



The Risk Management Quarterly

FALL 2010

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PRESIDENT'S MESSAGE

Greeting AHRMNY members, some of us are just back from Tampa from the annual ASHRM conference. The weather was wonderful, the presentations interesting, informative and inspiring. We are proud to say that our Board members Mike Midgley, Jose Guzman and Francine Thomas were standouts at ASHRM. Our New York contingent had fun and relaxed after a day of learning at our reception at the Marriot in Tampa.

In New York we started off the academic year with a comprehensive seminar on Healthcare Associated Infections: Applying Patient Safety Solutions to Emerging Liability Challenges with engaging and informative speakers. We thank Lexington/Chartis and the National Patient Safety Foundation for partnering with us on this event.

Our Education Committee has been working diligently over the last few months to plan conferences for this year so we ask that you save the date for December 10, 2010 for a half day conference at the New York Helmsley Hotel with a panel presentation on the actual application of the Family Health Care Decision Act now that we are 6 months into its implementation. In addition there will be a presentation on HIPAA, cyber liability, encryption issues and data breaches and another on e-discovery. We encourage our members to contact us whenever you have ideas for an educational topic you would like to see addressed.

The Publications Committee has been diligently working on articles and preparing this Risk Management Quarterly we are sure you will find it as informative and engaging as ever.

Our membership Committee reports 217 members have joined or renewed their membership for the 2010-2011 year. If you haven't renewed yet please do so as soon as possible. There is still time to join any committee that you are interested in. The commitment is usually a once a month conference call with some follow up planning and implementation of assignments.

Looking forward to seeing you in December.

Best regards,
Peggy

The Risk Management Quarterly (RMQ), the official journal of the Association for Healthcare Risk Management of New York, Inc. is published four times a year.

RMQ's Mission Statement: To enhance the quality of healthcare delivery through education, research, professional practice, and analysis specific to risk management issues.

This journal will contain articles on a wide variety of subjects related to risk management, patient safety, insurance, quality improvement, medicine, healthcare law, government regulations, as well as notices of improvement and other relevant information of interest to risk managers. The articles are usually written by **AHRMNY** members, so the journal serves as an opportunity for members to showcase their writing talents.

For the official **RMQ** Author Guidelines visit our website <http://www.ahrmny.com>

Please forward any ideas or submissions for publication in the **RMQ** to "Editors", via email with attachments to: ahrm@optimum.net

The deadline for submission & consideration in the next journal is December 15, 2010.

Reminder:

Maximum article length 3,500 words

Photo requirements: (high resolution JPEGs – at least 300 dpi)

AHRMNY will not publish those articles promoting products or services

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The information presented in

THE RISK MANAGEMENT QUARTERLY

is for educational purposes only and not intended to be relied upon in any particular situation.

AHRMNY is celebrating 25 Years!

Our custom made banner will be displayed at all of our upcoming programs.



**Celebrating 25 Years
Of Continuous Service
To The New York
Risk Management
Community**

1985 - 2010

AHRMNY was first incorporated on March 5, 1985 as The Association of Hospital Risk Management of New York, Inc.

DEVELOPING EMPLOYMENT LAW TRENDS IN HEALTHCARE

By Paul J. Siegel, Esq. and Ana C. Shields, Esq.

While legislatively driven, health care reform has become the center of intense national focus, health care employers concurrently have been forced to address a great many developing workplace legal issues. This article summarizes those trends.

I. INCREASE IN WAGE AND HOUR CLAIMS

An increasing number of wage and hour claims are being brought against hospitals and other health care providers in New York State and elsewhere. The health care industry is particularly susceptible to wage and hour claims due to diversification of operations, outdated wage-hour regulations and multiple sites at which services may be rendered. In one collective suit, for example, it was alleged that a health care system failed to aggregate hours where employees worked for two or more network hospitals during the same workweek. In another, a claimant alleged that hours worked for a hospital and at that venue through a temp staffing agency had to be aggregated. Both asserted that they worked more than 40 hours a week, but received less than time and one-half for the overtime hours.

Both the New York Labor Law and the federal Fair Labor Standards Act (FLSA) require that non-exempt employees be paid at least the minimum wage (\$7.25 per hour in New York) for all hours worked and no less than one-and-one-half the "regular rate of pay" for all hours worked in excess of 40 hours in a workweek. Bona fide meal periods do not count as "hours worked." Employers often deduct a 30-minute lunch period from an employee's total daily time worked unless the employee notifies the employer that he or she did not take a 30-minute lunch period that day. This practice is permissible provided employees record hours worked, including any work performed during the lunch period (and the employer accurately compensates the employee for the actual hours worked) and provided the employer system tracks compliance. Recently, employees have alleged that healthcare facilities automatically deducted time for meal breaks, but employees supposedly worked through the meal period. Lawsuits addressing these issues are pending in New York, Pennsylvania and elsewhere.

In addition to private litigation, health care employers must also contend with increased enforcement by the U.S. Department of Labor's Wage and Hour Division, which has hired several hundred additional investigators to identify and investigate potential wage and hour violations. Given the increased focus, employers in the health care industry should examine payroll practices to ensure compliance with federal and local wage and hour laws.

II. WORKPLACE SAFETY IN THE HEALTHCARE INDUSTRY

A. OSHA INSPECTIONS-INCREASED FOCUS ON NURSING HOMES

The Occupational Safety and Health Administration announced, on September 4, 2009, that it will focus comprehensive safety inspections upon high-risk establishments, including *nursing homes*. Through OSHA's Site-Specific Targeting ("SST") 2009 program, OSHA will survey injury and illness data from OSHA's 2008 Data Initiative Survey of 80,000 employers with forty or more workers. In its 2009 program, OSHA is dividing the primary list of establishments slated for inspection into three sectors: manufacturing, non-manufacturing, and nursing homes. The SST program emphasizes to employers the importance of ensuring safe working conditions for workers.

B. OSHA RECORDKEEPING NATIONAL EMPHASIS PROGRAM

(1) Review medical records, workers' compensation records, insurance records, payroll/absentee records and, if available, company safety incident reports, company first-aid logs, alternate duty rosters and disciplinary records pertaining to injuries and illnesses. Note that inspectors also are required to review records that are stored off-site.

(2) Independently reconstruct OSHA recordkeeping log entries for employees. This OSHA-created log will be compared against the employer's logs.

(3) Visit any off-site medical clinic to review medical records pertaining to the employees being investigated.

(4) Interview the designated record keeper. Inspectors will ask about company policies that may discourage reporting on the injury and illness records (e.g.) awards tied to the number of injuries and illnesses recorded on the OSHA log.

(5) Question employees about disparaging practices, e.g., "Have you ever been encouraged to not report an injury or illness or been encouraged to report an injury or illness as a non-work-related event or exposure?"

(6) Interview management representatives regarding the manner in which injuries and illnesses are recorded and determine the existence of incentive or disciplinary programs that may influence recordkeeping.

(7) Interview first-aid providers and other health care professionals. This interview will also seek to determine the extent to which employers may influence medical treatment of injured employees for the purposes of modifying OSHA recordability.

(8) Perform a limited walk-around of the main plant operation areas. The purpose will be to check for consistencies between the recorded injuries and illnesses and any violations observed in plain view.

C. SAFE PATIENT HANDLING BILL – NURSE PROTECTION ACT

Legislation was introduced on October 15th, 2009 by Senator Al Franken (Minn.) to require OSHA to require health care workers to use mechanical lift equipment when moving patients. Hearings were held on May 11th before the Committee on Health, Education, Labor and Pensions Subcommittee on Employment and Workplace Safety. The Nurse Protection Act would require OSHA to propose rules requiring hospitals to purchase and use safe patient lift devices, implement safe patient handling and injury prevention plans; track musculoskeletal injuries under a data system; train staff to use the devices safely; and evaluate their success. The bill includes whistleblower protections for health care workers who report violations of any safety standard.

D. PROPOSED RULE TO RESTORE MSD COLUMN TO OSHA 300 LOG

On January 29, 2010, OSHA issued a proposed rule to revise its recordkeeping requirements to require employers to record work-related musculoskeletal disorders. OSHA's final recordkeeping rule in 2001 required such disclosure, but the obligation was removed before the regulation became effective.

