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Relias Media

From **Relias**

OCTOBER 2022 Vol. 44, No. 10; p. 109-120

Active Shooter Risks Require Prevention, Response Plans

Active shooters can threaten people in virtually any place or situation, but healthcare facilities may be uniquely at risk because they are open to the public and frequently experience violence from patients and others.

Hospitals and other facilities should create an active shooter program that reduces the risk as much as possible and includes a response plan.

Hospitals have always been vulnerable during and after active shooter situations, regardless of where the incident occurs, because they are an essential element to the immediate response and recovery process during and after the event, says **Lisa Terry**, CHPA, CPP, vice president for vertical markets in healthcare with Allied Universal, a company based in Santa Ana, CA, that provides security systems to hospitals and health systems. She is the author of *The Active Shooter Response Toolkit for Healthcare Workers*.

> "WE MUST ACKNOWLEDGE THAT THERE HAVE BEEN A FEW ACTIVE ASSAILANT/ SHOOTER EVENTS OCCURRING WITHIN A HEALTHCARE SETTING, AND THE RISK CERTAINLY EXISTS."

"Because of the unique environment that is healthcare, hospitals are considered soft targets. We must acknowledge that there have been a few active assailant/ shooter events occurring within a healthcare setting, and the risk certainly exists," Terry explains. "Hospitals are open to serve the public 24 hours a day, and often encounter a crisis mentality within the population that they serve. It can be said that a hospital is a microcosm of a city."

Financial Disclosure: Consulting Editor **Arnold Mackles**, MD, MBA, LHRM, discloses that he is an author and advisory board member for The Sullivan Group and that he is owner, stockholder, presenter, author, and consultant for Innovative Healthcare Compliance Group. The relevant financial relationships listed have been mitigated. None of the remaining planners or authors for this educational activity have relevant financial relationships to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

HEALTHCARE RISK MANAGEMENT™

***Healthcare Risk Management*™, ISSN 1081-6534, including *Legal Review & Commentary*,™ is published monthly by Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468. Periodicals postage paid at Morrisville, NC, and additional mailing offices. POSTMASTER: Send address changes to Healthcare Risk Management, Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468.**

GST Registration Number: R128870672

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This activity is valid 36 months from the date of publication.

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In healthcare, anyone can be the first to encounter an active shooter or hostile event situation, but staff in the ED are at heightened risk, Terry says. EDs often are overcrowded and must be accessible by anyone presenting with a medical emergency at all times, so they are considered a high-risk area.

"There is no single variable of predicting acts of violence," Terry says. "However, one predictor of future behavior is past behavior. It is important to conduct a review after other incidents occur."

Start with EOP

A good place to start in addressing the active shooter risk is with the organization's emergency operations plan (EOP), Terry says. The International Association of Healthcare Security and Safety (IAHSS) Workplace Violence Prevention Bundle[1] and the Active Shooter Hostile Event Response Guideline are excellent resources in establishing standards that address the role of hospitals and healthcare systems in preventing, mitigating, and responding to these events.

If not already in place, Terry says hospitals should develop a threat management program that includes a standing threat assessment team. A security vulnerability assessment should be conducted on a regular basis as well as when new risks are recognized.

Terry says risk managers should consider these proactive security solutions and capabilities:

- More access control;
- Physical design of identified higher-risk locations;
- Duress/panic alarms;
- Video surveillance;
- Emergency/mass notification systems for staff, patients, and visitors anywhere on or adjacent to the property;
- Weapons detections systems, such as security dogs and handlers;
- Ongoing training and exercises within the organization as well as within the surrounding community.

Save Yourself First

Healthcare professionals should be taught that in an active shooter situation, their priority is to ensure their own safety, Terry says. This is a particularly important message for physicians and nurses whose first instinct might be to protect their patients.

"Healthcare workers have a personal and ethical commitment to be survivors and protectors. It's a unique environment where employees also make a commitment to assume responsibility for protecting the lives of others," Terry says. "It is important to train healthcare staff to 'Survive First. Protect When Possible.'"

Ongoing combined training and exercises with local first responders

EXECUTIVE SUMMARY

Healthcare organizations are at risk of active shooters. Hospitals and other facilities should reduce the risk where possible and prepare response plans.

- Emergency departments are at increased risk.
- Video surveillance and other technology can help.
- Staff should be trained to protect themselves.

is an excellent training method and can help instill the idea clinicians must protect their own safety if they are going to be useful to their patients.

A common training for priorities in active shooter situations is "Run, Hide, Fight":

• **Run:** Quickly identify the two nearest exits. If possible, run and help others escape.

• **Hide:** If you are trapped in an office, treatment room, or areas with doors, quickly secure the door. Lock it, barricade in any way, and turn off the lights. If in an open area or hallway, immediately move into a room and secure the door. Assist patients as much as possible, remembering your own safety first.

• **Fight:** As a last resort, fight for your life if confronted with an active shooter. This may include distracting, screaming, throwing objects, or using makeshift weapons to disarm the shooter. Once decision to fight is made, commit to this action completely.

Another common method of training is the 4 As, developed by the Center for Personal Protection and Safety (CPPS) to immediately assess and mitigate risks of violence.[2] Terry offers this summary:

• **Accept that something seems out of place.** This may be noticing doors are propped open, or a family member appears angry and anxious.

