU

By now you’re a pro with compliance investigations, but thanks to **Enron** — and other recent corporate scandals — experts say it’s time to add to your expertise on internal financial and accounting investigations, whether yours is a profit or nonprofit hospital.

You need to take steps now — even if you’re not experiencing financial or accounting woes — to ensure that the internal financial investigations you undertake for whatever reason will provide valuable and accurate information to your board of directors, withstand public scrutiny and protect sensitive information against discovery in a lawsuit.

Financial or accounting problems aren’t the only reasons for conducting internal investigations. Other reasons include routine testing for compliance, responding to internal or external audit results, preparing for litigation, assuring company compliance with previously given audit advice and providing advice to management and the board on the proper course of action for the company, says **Dale Hale**, senior vice president and general counsel at **Trinity Health** in Novi, MI. Speaking at a recent **American Health**

Lawyers Association teleconference, “Lessons for Healthcare from Enron.”

The good news is that financial investigations are a lot like the compliance work you’ve already been doing. For example, you need to designate a person or committee to be responsible for ordering internal financial/accounting investigations when appropriate. That could be the board of directors, the board’s audit committee, managers or the compliance officer. And the person or body ordering the investigation also must have authority to act on any problems that are turned up.

Under the recently enacted Sarbanes-Oxley Act of 2002 — federal legislation designed to improve the accuracy and reliability of the corporate disclosures publicly traded companies must make — the audit committee of a public company’s board of directors must have authority to authorize investigations “into any matters within the scope of their responsibilities,” notes **Paul DeMuro**, an attorney with **Latham & Watkins** in Los Angeles speaking at the same AHLA conference.

Other steps you can take to prepare for conducting bulletproof investigations include:

- **Investigation policies.** You need to establish investigation policies now, before you need them. In particular, Hale recommends that the policy address the scope of the investigation “that will be commissioned in cases where an investigation is necessary in order to protect against accusations that there was a cover up or a failure to investigate all the relevant matters.”

The policies also should identify who will conduct the internal investigation. Options include in-house counsel, outside counsel, consultants or a combination of some or all of these people. You’ll want to think this through carefully, as there are risks and benefits with every option. It’s a good idea to consult an attorney for advice on this issue when designing your policies.

The most important consideration in deciding who should perform the investigation is the attorney-client privilege. Be sure that you protect not only the investigation itself but also its results by cloaking it in the privilege. No matter whom you select, take a lesson from Enron: Make sure that the investigators are removed from real and perceived conflicts in the matters they’re investigating. That will lend real credibility to the investigation’s outcome, Hale insists.

- **Purpose.** The process you develop for conducting an investigation should include a step requiring that the person or body ordering it clearly defines the investigation’s purpose before it begins, counsels Hale.

- **Method.** Enron took a lot of heat, Hale says, because the law firm it hired to do an investigation did only a limited, preliminary investigation. If you want your investigation to withstand public scrutiny, it needs to be thorough. In fact, Hale recommends using the **HHS Office of Inspector General’s** self-disclosure protocol as a model for how to conduct a financial/accounting investigation.

- **Protect employees.** The attorneys who represent your company cannot also represent your employees. So you’ll need to decide whether you’re willing to provide attorneys to employees who might be involved in the subject of the investigation.

- **Investigation report.** Decide whether you want an oral or written report from investigators. You’re more likely to keep an oral report confidential, and that “may be a very important issue if you have a history of paper being disseminated outside or even within the organization that should be kept confidential,” Hale offers. On the other hand, a written report “brings in a different sense of rigor to the analysis and to the presentation. It also is tangible evidence that the organization can use to demonstrate that it took the investigation phase very seriously,” he says.

- **Corrective action.** Finally, your policies should specify that if the investigation reveals financial or accounting problems, action will be taken to correct them. “Audit committees and boards shouldn’t sit there and not question things or challenge things. They should be very much involved in the nature of the activities and understand them of the corporate entity,” DeMuro argues. That’s a big way to keep from being the next Enron. ❖

Slander & Libel

DOC STUCK WITH NEEDLE, SKEWERED BY COURT

When an emergency room doctor was pricked with a needle and tested positive for Hepatitis C, the hospital administration went into overdrive trying to figure out the best way to deal with it. The doctor, however, pinned the hospital with a slander and libel suit.

After sticking himself with a suture, Dr. **William Nelson**, medical director of the emergency department at **Southeast Georgia Regional Medical Center**, followed hospital procedures and submitted to blood tests. Although the patient was negative, Dr. Nelson tested positive for Hep C.