* * *

In sum, healthcare risk managers must add workplace law exposures to patient care concerns as high priority risks. Class and collective actions, like union organizing, present systemic, costly risks. Only aggressive risk control efforts can control those exposures.

Paul J. Siegel is an employment law and litigation partner of Jackson Lewis. He has represented management in employment discrimination, affirmative action and labor matters since 1976. In April of 1991, Mr. Siegel argued a landmark age discrimination case before the United States Supreme Court. Mr. Siegel graduated magna cum laude from the State University of New York at Buffalo (Phi Beta Kappa) in 1973 and received his Juris Doctor degree with honors from Emory University School of Law in 1976. In the insurance industry, he is a member of the Professional Liability Underwriters Society (PLUS), National Association of Professional Surplus Lines Offices (NAPSLO), Professional Insurance Agents (PIA), Professional Insurance Wholesalers Association (PIWA), and Risk & Insurance Management Society (RIMS) conferences.

Ms. Shields is a senior associate in the Long Island office of Jackson Lewis LLP. Since joining Jackson Lewis in June 2005, Ms. Shields has practiced exclusively in employment law and has been involved in proceedings before federal and state courts, the American Arbitration Association and administrative agencies. She has advised clients, conducting training and lectured on compliance with various state and federal laws affecting the workplace, including Title VII, Family and Medical Leave Act, Americans with Disabilities Act, Age Discrimination in Employment Act and New York State and City laws. Ms. Shields is a graduate of Harvard University (A.B., *cum laude*, 2000), and St. John's University School of Law (J.D. 2003), where she was a published member of the New York International Law Review. Among the awards of excellence, Ms. Shields was the recipient of the American Bar Association/Bureau of National Affairs Award for Excellence in Labor and Employment Law and the CALI Award for Excellence in Employment Law, Advanced Labor Law, and Jurisprudence.

SAVE THE DATE
Friday-December 10, 2010
8:30 am – 12:00 pm

Half-Day Educational Program

The New York Helmsley Hotel

**Family Health Care
Decisions Act Updates
Compliance & Privacy Issues
Electronic Medical Record in Discovery**

Full Program Brochure Available
www.ahrmny.com

Members of AHRMNY attend conference free of charge.
Continuing Education Credits for Risk Management
Certification will be provided through the American
Society for Healthcare Risk Management (ASHRM)

EXPANDING ACCESS TO HEALTHCARE

The Family Health Care Decisions Act: 83164 empowers family members and others close to the patient to make medical decisions for incapacitated patients. Currently, only 20 percent of individuals sign a health care proxy, leaving an overwhelming majority of patients without any guarantee that decisions will be made on their behalf by those closest to them. This legislation was passed by both houses and has been signed by the Governor.

SMOKERS' RIGHTS IN THE WORKPLACE

FORWARD: We asked the authors (Ricki E. Roer and Scott R. Abraham) to present an article on cigarette smokers' rights in the workplace given recent press about hospitals that will no longer hire candidates who smoke. The Monterey County Herald reported on March 31, 2010 that "The Community Hospital of the Monterey Peninsula" will no longer hire tobacco users of any kind." The hospital spokeswoman, Mary Barker, stated "As a health care organization, we have responsibility for maintaining a healthy and safe environment for all our employees, volunteers, patients and visitors....we are also committed to promoting wellness. We've had a nonsmoking campus for a number of years, and this is a natural extension of that policy." The article further quotes that workers who smoke, on average, miss 6.16 days of work a year because of illness, compared with 3.86 days for nonsmokers (*American Cancer Society.com*, www.law.capital.edu/Tobacco/workplace/costs_smoking.html). Barker also stated that the hospital "has found that it incurs higher health care costs in caring for its employees who smoke."

In addition, ECRI reported on April 7, 2010 that "St. Luke's Hospital and Health Network, a Bethlehem, Pennsylvania-based health system, will begin screening candidates for nicotine use starting May 1, 2010, not hiring those who test positive" (based on a March 31, 2010 *Intelligencer* article). "The change in policy was determined after learning of a similar policy change at the influential Cleveland Clinic (Ohio)." ECRI reports that "discriminating against hiring employees because of their off-duty activities is prohibited in 29 states."

By Pamela Monastero

INTRODUCTION

There are many issues to be considered when an employer seeks to limit its employees' cigarette use. Within the last two decades, cigarette smokers' rights in the workplace, as well as an employer's ability to make employment decisions based on an individual's status as a cigarette smoker, have been significantly affected by important pieces of legislation enacted both in New York and the federal Health Insurance and Portability and Accountability Act of 1996.

While an employer may limit all employees breaks to specified periods, i.e. lunch breaks only and/or prohibit hourly breaks, Section 201-d of the New York Labor Law, which took effect on January 1, 1993, grew out of efforts by tobacco lobbyists seeking to prevent employers from discriminating against employees who smoke. Section 201-d(2)(b) and (c) provides that:

Unless otherwise provided by law, it shall be unlawful for any employer or employment agency to refuse to hire, employ or license, or to discharge from employment or otherwise discriminate against an individual in compensation, promotion or terms, conditions or privileges of employment because of: . . . (b) an individual's legal use of consumable products prior to the beginning or after the conclusion of the employee's work hours, and off of the employer's premises and without use of the employer's equipment or other property; [or] (c) an individual's legal recreational activities' outside work hours, off of the employer's premises and without use of the employer's equipment or other property. . . .

One of the primary motivations behind the passage of Section 201-d was to "protect smokers and users of tobacco products against the extensive vigilantism which their lawful leisure time recreational activity ha[d] invoked in recent years."² Governor Mario Cuomo, in his message in 1992 approving the legislation, wrote that the proposed statute properly "strikes the difficult balance between the right to privacy in relation to non-working hours activities of individuals and the right of employers to regulate behavior which has an impact on the employee's performance or on the employer's business."³

Should an employer violate Section 201-d, the New York State Attorney General may commence a civil action seeking an order enjoining or restraining the commission or continuance of the alleged unlawful acts.⁴ The court may impose a civil penalty in the amount of three hundred dollars for the first violation and five hundred dollars for each subsequent violation.⁵ An aggrieved individual may also commence an action for equitable relief and damages.⁶

A decade later, New York adopted a strict ban on workplace smoking with the Clean Indoor Air Act, which took effect on July 24, 2003 and amended Article 13-E of the New York Public Health Law.⁷ The Act, in essence, banned smoking in virtually all workplaces state-wide, as well as a multitude of other public indoor locations. Sections 1399-o(1) and (15) of the New York Public Health Law restricts smoking in "places of employment"⁸ and "commercial establishments used for the purpose of carrying on or exercising any trade, profession, vocation or charitable activity, among other places." This amendment to the Act reflected the state's commitment to ensuring that individuals were protected from secondhand smoke.

To date, no federal statutes have been construed to regulate employer consideration of the smoking status of employees.⁹ The Americans with Disabilities Act of 1990 ("ADA"), which prohibits employers from discriminating against disabled individuals on the basis of their disability¹⁰ "in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment,"¹¹ does not protect individuals that do not have an impairment that substantially limits one or more major life activities.¹² As further discussed below, although there are disabilities that are associated with or can result from smoking, smoking is not, in and of itself, a disability because it does not limit a major life activity as required under the ADA.¹³

Title VII of the Civil Rights Act of 1964 ("Title VII") prohibits discrimination in employment based on race, national origin, sex, and religion.¹⁴ Because discrimination against smokers does not implicate, except perhaps tangentially, any protected classes, individuals subject to discrimination based on their

status as a cigarette smoker are not protected by Title VII.¹⁵ However, this does not prevent an employee from alleging that a company's smoking policy was disparately applied to him or her.

Very few federal courts have weighed in on the issue of whether smoking or nicotine addiction can be classified as a disability under the ADA. The District Court of Maryland in Brashear v. Simms, 138 F. Supp. 2d 693 (D. Md. 2001), stated that a smoking addiction does not qualify as a disability under the ADA, but rather is remediable. The court stated:

Common sense compels the conclusion that smoking, whether denominated as "nicotine addiction" or not, is not a "disability" within the meaning of the ADA. Congress could not possibly have intended the absurd result of including smoking within the definition of "disability," which would render somewhere between 25% and 30% of the American public disabled under federal law because they smoke. In any event, both smoking and "nicotine addiction" are readily remediable, either by quitting smoking outright through an act of willpower (albeit easier for some than others), or by use of such items as nicotine patches or nicotine chewing gun. If the smokers' nicotine addiction is thus remediable, neither such addiction nor smoking itself qualifies as a disability within the coverage of the ADA, under well-settled Supreme Court precedent.