• **Assess next steps.** Options might include closing doors, assisting a patient or family member, or calling for help.

• **Act on your best judgment.** Commit to your actions.

• **Alert law enforcement or appropriate leaders if necessary.** Allow the proper officials to further evaluate a potential threat before it escalates.

Active shooter scenarios should be included in any workplace violence prevention program, says **Georgia Reiner**, risk specialist for the Nurses Service Organization (NSO) in the Healthcare Division of Aon's Affinity Insurance Services in Philadelphia.

"Employers should empower nurses to identify signs of potentially violent behavior and how to respond in an active shooter situation," Reiner says. "Active shooting incidents are relatively rare but, unfortunately, have been increasing in recent years. Nurses need to be educated and trained so they can respond quickly and potentially save lives."

Hospital leadership must commit to preparing employees for an active shooter situation. That starts with identifying potential vulnerabilities at the facility. A vulnerability assessment should include identifying both internal and external risks and eliminating those risks to the extent possible.

Administrators also should provide a written plan for responding to active shooters, which may include evacuation or sheltering in place, Reiner says. Drills can teach staff how to carry out the response and allow leadership to critique the plans.

"Employee training should address different response options, assigning responsibilities to specific individuals," Reiner says. "The response plan also needs to include special considerations for areas like the emergency department, operating suites, infectious disease quarantines, and vulnerable areas like the NICU and ICU."

Allocate Resources Carefully

Budget constraints can affect planning, says **Rochelle R. Sweetman**, JD, risk management consultant with Marsh McLennan Agency in Sioux Falls, SD.

"To the extent that hospitals can provide additional security, they often apply those resources in the emergency department because that is one of the areas with the highest risk," Sweetman says. "That may include metal detectors and a high presence of hospital security. But that can be a very expensive process to get that level of security in place."

Deciding where to spend limited resources for security can be difficult. If a hospital considers installing metal detectors, it is reasonable to ask how many full-time equivalents that money would cover for floor nurses who could de-escalate an upset patient or family member before a shooting occurs. The same reasoning might apply to hiring additional security officers.

"These cost-benefit decisions have always been difficult in healthcare, but it can be especially difficult now with labor shortages and supply chain issues," Sweetman says. "When you add in the thought of an active shooter and the potential for stopping a tragedy, the decision can be even more challenging."

Among Top Threats

Active shooters in parking areas, on perimeter grounds, and inside medical service buildings predominantly rank in the Top 10 Likely Threats with High Impact of Loss compiled by Force Protect Security Consultants in Panama City Beach, FL. Founder **Frank Finley** works with healthcare facilities to improve security.

The ranking is based on comparing 87 different threat scenarios that may occur in a healthcare setting, he says. The

perpetrators tend to stem from angry patients, disgruntled employees, criminal action such as robbery, outside relations such as a domestic conflict, or in some cases, violent extremists.

"Based on our risk assessment results, emergency departments, outpatient mental health, and certain specialty care clinics are at highest risk of an active shooter," Finley says. "The introduction of the weapon threat typically stems from a patient approaching their maximum pain threshold and thus lashing out, or revenge toward a provider perceived not to listen to the patient's needs or provide the immediate pain relief and/or medication."

In the federal sector, including the Department of Veterans Affairs, Finley says additional high-risk departments include the compensation and pension office, quality management, and the executive leadership team or director, Finley notes. These departments are likely to experience an active shooter due to denied service-disabled compensation ratings or perceived lack of timely service.

Other factors can increase the risk, Finley says. These include the location of the facility (urban vs. rural), local crime operational tempo, perceived poor customer service, long wait times, disgruntled workforce, no means of screening, exposed staff, and lack of behavior recognition training for staff. A lack of standard operating procedures and rehearsals for active shooter situations also can increase the risk of injuries and deaths.

Hospitals should conduct a site-specific risk assessment and allow the results to dictate the risk mitigation measures to implement, Finley says. He suggests these options:

- Lock down all perimeter gates and building doors;
- Direct public traffic through a minimal number of entrances;
- Implement passive full-time weapon screening vestibules;
- Install behavior analytic camera systems;
- Position facial analytic camera systems to detect those on the FBI wanted list, terror watch list, and an internal "banned from property" list, or "requires escort" list;
- Protect reception desks/nurse stations with ballistic enclosures;
- Secure all doors with access control leading from public space to private exam space;
- Implement panic duress means at each keyboard and person-worn pendants;
- Implement defend-in-place mechanisms on doors.

History of Workplace Violence

Healthcare has long been identified as a higher-risk industry with respect to workplace violence, notes **Charles Randolph**, executive director of strategic intelligence with Ontic, a protective intelligence software company in Austin, TX. The American National Standard on Workplace Violence Prevention and Intervention recognized healthcare as a workplace violence "high risk" industry.[3]

The COVID-19 pandemic and new restrictions on abortion access have put added stress on patients, their families, and medical practitioners, contributing to increases in threats and violence affecting healthcare practitioners and facilities.