The lab tech told the lab administrator, who in turn informed the hospital administrator. The administrator asked the director of nursing about the seriousness of the disease.

On the advice of Southeast's legal counsel, the administrator called together an ad hoc group of physicians to discuss the situation. The ad hoc group was presented with the facts but Nelson was not identified by name. Although the ad hoc group failed to reach a consensus, Southeast sent a letter to **Sterling Miami Inc.**, Nelson's employer, explaining that Nelson tested positive for Hep C and limiting his privileges to non-invasive care until the hospital's executive committee could meet.

When the executive committee met six days later, Nelson attended. The executive committee placed no restrictions on Nelson other than universal precautions.

Despite this happy outcome, Nelson sued, alleging slander and libel, invasion of privacy and intentional infliction of emotional distress. The hospital moved for a summary judgment but Nelson maintained that there were questions of fact: Did the oral communication among the hospital administration and staff constitute slander? And was the letter to Sterling stating that Nelson was "diagnosed with Hepatitis C" libelous?

"A cause of action for libel or slander will fail," wrote Chief Judge **Alan Blackburn** of the **Court of Appeals of Georgia**, "if the statement is shown to be truthful." Nelson tested positive, ergo no slander or libel.

But Judge Blackburn extended the discussion. Supposing that a single test would fail to establish that Nelson was positive for Hep C, his claims would still lack merit because communications about his results were "not published, were privileged, and were made without malice."

Oral communication about Nelson's test results up the hospital hierarchy did not constitute publication, Blackburn ruled. It was all inter-corporate and limited to proper persons, and therefore excluded from the definition of publication. There was no evidence of malice but plenty of evidence that the hos-

pital acted on good faith, Blackburn opined. "Based on Nelson's failure to show publication and the existence of a good faith privilege," the judge concluded, "recovery is barred for slander or libel."

Judge Blackburn dispensed with Nelson's other claims in a similar, forthright fashion. His claim of emotional distress crashed because the defendants' conduct was "neither intentional or reckless nor outrageous or extreme," all needed to sustain the charge.

To win his invasion of privacy claim, Nelson needed to show disclosure that either placed him "in a false light in the public eye" or of embarrassing private facts. But Blackburn had already established that there was no public disclosure, hence no invasion of privacy. ❖

Nelson v. Glynn-Brunswick Hospital Authority, 2002 Ga. App. Lexis 1230 (Sept. 24, 2002).

Patient Safety

MEDICAL ERRORS BILL ADVANCES, BUT RECONCILIATION BATTLE LOOMS

Two key House committees gave strong — and perhaps surprising — endorsement to a medical errors bill. But concerns in the Senate over how the bill will affect malpractice litigation mean significant battles over the litigation likely are still in store.

By a surprising 33-4 margin, the House Ways and Means Committee Sept. 18 passed legislation intended to reduce medical errors. Sponsored by health subcommittee chair **Nancy Johnson** (R-CT), the measure would allow hospitals to voluntarily report errors and near-misses to "patient safety organizations" certified by the **Department of Health and Human Services**. PSOs would analyze the information and provide feedback to reporting institutions and the wider provider community.

After a contentious Ways and Means subcommittee mark-up, garnering ayes in full committee from senior health panel Democrat **Pete Stark** (CA) and all but four of his minority colleagues was a significant victory for Johnson and may give her proposal new momentum.

Johnson predicts a strong House floor vote in favor of her measure this year.

The Ways-and-Means-passed bill includes some changes to address Democrats' concerns. For instance, the bill includes new clarifications that it would not reduce the types of information currently

discoverable by injured patients in malpractice actions nor interfere with state laws that mandate error reporting in certain situations.

Additionally, measures to protect health care workers who report errors now include fines of up to \$50,000 per violation. After the subpanel mark-up, Stark had labeled the bill's whistleblower protections "a right without a remedy" because no penalties were included.

DHHS Secretary **Tommy Thompson**, in a statement following the Ways and Means vote, applauded the outcome and called on the rest of Congress to follow suit.

In a Sept. 25 voice vote, members of the House Energy and Commerce Committee joined their Ways and Means colleagues in adopting a voluntary reporting approach to combating medical errors. There are some relatively minor differences between the two bills. For instance, Commerce's version authorizes information technology grants for hospitals and contains lower penalties for hospitals that retaliate against employees who report medical errors.