Id. at 695 (citing Sutton v. United Airlines, Inc., 527 U.S. 471 (1999)).

However, the ADA Amendments Act of 2008 ("ADAAA"), which went into effect on January 1, 2009, overturned, inter alia, the Supreme Court's decision in Sutton that impairments must be considered in their mitigated state, supra; expanded the scope and definition of what constitutes a "disability"; and may open the door for further litigation in this area. Specifically, employees will attempt to demonstrate that: addiction—namely that of nicotine—is a protected class; diseases associated with smoking are protected by the ADA; and smokers are "regarded as" disabled by their employers. No federal court has ruled on whether nicotine addiction or smoking qualifies as a "disability" under the ADAAA and the U.S. Equal Employment Opportunity Commission has yet to take an official position on this issue.

In the minimal litigation in this field in New York courts, an employer's right to regulate cigarette smoking by its employees has been upheld. In Matter of Kridel v. Commissioner of Labor, the Third Department overturned an award of unemployment insurance benefits to an employee who continued to take breaks during the work day to smoke cigarettes even though she knew of the employer's policy prohibiting hourly employees from taking breaks except for a midday lunch break. 2008 NY Slip Op 6528, 2 (3d Dep't. 2008).

In Fortunoff Fine Jewelry & Silverware v. New York State Div. of Human Rights, the Second Department held that the complainant did not establish that at the time she sought an application to work at defendant she was disabled, or was wrongly perceived as disabled, within the meaning of New York Executive Law Section 292(21), based upon her smoking outside the workplace; and the plaintiff's status as a smoker outside of the workplace, without more, did not

constitute a disability within the aforesaid section. 227 A.D.2d 557 (2d Dep't. 1996). At the time that the plaintiff had applied for a position with Fortunoff in 1992, the company maintained a strict policy against hiring smokers. In its decision, the Second Department only cited to New York Labor Law Section 201-d without engaging in any substantive analysis of it as its review was limited to the determination of whether complainant had a viable disability claim.

Although New York companies are prohibited from taking adverse employment actions against an individual on the basis of that individual's status as a cigarette smoker outside of work, this does not prevent employers from implementing workplace policies to discourage its employees from smoking while at work. These policies can include reducing the number of breaks of its hourly employees and prohibiting employees from smoking anywhere on the employer's premises, including in company vehicles. However, employers must ensure that these policies are applied uniformly to all employees to avoid any claims of discrimination.

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- The premium differential is not more than 20 percent of the total cost of employee-only coverage (or 20% of the cost of coverage if dependents can participate in the program);
- The program is reasonably designed to promote health and prevent disease;
- Individuals eligible for the program are given an opportunity to qualify for the discount at least once per year;
- The program accommodates individuals for whom it is unreasonably difficult to quit using tobacco products due to addiction by providing a reasonable alternative standard (such as a discount in return for attending educational classes or for trying a nicotine patch); and
- Plan materials describing the terms of the premium differential describe the availability of a reasonable alternative standard to qualify for the lower premium.

While an employer has broad discretion to control its workplace, employers must remain acutely aware of New York's stringent prohibition of discriminating against employees based on their legal use of consumable products and recreational activities outside of the workplace, including smoking cigarettes.

¹ Labor Law Section 201-d(1)(b) defines "recreational activities" as "any lawful, leisure-time activity, for which the employee receives no compensation and which is generally engaged in for recreational purposes, including but not limited to sports, games, hobbies, exercise, reading and the viewing of television, movies and similar material."

LEGISLATIVE UPDATE

Information and Access to Breast Reconstructive Surgery

Effective January 1, 2011, Public Health Law 2803-0 is amended in relation to information and access to breast reconstructive surgery.

While existing federal and state law mandates insurance coverage for reconstructive surgery, no requirement currently exists to ensure that women have necessary information about surgical options that they may wish to consider.

Despite advances and progress in the diagnosis and treatment of breast cancer, there has remained a disparity in the care provided, particularly with respect to breast reconstructive surgery.

The bill is designed to educate women regarding the availability of reconstructive surgery and to enhance access to these services.

When a woman is diagnosed with breast cancer, she will be given information that clearly explains her right to coverage and her options as they relate to breast reconstruction. This is akin to the informed consent that a patient must sign before undergoing any surgical procedure.

The bill will also require that a patient receive information relating to referral to a reconstructive surgeon at the time of diagnosis or shortly thereafter if she chooses.

Because important decisions on cancer care such as the choice between having a mastectomy or a lumpectomy are influenced to a large part on the patient's understanding of reconstructive options, the reconstructive surgeon must be a part of the discussion from the very beginning.

WE WANT TO HEAR FROM YOU

We are asking our readers to submit articles to appear in the winter and spring editions of *The Risk Management Quarterly*. Submission of articles that focus on safe patient care practices, safe working environments, legal and financial updates in the health care arena are some of the topics we seek.

RMQ is published four times a year with a distribution of 200-300 copies per quarter.

Please forward any ideas or submissions for publication in the *RMQ* to "Editors", via email with attachments to: AHRM@Optimum.net

² McCavitt v. Swiss Reinsurance Am. Corp., 89 F. Supp. 2d 495, 498 (S.D.N.Y. 2000).

³ Memorandum dated August 7, 1992, filed contemporaneously with approval of the statute.

⁴ New York Labor Law Section 201-d(7)(a).

⁵ Id.

⁶ New York Labor Law Section 201-d(7)(b).

⁷ New York City passed similar legislation on March 30, 2003 (Local Law 47, the Smoke Free Air Act of 2002) banning smoking in all enclosed workplaces. N.Y. City Admin. Code §17-503 (2000).

⁸ Section 1399-n(5) defines "place of employment" as "any indoor area or portion thereof under the control of an employer in which employees of the employer perform services and shall include, but not be limited to, offices, school grounds, retail stores, banquet facilities, theaters, food stores, banks, financial institutions, factories, warehouses, employee cafeterias, lounges, auditoriums, gymnasiums, restrooms, elevators, hallways, museums, libraries, bowling establishments, employee medical facilities, rooms or areas containing photocopying equipment or other office equipment used in common, and company vehicles."

⁹ 70 Alb. L. Rev. 117, 125-127.

¹⁰ The ADA defines disability, with respect to an individual, as: "(a) a physical or mental impairment that substantially limits one or more major life activities of such individual; (b) a record of such an impairment; or (c) being regarded as having such an impairment." 42 U.S.C. § 12102(1); Buckley v. Consol. Edison Co. of N.Y., 127 F.3d 270, 272 (2d Cir. 1997).

¹¹ 42 U.S.C. §12112(a).

¹² 42 U.S.C. § 12102(2)(A) & (C); see Ryan v. Grae & Rybicki, P.C., 135 F.3d 867, 869 (2d Cir. 1998).

¹³ 70 Alb. L. Rev. 117, 125.

¹⁴ Id. § 2000e-2(a).

¹⁵ 70 Alb. L. Rev. 117, 126.

Ricki E. Roer is a Partner in the Wilson, Elser, Moskowitz, Edelman & Dicker, LLP, New York office, heading the firm's national employment litigation team. Ricki's national team of 130-plus attorneys addresses all aspects of employment and labor law relating to discrimination issues, contract disputes, ERISA, NLRB, collective bargaining negotiations, arbitrations, grievances and employment and labor law litigation. Additionally, she has an extensive experience in health care law and defamation law matters. Ms. Roer is a graduate of the University of Pennsylvania, B.A., American University – Washington College of Law, J.D., and Kings College - Oxford University, LL.M. International Law.

Scott R. Abraham is an associate in the New York City office of Wilson, Elser, Moskowitz, Edelman & Dicker LLP. He is a member of the firm's Labor and Employment Practice Group and focuses his practice on all aspects of employment and labor law. Mr. Abraham handles cases brought under all federal, New York State, and New York City anti-discrimination statutes, including Title VII, FMLA, FLSA, ADA, ADEA, 42 U.S.C. 1981 and 1983, ERISA, and the New York Labor Law. In law school, Scott was the recipient of the CALI Award for Excellence in Employment Law.