"Although the risk is often seen as coming from volatile patients directed at nurses, technicians, and doctors, healthcare facilities also face threats from current and former employees, including medical practitioners, as well as domestic violence threats from external sources to employees," Randolph says. "Hospitals that are affiliated with medical schools or research institutions may also face threats from students or applicants, as well as external threats to researchers conducting experiments in sensitive areas or using animals."

Workplace violence can affect any department within a hospital or healthcare setting, but departments or offices that are known areas of stress or emotional conflict may draw more threats and violent incidents, Randolph says. In addition to the ED, risk can be higher in ICUs, maternity units, and departments such as patient accounts or even parking facilities.

"All departments within a hospital or healthcare facility can benefit from training on how to de-escalate conflict, such as a hostile interaction with a patient or family member," Randolph says. "They should also be trained in how to report threats and other troubling behavior, and why it is important to do so."

Employer Obligations

In January 2022, The Joint Commission (TJC) issued specific workplace violence prevention requirements for hospitals and healthcare facilities.[4] Randolph says the best way for hospitals and healthcare facilities to prepare for and prevent workplace violence is to follow those requirements. These include creating a multidisciplinary workplace violence prevention team, training the team on threat assessment and workplace violence prevention, preparing all employees

on identifying and reporting threats and other troubling behavior, and installing a database to track and manage cases and incidents.

OSHA also has issued *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*,[5] notes **Denise Merna Dadika**, JD, an attorney with Epstein Becker Green in Newark, NJ.

Healthcare employers should review the OSHA and TJC resources when developing and reassessing workplace violence prevention programs, as well as any state requirements that may apply. Programs should include annual staff training on violence response protocols, including de-escalation techniques, response to alarm systems, use of safe rooms, escape plans, and the reporting physical or verbal violence toward healthcare workers.

"Healthcare employers have an obligation under the Occupational Safety and Health Act's General Duty Clause to maintain a workplace 'free from recognized hazards that are causing or likely to cause death or serious physical harm.' OSHA frequently cites employers for failing to take steps to prevent workplace violence, citing the General Duty Clause," Dadika says. "Preparing and adhering to a robust workplace violence prevention program will assist employers in discharging their obligation under the General Duty Clause."

Employees who suffer workplace injuries may seek compensation for injuries and lost wages under the employer's workers' compensation coverage, which generally will be the exclusive remedy available to an employee, Dadika says. However, an employee may proceed with a civil action where he or she can demonstrate their injuries were caused by an intentional wrong on the employer's part. ■

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Technology Helps with Active Shooter Prevention and Response

Technological options may help reduce the risk from active shooters. Technology is available to monitor people and predict dangerous behavior, and it can help during the incident response.

Technology can be especially helpful in healthcare because most hospitals include multiple entry points that are accessible to the public at all hours, says **Sharon Hong**, vice president of enterprise technology at Motorola Solutions.

"Hundreds to thousands of visitors and staff may pass through facilities daily," Hong says. "Security personnel are tasked with monitoring buildings and their surroundings, including public spaces, secure areas, and critical equipment, while also responding to incidents or requests for assistance in real time."

Technology, including security cameras with analytics, access control systems, and radio communication systems and devices, can work together to help hospitals respond faster and more efficiently to many threats, including active shooter scenarios, Hong says.

Hong offers these examples of technology available from various sources:

• Security cameras embedded with analytics can provide security with greater visibility and help detect unusual activity across facilities in sensitive or common areas and parking lots. These alerts can be sent directly to security personnel radio devices. In the case of a known assailant, hospital security personnel can import a person's license plate, name, and picture into the security database and issue a "be on the lookout" alert. If the person's vehicle enters the hospital's parking lot, license plate recognition software can identify it and automatically send an alert to security radios to assess the situation and dispatch security to the right location with details about the incident.

• Access control systems can manage staff and public access to buildings, allowing only authorized people to enter and prevent unwanted access to sensitive areas within a hospital, including the pharmacy, NICU, mother/baby unit, medical rooms, information technology department, supply rooms with valuable equipment, and hospital administration offices, among other areas. If a door is propped or forced open, the access control system sends security personnel an immediate alert to their radios and provides access to live camera feeds so they can survey the situation before responding.

• Concealed weapons detection systems in the ED or main entrance to the hospital can provide quick and seamless screenings without having to stop and frisk or remove items from a visitor entering the hospital. Using sensors and artificial intelligence, the system is designed to allow up to 1,800 visitors to walk through one of the scanning devices per hour and can detect a wide range of concealed weapons and threats, such as firearms, metallic weapons, and improvised explosive devices. If an item is detected on a visitor, an alert is displayed on a tablet showing the location of the potential threat on the person's body to security operators, where they can alert the organization's security staff.

• Radio devices connect team members and dispatch security in case of urgent needs such as managing an unruly patient or family member, locating a missing patient, or responding to attempts of unauthorized access. ■

SOURCE

- **Sharon Hong**, Vice President of Enterprise Technology, Motorola Solutions, Chicago. Phone: (847) 576-5000.

Say What You Mean: Imprecise Language Can Lead to Medical Errors

Patient safety can be threatened by the use of imprecise language in the operating room. Research suggests ambiguous instructions are surprisingly common. The surgical team members often do not realize comments are unclear and automatically use context clues to fill in the gaps.

