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Hospital Liability
In the Age of Health Reform

- Protecting Patient Safety

A Joint Hospital-Medical Staff Responsibility

An Overview of a Complex Subject.

For a more detailed account read:

- *"Preparing and Winning Medical Negligence Cases",*
  - *Cyril Wecht, editor:*
  - *3rd Edition 2009 Juris Publishing*
  - *Chapter 1 : Hospital Liability: R S Wilbur*

- First:

- Since time is limited

There are some important areas of liabilities affecting administration and medical staff.

I will NOT present them in detail
But it is important to know they exist:

1. EMTALA (Anti-dumping Law)

Hospital and staff liability for failure to at least stabilize critically ill patients before sending them to another institution. Especially when the transfer is based on inability to pay.

Government penalty under the act is in *addition* to any suit for malpractice vs. doctor and hospital.

Emergency Medical Treatment and Active Labor Act, (EMALTA), is an Act of Congress passed in 1986. (42 U.S.C. § 1395dd,)

2. HIPAA & EMR

Hospital and staff liability for failure to protect patient privacy in record keeping. Both Federal and, if more strict, State civil and criminal penalties apply. The Act does not bar liability actions as well.

HIPAA also promotes and regulates the Electronic Medical Records (EMR) which the current Federal Administration is supporting for all health care.

HIPAA (Health Insurance Portability and Accountability Act of 1996), Public Law 104-191.

3. Anti trust liabilities:

This is chiefly a problem for mergers and acquisitions of similar hospitals in the same catchment area, an important liability, but not usually for the medical staff.

However, actions by the administration of a community hospital against medical staff members, their spouses or partners because of their participation in the setting up of a competing specialty hospital or clinic directly impacts upon staff/administration relations and produces a liability for civil suits.

4. Stark Laws I. II. & III

This complex series of laws requires expert lawyers to untangle. The point for today is that financial relationships between physicians and hospitals which appear to the government to be intended to entice the physician to admit his patients preferentially to that hospital or laboratory create a financial liability.

With the current Federal interest in installing Electronic Medical Records (EMR) in both hospitals and doctors' offices, the area is murky.

5.Primarily Administration's Liabilities

a. Innkeeper responsibility

– Fire Prevention, Slips and Falls, Safe food, etc More stringent for hospitals where patients are unable to protect themselves

b. ADA (Americans with Disabilities Act)

c. Non-Profit Hospitals Charity Responsibilities:

Lose tax exemption without a sufficient amount of Indigent care

d. Administrative and Regulatory Law

Governmental and Joint Commission

e. Hazardous Waste Disposal

Infectious, sharp objects and nuclear.

f. Fraud Enforcement and Recovery Act of 2009

Whistleblowers

Second

The hospital and its medical staff's responsibility for the prevention of patient injury due to medical error.

To Err is Human (1999)and Crossing the Quality Chasm (2001)
Institute of Medicine (IOM) of the National Academy of Science

These seminal Reports focused attention on the enormous number of adverse events and deaths from medical error.

"Adverse events occur in about 10% of admissions to acute care institutions and these contribute to permanent harm or death in about 2% of admissions". "the problem appears to be of a similar order of magnitude in the USA, UK, Australia, Denmark, New Zealand and Canada."
J R Soc Med 2009 102:266

A. Hospital Administration Responsibility for its employees.

1. Liable for injuries from negligence (like most employers)

2. Screening of employees:

   Credentials: Training, Previous employment

   Criminal Record, Sex Abuse, Drugs etc.

3. Duty to direct and supervise patient care employees, independent of physician control in the case of nurses and pharmacists

4. Duty to establish and enforce Protocols, esp. Nursing

5. On-job training and retraining

6. Employed Physicians-Radiologists, Pathologists, Emergency Department MDs, Hospitalists, MD Managers, etc.

B. Hospital and Medical Staff Responsibility for Quality of Medical Care

1. Credentialing, Initial and Renewal

    a. Joining Hospital Staff

        i. Medical School esp. if foreign

        ii. Residency

        iii Fellowships (Need careful evaluation)

        iv. Licensure

            CHECK ! 5% are false)

            (N.E.J.M. Vol. 318:356-358, Feb 11, 1988 No.834 99)

        v. National Practitioner Data Bank

        vi. Previous Hospital(s)

            Must be accepted with caution

b. Credentialing for Performance of Procedures

i. General Area, e.g. Surgery

Residency Completion

Board Certification

ii. Specialty and Subspecialty

iii Specific Procedure(s) Prove it!

c. Recredentialing

i. Specialty & Subspecialty Recertification (MOC)

ii. Procedure (s) Statistics: Total # & Results

Critical – State of the Art Changes Rapidly

Past – Open Abdominal to Laparoscopic

Future – Robotic

Can not afford on the job training, learning curve is too dangerous

Community Hospitals: Too many doing too few

C. Risk Management and Quality Control

1. Hospital Staff Bylaws
   - a. Peer Review of Quality of Care
   - b. NOT Economic Credentialing
   - c. Fair Hearings: Adequate Notice,
   - d. Confidentiality. Freedom from Discovery