EDITORIAL COMMENT TO THE ARTICLE

A DIFFICULT AND CHALLENGING ROLE FOR HEALTHCARE RISK MANAGERS: MOTIVATING SAFER CARE

In this edition of *The Risk Management Quarterly*, we are pleased to provide our first article in a series of discussions with attorneys recognized for their expertise in representing medical malpractice claimants. The focus of our publication has traditionally been on medical-legal issues, healthcare legislation and regulatory concerns. For this edition, we reached out to Steven Pegalis, Esq. of Pegalis & Erickson, a noted claimants' attorney who co-authored a piece based on patient safety with Dr. Paul Gluck, Associate Clinical Professor at Miami School of Medicine, a Fellow at the University of Miami Center for Patient Safety and a founding member/past chair of the National Patient Safety Foundation. The authors hosted a lecture and reception at New York Law school entitled "The Intersection of Patient Safety and the Legal System" on March 22, 2010 and their article is in follow up to that lecture.

As Risk Managers, we analyze outcomes, policies and recommend protocols to prevent recurrences and look for potential hazards, to hopefully make systems safer prospectively. As the article points out, The Institute of Medicine's landmark report supports the premise that patient safety is enhanced by systems which make it easier to do the right thing and more difficult to do the wrong thing.

The article states "A concept that we propose is akin to making the healthcare risk manager the equivalent of the primary care physician guiding the patient through the complicated, often fragmented health care system." The concept of a patient having the benefit of an informed navigator in the healthcare system is an attractive one. Hopefully, this role will ultimately be fulfilled by someone in the patient's family support system. By improving medical literacy, the public will be more informed, adding to the checks and balances which enhance patient safety.*

However, the author's concept of having the healthcare Risk Manager assume a new role equivalent to "the primary care physician" is likely to trigger debate about whether this will increase tort liability by adding a new (perhaps greater) duty of care. AHRMNY is committed to improving patient education and safety within the healthcare industry. We believe this will be best accomplished by supporting safety initiatives and medical literacy and not by adding what may be construed as a legal duty for a risk manager to guide individuals through a healthcare experience. While the author does not propose that risk managers become guarantors of a safe venture through the healthcare institution, the reality is that a defined role, as proposed, would likely, in time, generate a duty and create a new layer of tort liability.

Expansion of the duties of healthcare risk management should focus on greater implementation of safety policies in the ever growing database of patient safety experiences with an eye towards broader scope and implementation.

**Further information on healthcare literacy can be found on the Joint Commission website "What did the doctor say: improving health literacy to protect patient safety," 2007).*

A DIFFICULT AND CHALLENGING ROLE FOR HEALTHCARE RISK MANAGERS: MOTIVATING SAFER CARE

By: Paul A. Gluck, M.D. and Steven E. Pegalis, J.D.

We were invited to submit this paper following a recent program at the New York Law School.¹ Paul A. Gluck, M.D. was the guest speaker.² The theme of the program given to a multi-disciplinary audience from the medical and legal professions composed of judges, lawyers, insurance executives, doctors, nurses, patient consumer advocates and private citizens was to promote a more constructive dialogue between the two professions. By bringing sincere professionals together, the ultimate goal of our collaboration is to benefit the public through improved patient safety.³

The day following the law school program, Dr. Gluck delivered a grand round lecture to physicians and other healthcare providers of the Department of Obstetrics and Gynecology at the Albert Einstein and Montefiore Hospitals.⁴

Safety: The Common Bond Between The Legal and Medical Professions

Since the mission of a law school and a medical school is to benefit the public and since safer healthcare is an obvious common ground, we embrace this opportunity to communicate with healthcare risk management professionals. We note that the mission of The Association of Healthcare Risk Managers of New York (AHRMNY) is “to enhance the quality of healthcare delivery through education, research, professional practice, and analysis specific to risk management issues.”⁵ Our joint mission with this paper is to try to reinforce and promote a moral leadership in which, if the potential we envision is achieved, healthcare risk managers could be one of the most effective voices for a culture of safety.

What is a Culture of Safety?

The definition of a culture of safety is:

“Organizations with a positive safety culture are characterized by communication founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures.”⁶

The Risk Managers Leadership Role

While patient safety concepts are relatively easy to define it is the implementation that is difficult. Patient safety initiatives cannot be sustained unless there is a receptive culture of safety. Leadership throughout the organization is critical to establish this culture. Risk managers must play a central role in establishing this culture of safety.

Healthcare risk managers are “insiders” typically perceived by healthcare professionals as on “our” side and not “outsiders” who might at times be viewed as engaging in

uninformed rhetoric with perhaps suspect motives. A concept that we propose is akin to making the healthcare risk manager the equivalent of the primary care physician guiding the patient through the complicated, often fragmented health care system.

The role of the risk manager has been changing. Previously the risk manager’s role was to minimize financial exposure of the organization after there was an adverse event (Retrospective). Now their role involves recommending clinical system changes to reduce the risk of similar adverse events in the future (Prospective).

Specialization and complexity often lead to fragmented, disconnected care. The primary care physician plays the central role in coordinating this care for each individual patient. The following is from a standard text:

The patient can benefit greatly from effective collaboration among health care professionals, but it is the duty of the patient’s principal physician to provide guidance through an illness. To carry out this difficult task, this physician must be familiar with techniques, skills, and objectives of specialist physicians and of colleagues in the fields allied to medicine. In giving the patient an opportunity to benefit from scientific advances, the primary physician must retain responsibility for major decisions concerning diagnosis and treatment.⁷

Patient Safety

Patient safety has been defined as the prevention of healthcare errors, and the elimination or mitigation of patient injury caused by errors. A healthcare error has been defined as an unintended outcome caused by a defect in the delivery of care to a patient.⁸

When medical errors occur producing patient injury, they occur one at a time. In a sense, the patient, as a consequence of the error, was not given an opportunity to fully benefit from medical advances. Isn’t it logical that the healthcare risk manager, the professional who must become familiar with the techniques, skills and objectives of each specialist physician, is uniquely in a position to see the big picture? By coordinating diverse healthcare activities which can breakdown leading to the unintended healthcare outcome, the healthcare risk focused on their area of expertise and fail to view their patient’s treatment from a system perspective.

The Institute of Medicine’s landmark Report lays out what has become the accepted approach to patient-safety. The emphasis is on systems of care intended to make it easier to do the right thing (avoiding errors) and more difficult to do the wrong thing (making errors).⁹

Though the Report urges a shift in focus from blame of past errors to a focus on preventing future errors, the Report also states that designing a better system does not mean that individuals can be careless and that “people still must be vigilant and held responsible for their actions.”¹⁰ Further, the Report states “unsafe care is one of the prices we pay for not having organized systems of care with clear lines of accountability”.¹¹

What we seek to focus healthcare risk management professionals on, in this paper, is a difficult but potentially rewarding challenge to proactively motivate individuals to be even safer than they already are. Focus should be on system change to make it easy to do the right thing and hard to do the wrong thing. Most health care professionals are highly motivated and try their best to help patients every day. The system in which they work is often flawed. We will make little progress in improving patient safety just by telling healthcare workers to try harder. Instead we must change the system.

The intrinsic ethically-motivated desire of most healthcare professionals to be patient advocates and thus, to do “good” (and avoid “bad”) for their patients is an incentive and a reward in and of itself. Healthcare providers must be receptive to change and embrace safety initiatives. The “culture of safety” envisioned by the Report is in a sense good people consistently and continually doing what they have dedicated their professional careers to do (i.e., be as safe as they can) as part of their daily diligence.

Ethical Accountability

There must, however, be a consequence to individuals for violating rules and being deliberately unsafe. Because there can be and sometimes are serious consequences to patients from unsafe care, there must be a rational response when individual healthcare professionals are unsafe, but the response shouldn’t be punitive.

The ethics of the profession make clear and unambiguous statements:

“Physicians should also acknowledge that in healthcare, medical errors that injure patients do sometimes occur. Whenever patients are injured as a consequence of medical care, patients should be informed promptly because failure to do so seriously compromises patient and societal trust. Reporting and analyzing medical mistakes provide the basis for appropriate prevention and improvement strategies and for appropriate compensation to injured parties.”¹²

Transparency is critical to create a learning culture in which everyone can learn from individual and system deficiencies. The risk manager must play the central role in this process, to gather information, critically evaluate system flaws and individual errors and subsequently suggest changes that will reduce the likelihood of recurrent errors. Finally the risk manager must create a resilient system in which errors that still occur are intercepted and do not cause patient harm.