Fortunately, the ambiguous comments usually are sorted out before the patient is harmed, but there is a risk of serious error, says **Andrew McKenzie**, PhD, associate professor of linguistics and affiliate professor in indigenous studies at the University of Kansas.

"We find that when surgeons are talking in the operating room, their language is not as precise as the surgery they are performing. There ends up being a lot of potential ambiguities that need to be corrected or repeated, or may be misunderstood," McKenzie explains. "A lot of those can lead to an error, a near miss, or potentially a delay. We suggest that people be aware of how their speech can be unclear even if it does not seem like that to them."

McKenzie's recent research addressed the risk to patient safety from imprecise language. McKenzie and colleagues reviewed video recordings of six surgical procedures performed by residents under the supervision of specialist physicians. The review revealed 31 instances of inexact language that could have led to a medical error.[1]

McKenzie is a semanticist. In the paper, McKenzie and colleagues described 14 categories of inexact language that could lead to a medical error. The authors defined deixis as "linguistic expression that explicitly refers to the utterance it was made in, the locations of the people participating in it, or the immediate context surrounding it." An example is, "Take this over there." In that instruction, "this" and "there" are potentially unclear, he explains.

McKenzie also cites an unclear anaphor, which is a phrase "for which antecedent is not clearly stated or multiple possible antecedents exist." He offers this example: "Bill went home. Ted came home later. He went right to sleep." In that statement, it is not clear who went to sleep.

Those ambiguities occur in surgery in addition to questions or suggestions that should be phrased as explicit instructions.

"We identified a large number of potentially ambiguous words and phrases used by surgeons in the OR," McKenzie and colleagues wrote. "The lack of patient injury suggests that much of the vague language was successfully interpreted by the subjects; however, we suspect there was still a large amount of ambiguous language that was unsuccessfully interpreted, or at the least required extra time and mental energy to interpret it."

Surgeons Open to Improvement

Often, surgeons are unaware they are using imprecise language, McKenzie says. Once the issue is pointed out to them, surgeons usually are enthusiastic about learning to become more precise when speaking during procedures.

"The rates and incidence of unclear language in surgery are not that much different from what we find in ordinary conversation," McKenzie notes. "We do a lot of work as listeners to fill in the gaps with shared knowledge, our previous experience with that person and others, and in the case of surgery, just knowing what the surgery is."

Gestures also can help clarify meaning, as when a surgeon says, "Cut here," and gestures to the right spot. Although these context clues may help the other person understand, reliance on such measures can increase the risk of patient injury, McKenzie explains. For instance, surgeons sometimes report their imprecise language to a resident was the result of trying to be polite rather than issue explicit, direct instructions. That is common in everyday conversation as well because

EXECUTIVE SUMMARY

Imprecise language during surgery can threaten patient safety. Research indicates comments and instructions during surgery often are subject to misunderstanding.

- A surgeon may think an instruction is clear but other team members may have to use context clues and hope to understand.
- Most surgeons are eager to be more precise when alerted to ambiguity.
- Efforts to speak politely may inadvertently lead to confusion.

people can perceive explicit language to be aggressive or condescending.

"Unless things get tense, the surgeons might not say very directly, 'Bring the retractor and place it at this exact spot.' They will just say, 'Retractor,'" McKenzie explains. "In surgery, we sometimes have to remember that trying to be polite can lead to misunderstandings and increase risk." ■

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Wrong-Site Surgery Still a Problem, Requires Vigilance

Despite many years of intense education and attention to prevention efforts, wrong-site surgery is on the rise. Hospitals and health systems must make sure their wrong-site prevention efforts have not weakened.

In 2021, 85 wrong-site surgeries were reported, according to the latest sentinel event data from The Joint Commission (TJC). That figure is up from 68 in 2020, and 52 in 2019. TJC notes reporting is voluntary and the figure may not represent the actual number of wrong-site surgeries. Many patient safety groups consider wrong-site surgery to be underreported.[1]

A review of 9,744 paid malpractice claims with surgical never events reported to the National Practitioner Data Bank (NPDB) revealed wrong procedure, wrong-site surgery, and wrong-patient surgery were the second most commonly occurring category, with retained foreign objects the first. Investigators noted wrong-procedure surgery was associated with a mean liability payment of $232,035. Wrong-site surgery was associated with a mean liability payment of $127,159, and wrong-patient surgery with a mean liability payment of $109,648.[2]

In one recent example, the Connecticut Medical Examining Board issued a $5,000 fine and a reprimand to an orthopedic surgeon who operated on the wrong knee of a patient in 2018. The board found the surgeon failed to follow the pre-incision protocol and failed to independently verify the site of the operation.[3]

Scheduling Can Be an Issue

Preventing wrong-site surgery requires continued vigilance, says **Tammy Williams**, MSN, RN, CPPS, program director with the Vizient Patient Safety Organization (PSO) in Irving, TX. Vizient works with healthcare organizations to improve safety and quality.

Prevention of wrong-site events requires attention to several areas within the healthcare system, addressing the issue both before the day of surgery, in preoperative holding, and immediately before operating.

"Common issues tied to these events include scheduling and documentation problems, as well as issues during the time-out process," Williams says. "We see three important opportunities for improvement: culture, scheduling, and time out." A strong culture of safety is the foundation for avoiding these and other sentinel events, she says.