     The Healthcare Quality Improvement Act of 1986 (**HCQIA**).
     (United States Code Title 42, Sections 11101 – 11152)

2. Assurance that the Mechanism is in place
   - Quality Control Staff
   - Appropriate Quality Review Committees

3. Assurance of a meaningful review of Clinical Care actually happens
   - M & M and other case statistics reviewed
   - Sentinel Medical Events identified and studied

D. Medication errors: Most frequent hospital error

1. Wrong Dose, Wrong Medicine, Wrong Patient, Wrong Time
2. Patient condition (Allergy or Genetic)
3. Drug/Drug Interaction
4. Over medication.----falls, etc. Nursing Convenience.

E. "Never Events" e.g. wrong operation, side, site, or person.
These are almost indefensible in court.

In 2002 the National Quality Forum listed some 27 (now 28) serious and largely preventable conditions which should "never happen to a hospital patient"
In 2007 Leapfrog Group (large purchasers of health care) endorsed not paying for these.
In 2005, Congress passed Pub.. L. 109-171 § 5001© at pg. 120 stat. 30.(2005), which excludes Medicare or Medicaid Payment for reasonably preventable conditions.
Centers for Medicare & Medicaid Services (CMS) on August 22, 2007, effective October 1, 2008 issued 73 Fed. Reg. 48473-48487. Use of "evidence-based guidelines" to prevent "Hospital Acquired Conditions" (HACs).

CMS will not pay for added expenses due to these:

1. Foreign Object retained after Surgery
2 Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers
5. Falls and Trauma
   - Fractures
   - Dislocations
   - Intracranial Injuries
   - Crushing Injuries
   - Burns
   - Electric Shock
6. Manifestations of Poor Glycemic Control
   - Diabetic Ketoacidosis
   - Nonketotic Hyperosmolar Coma
   - Hypoglycemic Coma
   - Secondary diabetes with Ketoacidosis
   - Secondary Diabetes with Hyperosmolarity

7. Catheter-Associated Urinary Tract Infection

8. Vascular Catheter-Associated Infection

9. Surgical Site Infection Following:
- Coronary Artery Bypass Graft (“CABG”) – Mediastinitis
- Bariatric Surgery
  - Laparoscopic Gastric Bypass
  - Gastroenterostomy
  - Laparoscopic Gastric Restrictive Surgery
- Orthopedic Procedures
  - Spine
  - Neck
  - Shoulder
  - Elbow

10. Deep Vein Thrombosis (“DVT”)/Pulmonary Embolism (“PE”)

E. Hospital Reaction to a "Never Event" or "HAC"

Leapfrog Group Directive: "After a "Never Event"

Apologize to patient and family
(Some State Laws protect this)
Report to Joint Commission or other safety organization
Perform a root cause analysis
Waive all costs directly related to the error

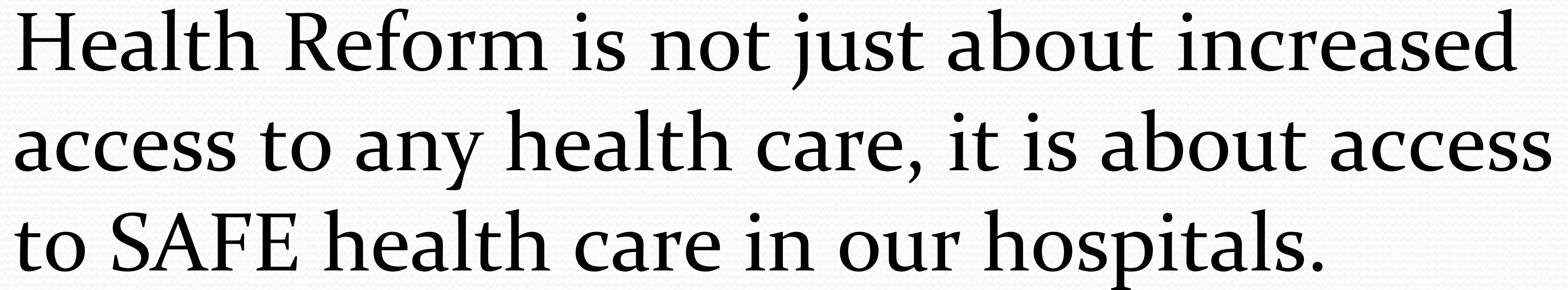
Conclusion

- The current quality of patient care in the United States is far below what it should be and what it can be.

- Hospitals and hospital systems which have adopted air safety type methodology and rigorously enforced it have succeeded in reducing the number and severity of medical errors and patient injuries. It can be done.

When errors are considered as flaws in the system to be corrected by cooperative action and not as torts or "wrongs" to be hidden from liability suits, they will be corrected and patient safety will benefit

Working together, hospital administrators and medical staffs can reduce the present needless patient injury due to medical error and can give the safe care which people rightly expect to receive when they entrust us with their health and their lives.



Thank You