Neither the legal nor medical professions intend that isolated errors have punitive consequences for individuals unless there is willful and repeated disregard for patient safety.¹³ Medical errors, when they occur, have been referred to as “treasures” because the information can be used to prevent or at least reduce the incidence of recurrence.¹⁴ Logically, the individual who embraces the ethical concept of learning from errors will continually strive to make his or her practice safer. In contrast, other colleagues who refuse to develop a system perspective and learn from others are unwittingly drifting toward a similar errors. How does the healthcare risk manager engage those who have a safety mindset as allies in an effort to identify and motivate those who are unwittingly drifting toward unsafe practice destined to repeat similar error that never should have occurred in the first place?

Some healthcare professionals can be lax and/or stubborn, unwilling to change old habits. This is a harsh reality that cannot be ignored.

Though delivery of the “bad” news by the healthcare risk manager to those professionals who remain lax and/or stubborn would no doubt be a most unpleasant part of the job, we must note that somebody must deliver the message.

Lax and/or stubborn health care tend to dismiss legitimate concerns using the defense that patient expectations are unreasonable and lawyers who represent patients are greedy and only pursue frivolous claims. That attitude is a formula for disaster with little chance for those practitioners to institute constructive patient safety initiatives in their practice.

There are medical “leaders” such as those cited by the anesthesia specialty.¹⁵ These “leaders” are potential allies who would welcome and support your patient-safety efforts. Affirmatively seeking out these leaders and promoting constructive alliances is something that can be done. Hospital administrators and the board of trustees overseeing each hospital will welcome risk managers’ efforts as a natural extension of their own mission statements which always include a commitment to quality care. These hospital leaders are critical in creating a receptive culture for the system changes recommended by risk managers.

A broad range of available patient-safety initiatives exist and information in this regard is constantly being revised and updated. One known and continuing barrier to patient-safety is the fact that as medical care continually becomes more complex, the likelihood for error continually increases.¹⁶ Reducing complexity is thus an appropriate patient safety strategy. Another barrier that has perhaps not been addressed as fully as it should, is the normal human tendency not only to err (which sometimes occurs) but also the human tendency to want to believe that bad patient outcomes were not due to error even when in fact they were. System changes must; therefore, make it difficult to make mistakes.

A Culture of Safety Should be a “Just” Culture

Another important role of the risk manager is to help establish a just culture that balances individual responsibility with system accountability.¹⁷ Inadvertent lapses are managed by changing the system and consoling the individual. At risk behaviors are managed by coaching the individual. However reckless behavior with a conscious disregard for patient safety is not tolerated and managed through remedial action and punishment. The Board of Directors and CEO must assert their leadership role in supporting this policy even if it means sanctions against practitioners who generate high revenue for the hospital.

In a sense human nature (good and bad) is a permanent condition. The good part is something we want to recognize and celebrate and the bad part (rationalization and “lip service” to safety) is something that cannot be tolerated.

Conclusion

Individual and organizational motivation for embracing changes that improve safety will achieve the following:

Ethically motivate individuals to do the right thing;

Improved patient and provider satisfaction;

Reduce medical risks;

Reduce economic exposure with potential non-payment (e.g., National Quality Form “Never Events”);

Reduce liability and litigation cost and exposure.

The primary care physician might be a patient’s most valuable advocate for a potentially dangerous medical journey. The healthcare risk manager can, in our view, become the most valuable “team” player to achieve the culture of safety that everyone agrees is, and must be, integral to all healthcare activities.

ENDNOTES

1. The Diane Abbey Law Center for Children and Families at New York Law School presented the First Annual Pegalis & Erickson Lecture: “The Intersection of Patient Safety and The Legal System” at New York Law School on March 22, 2010.
2. Dr. Gluck, a Board Certified Ob/Gyn, is currently a Fellow at the Center for Patient Safety, University of Miami Miller School of Medicine, where he participates in on-going research and professional education. Dr. Gluck is a past chair and a founding member of The National Patient Safety Foundation. (NPSF) E-mail: info2NPSF.org.
3. Members of the audience who participated in the program dialogue included among others a prominent jurist spear heading a judicial program to more efficiently and expeditiously resolve medical liability cases; a high ranking medical liability insurance claim manager; representatives of the Greater New York Hospital Association; a consumer patient advocate; the chairman of Obstetrics and Gynecology and Women’s Health at

The Albert Einstein College of Medicine; and a physician-attorney employed by the New York State Office of Professional Medical Conduct (OPMC).

4. Grand Rounds At The Albert Einstein College of Medicine, Dept. of Obstetrics-Gynecology and Women’s Health, March 23, 2010.
5. Source: The Association For Healthcare Risk Management of New York, Inc.
6. Advisory Committee on the Safety of Nuclear Installations, U.K., 1993.
7. Kasper, D.L., Braunwald, E., Fauci, A.S., Hauser, S.L., Longo, D.L., Jameson, J.L., Eds. Of Harrison’s Principles of Internal Medicine, 16th Ed., (2005) p. 1).
8. Definitions approved by the NPSF Board, July 2003.
9. See Generally, Institute of Medicine, To Err is Human: Building A Safer Health System (Linda Kohn, et. al., eds, 2000).
10. Id - at p. 5.
11. Id - at pp. 3-5.
12. Medical Professionalism in the New Millennium: A Physician Charter, Ann. Intern. Med. 2002; 136:243-246.
13. See: Bing v. Thunig, 2 N.Y.2d 656, 666 (1957). Liability is premised on the moral concept that the negligent party should be responsible and also to act as a warning that the law demands the exercise of due care.
14. David Blumenthal, Making Medical Errors into ‘Medical Treasures’, 272 JAMA 1867 (1994).
15. See: David M. Gaba, Anesthesiology As A Model For Patient Safety in Health Care, 320 Brit. Med. J. 785 (2000) noting that strong leaders emerged willing to admit that patient safety was imperfect and that interventions could be planned to achieve better outcomes.
17. David Marx www.justculture.org

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Dr. Gluck is a Founding member and Immediate Past Chair of the Board of Trustees, National Patient Safety Foundation and continues to serve on their Board of Governors. Currently he is a member of the Quality Improvement and Patient Safety Committee of the American College of Obstetricians and Gynecologists (ACOG). Dr. Gluck also was Director of the ACOG Voluntary Review for Quality of Care Program.

According to *Black's Law Dictionary*, the legal definition of death is as follows:

The cessation of life; the ceasing to exist; defined by physicians as a total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc.¹

Death, according to this definition, is precise and unambiguous—when the body ceases functioning. However, in 1968 a Harvard Medical School Ad Hoc Committee (comprised of ten physicians, an historian, and a theologian) sought to re-examine this definition in light of advancements in medical technology. In their report, they stated:

From ancient times down to the recent past it was clear that, when the respiration and heart stopped, the brain would die in a few minutes; so the obvious criterion of no heart beat as synonymous with death was sufficiently accurate. In those times the heart was considered to be the central organ of the body; it is not surprising that its failure marked the onset of death. This is no longer valid when modern resuscitative and supportive measures are used. These improved activities can now restore 'life' as judged by the ancient standards of persistent respiration and continuing heart beat. This can be the case even when there is not the remotest possibility of an individual recovering consciousness following massive brain damage.²

Despite both acknowledging the traditional notion of death and accepting it as appropriate in its own time, the committee ultimately deemed it unfitting for the modern medical climate. Contemporary medical techniques are able to restore a heartbeat without the mind, able to breathe for a patient without functioning lungs, and able to feed a patient unable to move. These practices restore life, as defined by bodily functions—by a heartbeat or a flutter of the eyelids—but are not always able to salvage what constitutes living in any practical sense.