Scheduling requires coordination between the operating room, physician offices, and other departments. Those interactions all pose a risk of error. Electronic scheduling systems can help reduce the risk, but physician offices that are not directly affiliated with the hospital may have trouble with interoperability. For that reason, some surgeries are scheduled

EXECUTIVE SUMMARY

Wrong-site surgery continues despite efforts to stop this sentinel event. Risk managers should ensure continued diligence in prevention efforts.

- A culture of safety is essential to reducing the risk.
- Wrong-site surgeries are underreported.
- Time out procedures must be strictly followed.

on paper, which Williams says can introduce the possibility of incomplete information and the use of abbreviations that might be unclear or misunderstood.

"A key recommendation for years has been to not accept verbal bookings because they present a high risk," Williams notes. "There also can be issues around key clinical documents having incorrect information in them, so there must be processes and barriers to catch those errors. These can be checks prior to the day of surgery and the pre-procedure verification, which includes cross-checks between the different documents, and means that most errors will be caught prior to the day of surgery."

Time Outs Must Be Consistent

The time-out process in the operating room is the last chance to catch errors, so it must always be performed carefully, Williams says. The team must take the time to review documentation and confirm all necessary elements, including the patient identification and procedure, before beginning the surgery.

"It is really critical that the entire surgical team participates in the time-out process, and it is very important that there not be variation in the process across surgical teams in the organization," Williams explains. "Any work that can be done to hardwire that time-out process into the culture is valuable."

Some hospitals have created prevention efforts that include video monitoring of the time-out process, Williams says. The video can be monitored in real time and reviewed after surgery to identify any opportunities for improvement.

Wrong-site surgery data indicate 46% are near misses, says **Ellen Flynn**, RN, MBA, JD, principal leader of the Vizient PSO. A near miss on a wrong-site surgery is a valuable opportunity to study the processes that led to that moment — both the processes that allowed an error to creep in and the processes that caught it.

"Embrace those near misses and dig deep to understand why they occurred and how they can be prevented. Let staff know that those near misses are being studied and used to improve safety in the organization," Flynn explains. "Staff must feel that they can speak up, voice a concern, escalate, and stop the line when needed."

Never Events

Wrong-site surgery must be a "never event," says **Ehsan Natour**, MD, PhD, a cardiothoracic surgeon in Maastricht, Limburg, Netherlands.

"If a problem or a complication is rare, we usually don't focus on it, we mostly think it will not happen to us," Natour says. "Studies demonstrate that experienced surgeons are more involved than the younger colleagues. This has to do with the hierarchical system in patient care."

Wrong-site surgeries are a failure of the system, not of the individual, Natour explains. "There are clear implications to face this problem. When all members of the caring team became owners of the process and are allowed and empowered to identify and [call] out any deviation noticed from the protocol, a culture of patient safety is secured," he says. "This will reduce the wrong-site surgery."

Natour suggests addressing these factors before intervention and before anesthesia, with participation of the patient:

- Before the intervention, conduct a time-out involving all team members.
- Are all documents available? Verify patient, procedure, and site.
- Is the surgical site marked and verified? This should be confirmed immediately before the procedure by the responsible surgeon and by team members. If possible, the patient should confirm the correct site.
- Once the equipment, personnel, and all documentation are available and confirmed through all members, only then may the procedure start.
- Reduce stress throughout the procedure.

"Those steps secure a multiple independent check, detect discrepancies during the whole procedure, and provide an excellent prevention of wrong-site surgery," Natour says. "Participating in the ownership together with the patient creates proactive involvement of every single member of the team instead of a routine check-off of the steps."

Duplicate records also can contribute to wrong-site surgery, says **Gregg Church**, president of 4medica, a Marina Del Rey, CA-based company that provides data management services to hospitals and health systems. Some hospitals use two different record systems because interoperability issues or legacy systems cannot be updated, resulting in duplicate records for the same patient that might not be consistent.

"The care team may have to figure out which information resides in which repository, which just increases the risk of an error or omission that can lead to wrong-site surgery," Church explains. "We also see data overlay, which is the worst, when the data from multiple patients

gets comingled. We hear it all the time because there are so many different systems where medical records exist." ■

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Better Recruitment Can Improve Safety During Staff Shortages

As staff shortages threaten patient safety, hospitals and health systems are eager to bring more clinicians on board. But this is becoming harder, especially for the most desired candidates. Improving the application and hiring process can improve patient safety.

The staffing challenge has plagued healthcare employers for years, and the demands are increasing. CMS recently updated its guidance for skilled nursing facilities to obtain five-star ratings, requiring a five-star staffing metric to receive this rating.

A big driver for staffing shortages is the difficulty in recruiting effectively, says **Rishabh Parmar**, head of strategy and operations for clinician jobs marketplace Vivian Health in Dallas.

Once qualified staff are hired, the next problem is retention.

When recruiting, healthcare facilities should pay attention to the application process, Parmar says. Nurses who are interested in an employer can be deterred when the application process is too cumbersome, and a large proportion may stop before completing it.

Pay transparency is another significant issue for applicants, Parmar notes. If applicants cannot assess the pay level quickly and easily, they are unlikely to proceed. The pay level does not have to be exact; a range showing the minimum and maximum can be effective. Applications from clinicians can increase 10% to 35% when pay levels are added to a job posting. That improvement is seen across all pay levels, not just for the healthcare employers offering the highest pay.