In the Senate, **James Jeffords** (I-VT), **John Breaux** (D-LA), and others who have sponsored a bill similar to the two House Committees' are still negotiating with Sen. **Edward Kennedy** (D-MA), who has expressed misgivings with a sole reliance on voluntary reporting and concerns that overly generous confidentiality protections could allow hospitals and physicians to keep evidence of malpractice from injured patients. ❖

Quality Reporting

HOSPITALS SIDLE TOWARD QUALITY REPORTING

Hospitals likely will face quality reporting mandates in the near future — but what kind of data will be covered by the requirement remains unclear.

Once home health reporting gets off the ground early next year, hospitals almost certainly will be the next provider group to face quality reporting requirements from the **Centers for Medicare and Medicaid Services**. However, research is still in the earliest stages on the kind of quality information hospitals believe will be most useful to patients, said **American Hospital Association** senior vice president **Carmela Coyle** Sept. 16.

Reportable nursing home measures scheduled for national rollout in November — including, for example, the percentage of residents who develop pressure ulcers — represent one type of reportable data, but are "intended more for clinicians," says Coyle. While AHA knows there's a place for clinical reporting, the organization is more interested in seeing development of measures "more targeted toward the public," which "might look very different."

That's why much of the current debate over reportable measures centers on the question, "Are you looking to share information or data?" Coyle says. Hospitals are most interested in information that can drive consumer choice, measures that gauge patients' experiences with a given provider, such as "How much time did the nurses spend with you? Was your medication checked and rechecked?" she suggests.

A small-scale hospital quality-reporting pilot could take place as early as next year, CMS Administrator **Tom Scully** said recently. But such a pilot would include clinical measures only, while a pilot of the consumer-oriented measures hospitals find most interesting is a couple of years down the line, Coyle says. ❖

Medicare

BELATED RFA OFFERS RATIONALE FOR "ONE-HOUR RULE"

When the **Centers for Medicare & Medicaid Services** issued its patients rights condition of participation for Medicare hospitals in July 1999, hospitals cried foul — and ultimately sued the agency — over a controversial component of the rules governing the use of patient restraints. CMS won in court on all counts but one, and the meager fruits of the hospitals' partial victory appeared in the Oct. 2 installment of the *Federal Register*.

The so-called "one hour rule," which was the bone of contention, requires hospitals to provide an in-person evaluation of a patient, by a doctor or licensed independent practitioner, within one hour of using restraints or placing a patient in seclusion because of violent or aggressive behavior. Hospitals maintained that requirement would be outrageously costly, if not flat-out impossible to fulfill. When hospital groups sued the agency over the rule, they hoped to enjoin the agency from enforcing it — but they ultimately lost that battle and

won out only on a relatively minor count relating to the Regulatory Flexibility Act. The court, while allowing the “one-hour rule” to remain in effect, ordered CMS to redo its regulatory flexibility analysis to better describe the agency’s efforts to consider a range of alternative approaches and weigh their probable effects.

Among other things, the new RFA says CMS considered such things as allowing off-site staffers to evaluate restrained patients via telephone and not putting a time limit on the post-restraint evaluation, but ruled them out because it believed speedy, expert medical involvement is necessary when restraint or seclusion is used. ❖

Editor’s Note: To see the revision, go to www.access.gpo.gov/su_docs/fedreg/a021002c.html.

Legislation & Regulation Update

FEDS ANTICIPATE STEPPED-UP EXCLUSIONS IN 2003

If you think the campaign against health care fraud is winding down as more and more providers adopt compliance programs and make efforts to get their act together, take a peek at the latest Work Plan from the **HHS Office of Inspector General**.

Released Oct. 2, the document reveals that the feds believe there are still too many bad apples out there, despite significant progress on the compliance front in recent years. Indeed, the OIG says it expects misconduct egregious enough to warrant ouster from Medicare and Medicaid could be on the rise. “In coordination with OI [the Office of Investigations, the OIG’s investigative arm], we anticipate receiving an increased number of cases in which the evidence supports exclusion from federal health care programs,” the OIG’s Office of Counsel to the Inspector General warns in its section of the plan.

OCIG also says it plans to intensify its scrutiny, through increased site visits, of providers that are currently bound by corporate integrity agreements and fraud settlements with integrity provisions. “Additionally, we will increase our coordination with CMS on appropriate measures regarding entities with ongoing problems,” the plan indicates.

OCIG says it plans to revise guidance for the hospital industry in fiscal year 2003.

The OIG’s investigative focus areas for the year will include pharmaceutical fraud — the plan

has an entirely new section on Medicaid drug reimbursement — and quality of care issues for beneficiaries who live in care facilities such as nursing homes. However, the agency “will not allocate resources to investigations of individuals, facilities, or entities that committed errors or mistakes on claims submitted to the Medicare or Medicaid program,” focusing instead on deliberate misconduct.