Clear-Cut-Decision

While clearly needed and appropriate, this change in the legal definition of death has triggered an onslaught of ideological issues concerning the legal nature of death, the ability of government to regulate it, and just how patients, doctors, and family members are permitted to bridge the gap between brain death and traditional death. Legal cases concerning a patient's right to refuse medical treatment (or more commonly a patient's "right to die") generally fall into four classifications. The first, "the patient with decision-making capacity" and the second, "the patient without

capacity but who had earlier expressed treatment preferences for end-of-life care" result in very few complications.³ For example, in the Matter of Re Eichner the court ruled that the respirator be removed from an incompetent 83-year-old suffering from brain damage and in a vegetative state due to clear and convincing evidence from statements made by the patient when competent that "he did not want to be maintained in a vegetative coma by use of a respirator."⁴

Courts across the nation have consistently maintained the right of a competent patient to refuse medical treatment as long as the interest of the patient is properly balanced against certain state interests—including the preservation of life, the prevention of suicide, the protection of third parties, and the preservation of the ethical integrity of the medical profession. The Fourteenth Amendment states that "no State shall deprive any person of life, liberty, or property without due process of law."⁵ This clearly indicates that every person has a liberty interest under the due process clause; however, this private interest must be balanced against relevant state interests.

Not as Clear-Cut

Now, for the third classification, consider a patient, once competent but now incapacitated, who has made no previous "expression of treatment preferences."⁶ In this instance, courts have articulated standards for proxy decision making wherein an individual other than the patient would assist in decision-making for the patient. Generally speaking, case law has followed the trend that merely losing the ability to implement the right to refuse medical treatment does not necessitate the loss of the right itself. Instead, another person can exercise the right on the patient's behalf. However, acceptance of proxy (or "substituted") judgment varies from state to state.

For example, In re Westchester County Medical Center on behalf of Connor, the New York Court of Appeals refused to accept anything less than the clearly expressed wishes of a patient. In addition to rejecting the proxy's attempt at refusal of medical care by "substitute judgment," the court granted an order to insert a feeding tube into a 77-year-old woman rendered incompetent by a series of strokes over the objection of her family members.⁷ The court reasoned that the substituted judgment approach was discordant with its "fundamental commitment to the notion that no person or court should substitute its judgment as to what would be an acceptable quality of life for another."⁸

In complete contrast to the New York decision, the California Court of Appeals permitted the removal of a feeding tube from a 44-year-old man in a persistent vegetative state as the result of an auto accident In the Matter of Conservatorship of Drabick. Citing a state probate statute, the court argued that

state law allowed the proxy to order the withdrawal of life-sustaining treatment “when such a decision was made in good faith based on medical advice and the conservatee’s best interests.”⁹ Framing the discussion in terms of respect and dignity, the court contended that respect for individual is best upheld by allowing a proxy “to make a decision that reflects a patient’s interests more closely than would a purely technological decision to do whatever is possible.”¹⁰

Even Less Clear-Cut

Lastly, for the fourth classification, consider the patient who was never competent to make end-of-life decisions: a child or mentally disabled person.

In Superintendent of Belchertown State School v. Saikewicz, the court justified withholding chemotherapy from a retarded 67-year-old man suffering from leukemia on the basis of both the right to privacy and the right to informed consent.¹¹ The court ruled that it was irrational to ground choices on what one thinks the never-competent would have chosen. However, because “the value of human dignity extends to both,” they implemented a “substituted judgment” policy whereby a “best interest” standard was adopted that obliged the proxy to make the decision in the patient’s best medical interest (in coordination with an attending physician).¹² ”

In the Matter of Conroy, the court pronounced that a “person doesn’t lose the right of self-determination merely because they cannot sense the violation.”¹³ They found that as a result of this, incompetent individuals retain the right to decline medical care. However, the court ruled that the right must be exercised by a surrogate decision-maker “using a ‘subjective’ standard” when there was clear evidence that the incompetent person would have exercised it.¹⁴

In the Matter of Storar, the court went in the other direction with its ruling that it would be impossible to establish the desires of a severely retarded 57-year-old man afflicted with bladder cancer. The court ruled that blood transfusions both maintained the patient’s mental and physical abilities and did not entail disproportionate pain. The court even went so far as to state that it would “not allow an incompetent patient to die because someone feels it is best for one with an incurable disease.”¹⁵

Thus, although most courts maintain that a never-competent person retains the right to refuse medical treatment, there is little if any consensus about how that right should be exercised. Some states rely on substituted judgment while others attempt to find some subjective standard while still more reject the practice altogether. The case history suggests that the way a court will rule on a never-competent patient’s varies tremendously from state to state and from circumstance to circumstance.

Karen Quinlan

The Matter of Karen Quinlan was one of the earliest cases directly addressing the end-of-life issue. On April 15, 1975,

Karen Quinlan collapsed at a party for reasons still unclear. Although doctors were able to save her life, she suffered severe brain damage and lapsed into a coma. According to the standards constituting brain death (as set forth by the previously mentioned Harvard Medical Ad Hoc Committee), Karen Quinlan was not “brain dead.”¹⁶ She was, however, reliant upon a respirator and in what doctors now call a “persistent vegetative state.” Coined in 1972 by Dr. Fred Plum, the term applies to “a body which is functioning entirely in terms of its internal controls” but without self-awareness in any substantive or learned manner.¹⁷

After profound consultation with his priest and chaplain, Karen’s father, Joseph Quinlan, sought appointment as guardian of “the person and property of his daughter” in the hopes of ceasing all remarkable medical procedures sustaining her.¹⁸ Although medical consensus conceded that due to Karen’s “severe brain and associated damage,” she would never be “restored to cognitive or sapient life,”¹⁹ Karen’s doctors opposed her father’s actions. Ultimately, the court appointed Joseph Quinlan as guardian of his daughter with “full power to make decisions.”²⁰

The court justified this decision primarily due to Quinlan’s right to privacy. The court found that the only practical method to prevent Karen’s loss of privacy “was to allow her guardian and family to decide whether she would exercise it in those circumstances.”²¹ Grounded in the Federal Constitution and justified by legal precedent, the court stated that in the case of Karen Quinlan:

No external compelling interest of the State could compel Karen to endure the unendurable, only to vegetate a few measurable months with no realistic possibility of returning to any semblance of cognitive or sapient life.²²

Thus, the court ruled that Joseph Quinlan had the right to remove his daughter from a ventilator in order to preserve her right to privacy. After Quinlan, however, state courts moved away from the privacy justification for refusal of medical treatment and towards other rationalizations.

Other Justifications

Common-Law Informed Consent

The right of a patient to refuse medical treatment “is a function of the importance accorded to autonomy” in American courts, society, and culture.²³ Consent is central in medical care because of the importance that the American common-law tradition places on freedom—not only the positive freedom to what one wants within certain bounds, but also the negative freedom to be free from outside forces acting upon oneself. Thus, insofar as the common-law strives to protect one from assault—from “unlawful touchings”—it also enables one to refuse medical treatment which, in this case, operates as an unlawful touch.²⁴ In this same vein, an end of life decision—defined as a decision to accelerate death whether by active or passive means—is justified by the innate American respect for the principle of autonomy and the common-law tradition protecting one against assault.

For example, in re Estate of Longeway, the Supreme Court of Illinois ruled that a 76-year-old woman “rendered incompetent from a series of strokes” had the right to refuse artificial nutrition and hydration.²⁵ While the court found the Federal right of privacy tenuous, it ultimately justified the decision by means of the doctrine of informed consent.²⁶

State Legislation

As mentioned earlier, in the Matter of Conservatorship of Drabick, the California Court of Appeals justified the removal of a feeding tube from a 44-year-old man by means of a California probate statute. The State Probate Act (of California) permitted a proxy to exercise a patient’s right to refuse medical treatment “in the event that the ward was terminally ill and irreversibly comatose.”²⁷ Thus, states can rely, if relevant, on certain statutes and acts passed by their legislature.

Nancy Cruzan

On January 11, 1983, Nancy Cruzan was thrown from her car after losing control at the wheel. Paramedics found her face-down in a water-filled ditch with no vital signs. Although doctors were able to resuscitate her, Nancy never fully regained consciousness and remained in a persistent vegetative state. After hoping for recovery for close to five years, Nancy’s family accepted that there was no longer any reasonable hope for improvement. The Missouri Supreme Court denied the Cruzans’ claims several times. First, the court argued that the State Constitution did not provide for a degree of privacy that would justify an individual’s right to refuse medical treatment. Second, the Missouri Supreme Court argued that the state’s interest in preserving life was especially compelling in Nancy’s case because she was not terminally ill but could continue living for almost a normal duration. The court also conceded that it was fearful of establishing a precedent that would apply not only to Cruzan but any number of handicapped people.²⁸ Lastly, the Missouri Supreme Court ruled that its rejection was based primarily on the fact that there was no “clear and convincing evidence that she [Nancy] would not wish to continue her vegetative existence” thereby establishing an evidentiary requirement.²⁹ After several rounds of rejection in Missouri courts, the United States Supreme Court agreed to hear the Cruzans’ case.