"Another issue is the lack of engagement. A lot of times, nurses will go through this cumbersome application process, and then it takes 20 to 40 days to hear back and connect with the hiring managers," Parmar says. "That lack of engagement can have a big impact when we have a staff shortage and there are other employers competing for these applicants." Reducing the time from application submission to interview to an average of five days can improve hiring by 35%, he adds.

Insufficient or outdated technology also can be a deterrent. With so many employment opportunities available, those seeking a job will gravitate toward employers with the most up-to-date technology that makes their jobs easier and more productive, Parmar says. ■

EXECUTIVE SUMMARY

Staffing shortages continue to threaten patient safety. Improved recruiting can help ensure proper staffing for patient care.

- CMS updated staffing requirements for skilled nursing facilities.
- The application process can be too long and tedious.
- Prompt response to candidates can improve hiring.

REFERENCE

1. Centers for Medicare & Medicaid Services. *Design for Care Compare Nursing Home Five-Star Quality Rating System: Technical Users' Guide*. July 2022. https://go.cms.gov/3Qgkp13

OIG Issues Alert on Telemedicine Fraud

The Department of Health and Human Services Office of Inspector General (OIG) recently issued a Special Fraud Alert on arrangements with telemedicine companies, describing seven characteristics that could suggest a risk of fraud and abuse.

The alert addresses potential kickbacks and substandard medical practices designed to generate medically unnecessary orders and prescriptions. Some telemedicine companies have "exploited the growing acceptance and use of telehealth" and present "the potential for considerable harm to federal healthcare programs and their beneficiaries," according to OIG.[1]

OIG issued the alert in response to repeated requests to testify in cases involving telemedicine fraud, says **Nathaniel M. Lacktman**, JD, partner with Foley & Lardner in Tampa, FL. The alert is OIG's position on what they will testify to regarding the issue.

"Simultaneously, it is a message to the industry at large that an increasing number of arrangements with a similar pattern have been identified, and the government wants them to stop it," Lacktman says. "The bullet points they lay out in the alert are an amalgamation of different factual scenarios that the government has seen emerge, with suspect conditions or red flags. It can serve as a mini-audit tool to help reduce the risk they are violating the Anti-Kickback Statute."

Lacktman notes major red flags outlined in the OIG alert. The first concerns whether the telemedicine experience and the flow of funds mirror the typical way a patient interacts with a doctor or other provider. If not, that might signal a problem. Another addresses telemedicine arrangements that offer patient inducements, such as waiving copay fees or offering anything else of value, which Lacktman calls a major red flag.

"Eliminating the patient's financial responsibility may cause the patient to become reckless and overuse the resource," Lacktman explains.

OIG also advised using caution regarding who is paying for the telemedicine service. Typically, the patient or the insurance company would pay the medical group directly, but any arrangement in which payment is made by a pharmaceutical company or marketing group would be suspect.

OIG Warning Signs

OIG laid out these warning signs that an arrangement with a telemedicine provider may not be proper:

- The patients were identified or recruited by the telemedicine company, sales agent, telemarketing company, recruiter, call center, and/or through internet, TV, or social media ads for free or low-cost items or services;
- The provider cannot meaningfully assess the medical necessity of ordered or prescribed services due to lack information from the patient;
- Provider compensation is based on the volume of items or services ordered or prescribed, which may be characterized as compensation based on the number of medical records reviewed;
- The telemedicine company does not accept insurance from any payor except federal healthcare program beneficiaries;
- The company claims to only service individuals not enrolled in federal healthcare programs but may in fact bill these programs;
- The company only provides one product or a single class of products, such as durable medical equipment, genetic testing, diabetic supplies, or various prescription creams, potentially restricting treatment options.

Lacktman notes the list is not exhaustive, and the presence or lack of any these factors does not automatically mean the arrangement is legal or illegal. ■

REFERENCE

1. Office of Inspector General. Special Fraud Alert: OIG alerts practitioners to exercise caution when entering into arrangements with purported telemedicine companies. July 20, 2022. https://bit.ly/3Ty41vz

SOURCE

- **Nathaniel M. Lacktman**, JD, Partner, Foley & Lardner, Tampa, FL. Phone: (813) 225-4127. Email: nlacktman@foley.com.

COMING IN FUTURE MONTHS

- Changes to the Stark Law
- Liability for nurses on the rise
- Which safety indicators to track
- Risks from "granny cams"

HEALTHCARE RISK MANAGEMENT™

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CME/CE QUESTIONS

1. **What does Lisa Terry, CHPA, CPP, say is the first priority for healthcare employees in an active shooter situation?**

   a. Save yourself
   b. Save patients
   c. Call 911
   d. Report the incident to administration

2. **The latest sentinel event data from The Joint Commission indicate:**

   a. rates of wrong-site surgery have increased from 2020 and 2019.
   b. rates of wrong-site surgery have decreased from 2020 and 2019.
   c. rates of wrong-site surgery are holding steady.
   d. there were no reports of wrong-site surgery within the past three years.