To see the Work Plan, go to <http://oig.hhs.gov/publications/docs/workplan/2003/Work%20Plan%202003.pdf>.

• **House Votes For Bush-Backed Malpractice Caps, But Senate A Barrier.** By a mostly party-line vote of 217-203, the House passed a law that would limit noneconomic damages — such as those for pain and suffering — to \$250,000. The measure, which has President Bush’s strong support but has little chance to pass the Senate as presently composed, would also place stricter limits on punitive damages, on the timeframes in which cases could be filed, and on fees for plaintiffs’ attorneys.

• **Hospital Mergers Target Of New Task Force.** In a bid to “reinvigorate” its antitrust efforts on the hospital merger front, the **Federal Trade Commission’s** Bureau of Competition has announced formation of a new Merger Litigation Task Force, which will focus on both hospital and retail merger activity. The task force’s charge includes “a review of, and potential challenge to, consummated transactions that may have resulted in anticompetitive price increases,” according to a commission press release. **Michael Cowie**, an assistant director in the bureau of competition, heads the group. ❖

Industry Notes

HOSPITALS STILL DROPPING BALL ON MEDICATIONS

Nearly one medication dose in five administered in hospitals and skilled nursing facilities is given in error. So find **Kenneth Barker** of the **Auburn University** School of Pharmacy and colleagues.

Their study, reported in the Sept. 9 issue of the *Archives of Internal Medicine*, finds that 7 percent of errors are potentially harmful, as judged by an expert panel of physicians.

Medications given at the wrong time account for 43 percent of errors. Omissions make up another 30 percent, wrong dose 17 percent and unauthorized drug 4 percent.

The study used data collected from a random sample of 36 hospitals.

- Claims that Florida is facing a malpractice litigation crisis are a sham, says consumer advocacy group **Public Citizen**. The group blames rising med mal insurance liability rates on lousy investing by insurers, not on the number or size of awards in malpractice lawsuits.

Medical injuries reported by Sunshine State hospitals exceed malpractice claims six to one, Public Citizen claims in a Sept. 17 report. A few rotten doctors — 6 percent — are responsible for half the malpractice. The group also argues that the Florida Board of Medicine “is dangerously lenient with doctors.” Twelve doctors in the state have paid 10 or more malpractice claims but have never been disciplined by the Board, says Public Citizen.

To read the report, go to www.citizen.org/congress/civjus/medmal/articles.cfm?ID=8282.

- Philadelphia gets a disproportionate share of malpractice awards and settlements, reports the *Philadelphia Inquirer*. Eight of 13 awards topping \$1 million granted in the state this year stem from City of Brotherly Love-suits.

Doctors and hospitals argue that Philadelphia juries give high awards, drawing suburban plaintiffs to sue in the city on the ground that the doctors and hospitals have business ties there. Patients in the city win 40 percent of malpractice suits, according to the *Inquirer*, compared to 20 percent in suburban counties.

- Hospitals are to blame for accelerating health care costs, argue **Bradley Strunk** of the **Center for Studying Health System Change** in Washington and colleagues. In their annual review of factors of health care costs underlying private health insurance, published in *Health Affairs*, the authors say that hospital spending accounted for more than half of total increases. Spending on outpatient hospital services, at 16.3 percent, was the fastest-growing component, overtaking prescription drug spending, last year’s cause celebre.

The article is available at www.healthaffairs.org/WebExclusives/Strunk_Web_Excl_092502.htm.

- Federal prosecutors this summer shut down their criminal investigation of individual employees of hospital chain **HCA** — and the move did a lot to loosen the discovery logjam in the epochal cost report probe of the Nashville, TN-based company. But disagreements about who should be

produced as witnesses and what kinds of documents need to be on the table still linger.

Early this year, HCA put a freeze on offering up 76 employees for depositions in some of the numerous whistleblower cases the **Department of Justice** has joined against the company. HCA maintained in part that the witnesses shouldn’t have to be deposed until they knew whether they were targets of the criminal probe. With that issue off the table, at least one discovery impasse had been in some measure resolved.

But serious disagreements still fester. “Significant discovery disputes continue to dominate the landscape of this litigation,” the DOJ asserts in a Sept. 16 court filing — especially in the qui tam cases that involve cost report issues.

The DOJ notes in the filing that settlement negotiations on the cases continue. ❖

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