State and Federal courts are significantly different because they seek to answer different questions. State courts have any number of sources available to them when making a decision including state constitutions, statutes, and common law. However, the Supreme Court’s only reference must be the Constitution because its only task is to decide if a lower court judgment accords with the Constitution of the United States. Thus, although the Cruzan is commonly referred to as the first case in which the Supreme Court considered the “right to die,” that is not factually accurate. Rather, in the Cruzan case, the Supreme Court decided whether the state

of Missouri was allowed to prohibit ending Nancy Cruzan’s life under the justification that, prior to her accident, she had not explicitly stated her feelings about extraordinary life-preserving medical techniques.

In a 5-4 decision, the Supreme Court ruled in favor of the State of Missouri. While the court acknowledged the importance of the due process clause and the privacy consideration, it ruled that they do “not require a State to accept the ‘substituted judgment’ of close family members in the absence of substantial proof that their views reflect the patient’s.”³⁰ Continuing to agree that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition, the court pointed out that Missouri did recognize the effectiveness of a surrogate decision-maker in certain circumstances. Furthermore, the court asserted that there was nothing in the Constitution that prevented Missouri from establishing a “procedural safeguard to assure that the action of the surrogate conforms as best it may to the wishes expressed by the patient.”³¹

The court also took great care to mention that all states, whether requiring explicit statements or more general expressions of desire, require “a clear and convincing standard of proof for such evidence.”³² There is nothing unconstitutional about the idea of substituted judgment in and of itself; however, similarly there is nothing unconstitutional about implementing a stringent policy regulating such judgment either. Indeed, in the Matter of Michael H v. Gerald D., the Court maintained the constitutionality of California’s privileged treatment of traditional family relationships. However, such a ruling does not mean that the converse must hold as well. Simply because a state may allow favored treatment of certain relationships does not mean that the Constitution mandates such conduct.

Ultimately, however, the family request was granted by a Missouri state court after presenting additional evidence proving that Nancy would have, if competent, refused medical treatment in the given circumstances. Nancy’s feeding tube was removed on December 15, 1990, and she died twelve days later.

Terri Schiavo and “the Culture of Life”

A 27-year-old Florida woman by the name of Terri Schiavo has provoked the most recent debates in the right-to-die movement. After collapsing in her home due to a potassium imbalance, Schiavo lived in a persistent vegetative state “in nursing homes, with constant care, being nourished and hydrated through tubes.”³³ Eight years later, Schiavo’s husband petitioned the court to decide whether to discontinue feeding; the case didn’t make national headlines, however, until Terri’s parents pitted themselves against her husband. As the case stormed media outlets, it became less about Terri’s own wishes and more about the political

ramifications of a life or death decision. For the first time in the history of the United States, Congress met in a special emergency session (March 20, 2005) to pass legislation that would apply only to the prolongation of one person's life — that of Terri Schiavo.³⁴ President Bush encouraged the legislation, and Terri became a symbol for the "culture of life." Her case assumed political importance above its own merits. It was no longer about her own wishes with regards to her medical care but rather about what the politicians could make her life (and death) mean to potential voters.

Even in the midst of all the political maneuvering, what needs to be remembered is that conflicts involving the refusal of medical treatment for incompetent patients near the end of death "are not primarily legal in nature." On the contrary, the law regarding this has been astonishingly constant since Quinlan. First, competent patients have the right to refuse medical treatment including treatment that will save their lives as long as there are no countervailing state interests at play. Second, incompetent patients also have a right to refuse medical treatment and the self-determination to do so. However, the choice must be made by a competent adult through the appropriate avenues advocated and advanced in each state. Whether this entails signing an advance directive before an accident can happen, making one's views known to one's family members, or following the necessary steps to implement substituted judgment after the accident occurs depends on the state in question. If there is no way to ascertain the patient's desires, then treatment decisions are made based on the patient's best interests as determined by a group of physicians, family members, and court officials.

What does this mean for risk management professionals?

Encouraging patients to sign advance directives and make their wishes known to their family members before an accident occurs is the best way of eliminating any ambiguity when making end-of-life decisions. If this proves difficult, whether because a patient is already incompetent or for other reasons, the best practice is undoubtedly to know and understand the process. Be able to advise patients and their family of their rights, how to exercise them, and what to do if they feel those rights are being ignored or overlooked. The new definition of death has obscured certain facets of medicine; however, the best practice is and will remain to be staying as informed as possible regarding the process concerning end-of-life decisions in addition to encouraging patients to become informed. Finally, careful documentation by the practitioner of all relevant information, including discussions with family members, will facilitate resolution of conflicts if they occur.

¹ *In the Matter of Karen QUINLAN, An Alleged Incompetent*, 70 N.J. 10, 355 A.2d 647 (1976).

² Quinlan, *supra* note 1.

³ Walker, Robert M. "Ethical Issues in End-of-Life Care." *Moffitt Cancer Center*. Moffitt Cancer Center and Research Institute, 1996. Web. 13 May 2010. <<http://www.moffitt.org/moffittapps/ccj/v6n2/article4.htm>>.

⁴ *In the Matter of Philip K. EICHNER, On Behalf of Joseph C. Fox, Respondent*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266.

⁵ "The Constitution of the United States," Amendment 14.

⁶ Walker.

⁷ *In the Matter of Westchester County Medical Center, On Behalf of Mary O'Connor, Appellant*, 72 N.Y.2d 517, 534 N.Y.S.2d 886, 531 N.E.2d 607 (1988).

⁸ *Westchester County*, *supra* note 7.

⁹ *In the Matter of the Conservatorship of the Person of William J. Drabick III*, 200 Cal.App.3d 185, 245 Cal.Rpte. 840, 488 U.S. 958, 109 S.Ct. 399, 102 L.Ed.2d 381 (1988).

¹⁰ *Conservatorship of Drabick*, *supra* note 9.

¹¹ *Superintendent of Belchertown State School et al. v. Joseph SAIKEWICZ*, 373 Mass. 728, 370 N.E.2d 417 (1977).

¹² *Superintendent*, *supra* note 11.

¹³ *In the Matter of Claire C. Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985).

¹⁴ *Conroy*, *supra* note 13.

¹⁵ *In the Matter of John Storar*, 438 N.Y.S.2d 274.

¹⁶ Quinlan, *supra* note 1.

¹⁷ Quinlan, *supra* note 1.

¹⁸ Quinlan, *supra* note 1.

¹⁹ Quinlan, *supra* note 1.

²⁰ Quinlan, *supra* note 1.

²¹ Quinlan, *supra* note 1.

²² Quinlan, *supra* note 1.

²³ Walker.

²⁴ Walker.

²⁵ *In re Estate of Longway*, III.2d 33, 139 Ill.Dec. 780, 549 N.E.2d 292 (1989).

²⁶ Longway, *supra* note 25.

²⁷ *Conservatorship of Drabick*, *supra* note 9.

²⁸ "Court and the End of Life - The Case of Nancy Cruzan." *Library Index*. 2010. Web. 13 May 2010. <<http://www.libraryindex.com>>.

²⁹ *Nancy Beth CRUZAN, by her Parents and Co-Guardians, Lester L. CRUZAN, et. Ux., Petitioners v. Director, Missouri Department of Health, et al.*, 497 U.S. 261, 110 S.Ct. 2841.

³⁰ *Cruzan*, *supra* note 29.

³¹ *Cruzan*, *supra* note 29.

³² *Cruzan*, *supra* note 29.

³³ Annas, George J. "'Culture of Life' Politics: The Case of Terri Schiavo." *New England Journal of Medicine* (2005). Web. 13 May 2010. <http://www.bc.edu/bc_org/avp/law/st_org/lrp/annas0607.pdf>.