3. **What does Tammy Williams, MSN, RN, CPPS, recommend as one way to minimize the risk of wrong-site surgery?**

   a. Strictly adhere to time-out procedures, with consistency across all surgical teams.
   b. Allow only senior surgical team members to participate in time-out procedures.
   c. Conduct a second time-out after the procedure has begun.
   d. Defer to the surgeon's notes in any time-out discrepancy.

4. **What does Andrew McKenzie, PhD, say is one reason surgeons use imprecise language when instructing residents?**

   a. Time pressures
   b. Distraction
   c. Trying to be polite
   d. Trying to show hierarchical authority

CME/CE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

- Describe the legal, clinical, financial, and managerial issues pertinent to risk management.
- Explain the impact of risk management issues on patients, physicians, nurses, legal counsel, and management.
- Identify solutions to risk management problems in healthcare for hospital personnel to use in overcoming the challenges they encounter in daily practice.

LEGAL REVIEW & COMMENTARY
EXPERT ANALYSIS OF RECENT LAWSUITS AND THEIR IMPACT ON HEALTHCARE RISK MANAGEMENT

Appellate Court Affirms $806k Verdict for Failure to Treat Psychotic Symptoms, Suicide Attempt

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The Law Offices of Damian D. Capozzola
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***Jamie Terrence**, RN*
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News: A woman with a history of psychosis was diagnosed with bipolar disorder, borderline personality disorder, and generalized anxiety order. The patient was admitted to a hospital after attempting suicide. She was placed on a low dose of Ativan based on the attending physician's order and was evaluated by a consulting psychiatrist.

However, the consulting psychiatrist discharged the patient without additional medical or inpatient psychiatric treatment. The patient attempted suicide again and suffered third-degree burns over almost half her body. The patient filed a malpractice suit and was awarded more than $800,000 by a jury. A trial court and appellate court denied the defendant physician's post-trial challenges.

Background: A woman was diagnosed with bipolar disorder, borderline personality disorder, and generalized anxiety disorder. She visited a medical center twice and a hospital once after expressing suicidal ideation. The following month, the patient attempted to commit suicide by overdosing on prescription antidepressants and pain medication. She was admitted to a hospital and received a low dose of Ativan pursuant to the attending physician's order.

A consulting psychiatrist at the hospital evaluated the patient. Her medical records indicated she did not see a primary treating psychiatrist. The consulting psychiatrist knew the patient would see a social worker in eight days. The patient's mother promised to monitor the patient and control her medications until a psychiatrist could conduct an evaluation.

The consulting psychiatrist discharged the patient to her mother's care without any further medication or any inpatient psychiatric treatment. According to the consulting psychiatrist, stronger mood-stabilizing medications beyond Ativan are available, but these medications posed potential complications and side effects. The patient was discharged the same day she was evaluated by the consulting psychiatrist.

> THE CONSULTING PSYCHIATRIST DISCHARGED THE PATIENT TO HER MOTHER'S CARE WITHOUT ANY FURTHER MEDICATION OR ANY INPATIENT PSYCHIATRIC TREATMENT.

Two weeks later, the patient attempted suicide by dousing herself in hairspray and setting herself on fire, resulting in third-degree burns on 42% of her body. The severity of the burns required four skin grafts and nearly two dozen laser surgeries.

The patient filed a malpractice suit against the consulting psychiatrist, the attending physician who prescribed the Ativan, and the hospital. During trial, the patient dismissed her claims against the attending physician and hospital. Both the patient and the consulting psychiatrist provided expert testimony from several witnesses, including psychiatry experts and burn specialists.

One psychiatric expert noted the patient should have been sent to inpatient care upon discharge, which would have been the safest level of care for her at the time. The

expert further testified the consulting psychiatrist did not prescribe the patient a mood stabilizer or an antipsychotic medication, despite the patient's diagnosis of bipolar illness and psychotic symptoms.

The found in favor of the plaintiff and awarded $806,288.68: $246,288.68 for past economic damages, $260,000 for past noneconomic damages, and $300,000 for future noneconomic damages. The defendant filed post-trial motions to reduce the damages, and to request a new trial based on alleged juror misconduct. According to jurors, one juror stated they conducted their own research on the internet about Ativan and relayed such information to the other jurors. The trial court denied the defendant's post-trial motions. An appellate court upheld the verdict.

What this means to you: Important substantive and procedural lessons can be learned from this case. First and foremost, the jury's significant award was based on the defendant's failure to provide treatment. In this case, there was no dispute the consulting psychiatrist evaluated the patient and reviewed her medical records. Instead, the consulting psychiatrist failed to act on this information, and failed to provide treatment based on the patient's known conditions. While the patient did receive some treatment, the patient alleged — and the jury agreed — this was insufficient given the patient's condition and history.

It is critical to not only review the patient's condition and history, but to act on the information if a reasonable physician under the same or similar circumstances would take such action. Failing to do so constitutes malpractice. Here, the patient successfully argued and demonstrated with expert testimony that she should have been prescribed other medications in addition to Ativan or should have been sent to inpatient care. The defendant consulting psychiatrist claimed Ativan provides "some mood-stabilizing properties and helps with agitation," but this was insufficient treatment given the patient's background and condition.