³⁴ Annas.

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Risky Business

“When Common Sense is Uncommon”

By: Pamela Monastero, MBA

Dear Risk Manager:

This column, which will appear regularly in the *RMQ* journal, is designed to assist both the novice and seasoned risk manager by presenting brief *pearls of wisdom* based on the experiences of our colleagues. The column is anonymous and we encourage our members to submit their experiences which may be e-mailed to Pamela.monastero@nychhc.org or mailed to AHRMNY, P.O. Box on the RISKY BUSINESS form which can be found on our website at www.AHRMNY.com. The form permits confidentiality.

COMMON SENSE TIPS FOR STAFF:

This quarter's column is devoted to continuity of care of patients as it relates to patient hand-offs. In both the professional and personal arena, I have witnessed instances where patients (in-patients--including direct admissions from nursing homes, newborns, same day surgery patients) have not been “endorsed” to physicians, nurses or have an assigned admitting attending. As risk and quality managers, we puzzle over how such events occur. Often, what seems to be common sense somehow gets overlooked. We all have hand-off protocols in place and many facilities use the techniques of TeamSTEPPS training and Crew Resource Management, yet these events continue to occur. Three hand-off related scenarios are presented below for your consideration. Risk Managers should encourage their medical, nursing and administrative leadership to conduct periodic reviews of how patients are assigned to caregivers, how hand-offs/communication among caregivers is actually 'operationalized' and whether or not the forms completed for SBAR are being used robotically and not as intended.

- A new nurse manager is hired to supervise the newborn nursery at an urban community hospital. She is very experienced (over 20 years of hands on nursing care and management experience) and comes highly recommended. Her supervisor, the nursing director for labor and delivery and newborn services, discovers that a newborn infant was never endorsed to a nurse for a shift. While there was no untoward patient outcome, the infant was not assessed or treated for an entire shift. The hospital had stringent procedures in place for nursing change of shift and patient assignments and no one involved could understand how such an event occurred. The nurse manager was terminated from her position.

TIP: periodic review of existing processes presents proactive opportunities for enhancing patient safety and risk reduction.

- An out patient (my family member) underwent day surgery for a broken finger. The procedure was performed under local anesthesia, hardware was inserted and the surgery was uneventful. The physician told the patient that he would be discharged from the ‘recovery area’ after about 20 minutes. The patient’s stretcher was then positioned in front of the nursing station in the ‘recovery area’ where he was later rounded by the surgical resident. A half hour later, the patient’s family member approached the nursing station to state that the patient had not been seen by a nurse and had not received medication for an upset stomach as ordered by the physician. The nurse responded that she would let the patient’s nurse know. Another half hour passed and the patient still was not attended to by nursing staff for check of vital signs, administration of medication, etc. About 1 ½ hours after the surgery, the patient’s operating room nurse emerged from the O.R. and questioned why the patient was still in the ‘recovery area.’ We relayed our experience to her and she had a nurse evaluate the patient. The nurse, who was very defensive, stated “it was the doctor’s fault, he did not leave the chart at the nursing station to let us know that the patient was here.” When the family member mentioned that the patient was sitting right in front of the nursing station for 1½ hours and that a nurse was told the patient was not attended to, no response was received.

TIP: this scenario illustrates a complete lack of common courtesy, common sense and lack of caring. Active listening skills and avoiding defensiveness must be an on-going part of staff education. Supervising staff should periodically conduct spot checks of hand-off processes/communication to review the efficacy of systems in place.

- A long term care patient is a direct admit to a community hospital’s medical/surgical unit. The hospital has an affiliation agreement with the long term care facility and several hospital physicians care for patients at the long term care facility as well as being employed by the hospital. The patient is admitted to the hospital on a Friday under Dr. X’s name. Dr. X is not scheduled to be on duty at the hospital that weekend but the patient’s addressograph lists Dr. X as the physician of record. The patient is rounded by medical residents and nurses over the weekend, medications are ordered and given and a history and physical is documented without attending supervision or input. While no harm was done to the patient and the treatment rendered was deemed to be appropriate, the circumstances beg the question as to why the nurses and residents failed to escalate the situation that a patient had no attending? They failed to call the Clinical Chair or Administrator on Duty to report the mishap.

TIP: *again, hand-offs come into play as well as checking systems in the admission process and escalation of important issues to leadership. More important, however, is the issue of staff acting robotically without an independent thought process.*

Tools, Resources and Literature:

- Teamstepps.ahrq.gov/abouttoolsmaterials.htm
- Joint Commission (www.jcaho.org) – there are several publications related to active listening
- “The new paradigm of crew resource management: just what is needed to re-engage the stalled collaborative movement?” *Jt Comm J Qual Improv.* 2002 May;28(5):233-4.
- National Patient Safety Foundation (www.npsf.org) – there are several publications related to patient safety and active listening.



**ON NEW YORK CHAPTER MEMBERS
ASHRM ANNUAL CONFERENCE • OCT 13-16, 2010 • TAMPA, FLORIDA**

BRAVO to Jose Guzman, Jr, RN, MS (Presenter) and Francine Thomas (Co-presenter) for their ASHRM Presentation: New Paradigms in Long-Term Care (LTC) Services, New Liabilities- Shift in Healthcare Services

CONGRATULATIONS to Michael Midgley (Elected to the ASHRM Board) and Jose Guzman, Jr. (Elected member of ASHRM Nominating Committee)



Jose Guzman – AHRMNY Board of Director



ASHRM President-elect Michelle Hoppes and AHRMNY Past-president Michael Midgley



Michael Midgley (sixth from left)

Summary of AHRMNY's 9/21/10 Fall Conference

The Healthcare Division of Lexington Insurance, a division of Chartis, Inc. and the National Patient Safety Foundation invited AHRMNY members to attend their seminar "Healthcare Associated Infections: Applying Patient Safety Solutions to Emerging Liability Challenges.

This full day educational program, with time for a buffet lunch and networking with colleagues, explored infection prevention and control from a patient safety and risk management perspective, identifying effective strategies that organizations have used in their efforts to reduce healthcare associated infections (HAIs). The event was well received with over 100 in attendance.

Emily Rhinehart, RN MPH CIC CPHQ, Vice President and Division Manager, Global Loss Prevention, Chartis, Inc. provided introductions and perspective throughout the day.

Russ Nassof, Esq., a nationally known speaker on the issue of HAIs, explained how several factors have combined to create the "perfect storm" of heightened awareness and increasing liability and risk. In describing the prevalence of HAIs, Russ quoted John Nance, stating "The average suitcase on an airline flight is safer than the average person in a hospital". Russ cautioned that while a zero infection rate is a great goal, it is a dangerous precedent from the liability perspective.

The morning session concluded with a moving presentation by Victoria Nahum, a nationally known advocate on patient and family involvement in HAI prevention. Victoria founded the Safe Care Campaign (www.safecarecampaign.org) after three different members of her family were infected in three different hospitals, in three different states, in just a ten month period. Her son, Joshua, died from an infection acquired at the hospital, but not until after the bacterial infection resulted in his becoming a permanent ventilator dependant quadriplegic. He was 27 years old. Victoria provided invaluable insights not just to the impact HAIs have on patients and their families but how they can become instrumental partners in facilities' HAI prevention programs.

Following lunch, Denise Murphy, VP for Quality and Patient Safety at Main Line Health System in Philadelphia discussed infection prevention approaches based upon systems engineering and human factors theory that have created positive results. Denise, past president of APIC, has utilized performance improvement methods such as PDCA, Six Sigma DMAIC, "Lean" Engineering to improve outcomes dramatically at her facility. Along with traditional infection prevention strategies and performance improvement methods Denise stressed the importance of complimentary strategies including culture and systems thinking, teamwork, situational awareness and peer checking. Using these tools she demonstrated how Barnes-Jewish Hospital was able to become a top performer, decreasing HAIs and the associated excess length of stay. In the end she convinced us ZERO is possible and achievable!

Sheila Namm, Esq., RN, MA, VP Professional Affairs at Maimonides Medical Center finished the daylong program by examining the emerging liability challenges associated with HAIs. Ms. Namm stressed the natural alignment between Infection Prevention and Risk Management. The challenges relating to public reporting, national standards, never events and discoverability of data were all thoroughly explored.

AHRMNY

2010-2011

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