The patient's expert testified the applicable standard of care required a physician to determine which medications work or do not work and why — a determination that is customized to each patient by considering safety, tolerability, efficacy, price, and simplicity of dosing and administration. These factors and considerations are part of a complex treatment plan the consulting psychiatrist made no effort to implement. But care providers must be cautious not to shirk such responsibilities merely because such implementation takes time and attention. In this case, the consulting psychiatrist failed to take an appropriate course of treatment that would have included additional medication testing and administration — and bore liability as a result.

Providers also must consider the fact that antidepressants and antipsychotic medications — unlike Ativan, an anxiolytic — do not take effect immediately, or even within a few days. Many can take weeks to become effective enough to prevent a patient from harming herself or others. A consulting psychiatrist may be reluctant to prescribe these medications without consulting the patient's primary psychiatrist because abrupt cessation might be dangerous if the primary psychiatrist objects to the drug based on the patient's history. While these facts justify the consulting psychiatrist's reluctance to prescribe, they simultaneously require the patient be continually monitored by skilled personnel trained in suicide precautions and interventions in an inpatient setting until such time as a treatment plan, either pharmacological or behavioral, has been initiated and shown to be effective. At that point, the provider can consider releasing the patient to the custody of a parent, guardian, or other untrained individual. This is the standard of care, and anything less may be considered negligent. On a side note, cases such as this are not rare. The availability of these inpatient psychiatric settings is scarce, and patients may spend days on psychiatric holds in EDs until placement is found. Political pressure by hospital administration on the consulting psychiatrist to discharge these patients quickly can be significant and must be monitored and addressed.

The defendant raised multiple post-trial challenges, arguing the patient's injuries did not fall within the "catastrophic personal injury" category based on that state's law, and claiming juror misconduct occurred. While the courts rejected these arguments, these still provide a mechanism for providers to challenge issues and potentially reduce or eliminate adverse findings and jury determinations.

Many states enacted different rules about limitations on malpractice damages awards. It is important for providers and their counsel to understand the specifics of these limitations. Here, the defendant argued the patient was not entitled to higher noneconomic damages since she did not suffer "irreversible failure of one or more major organ systems."

The court disagreed, noting the patient's expert testified the patient's skin could not heal itself, and even

though the patient received medical intervention, her injuries were so significant that if she did not receive surgical intervention, she likely would have died. The patient was left with hypertrophic scarring and suffered from permanent mobility issues, functional loss, discomfort, nerve damage, and increased sensitivity to sun exposure. If the defendant had been successful, it would have limited the jury's damages, reducing the maximum to $400,000 for noneconomic damages.

Similarly, the defendants claimed a juror engaged in misconduct, which justified a new trial. Typically, jurors are advised by the court not to engage in their own investigations, research, or evidence-gathering. A juror's misconduct may rise to such a degree that it affects the core of the case and requires a new trial in the interests of justice.

While these circumstances are rare, they do occur, and can present an opportunity for a party to challenge an adverse verdict. In this case, the court determined no prejudicial misconduct occurred, and even if it had, such extraneous evidence was immaterial to the consequential facts. Nevertheless, providers faced with an adverse verdict should explore post-trial challenges to evaluate which, if any, are applicable and potentially fruitful. ■

REFERENCE

- Decided Aug. 23, 2022, in the Missouri Court of Appeals, Western District, Case Number WD84990.

No Liability for Telemedicine Company or Hospital Over Stroke Treatment

News: A woman suffered a stroke and was admitted to a hospital for treatment. The hospital physician sought a consultation with a telemedicine company. A neurologist assigned by the company determined treatment with tPA, a medication that breaks up blood clots and restores blood flow, was appropriate. The patient consented and received the treatment, but ultimately suffered a hemorrhage and died.

The patient's husband filed a malpractice suit, claiming the care providers delayed treatment — which took more than two hours after the patient's admission — and requesting a consultation. However, experts testified the risk of hemorrhage was prevalent even if treatment had been provided earlier. The trial court granted the defendants' summary judgment, which was upheld on appeal.

Background: In July 2014, a woman was taken to the ED around 11:00 a.m. after her friend noticed she could not speak. Nurses alerted the physician of the possibility of an ischemic stroke. The physician examined the patient and ordered a CT scan and lab work before requesting a neurology consult with a telemedicine company that provides on-call specialists to help determine whether the patient is a candidate for tPA. The physician requested the consult at 1:07 p.m.

A nurse at the telemedicine company reviewed the patient's information, spoke with the physician at the hospital, and sent the patient into a queue to await lab and CT results before assigning a neurologist. The nurse prioritized the patient as "intermediate" rather than "high" because the physician noted the patient was improving and could speak.

The attending physician received lab work and CT scan results around 1:50 p.m. and provided those to the telemedicine company. However, over the next half hour, the patient's condition worsened, her ability to speak diminished, and she became more confused. The physician hospital nurse followed up with the telemedicine company, and a neurologist was assigned at 2:56 p.m. The neurologist determined tPA was appropriate, and informed the patient and her husband of the risks, including the possibility of hemorrhage.

The patient and her husband consented to treatment, and the hospital staff administered tPA at 3:17 p.m., which was within the 4.5-hour treatment window advised for the medication. The patient ultimately suffered a hemorrhage and did not survive.

The patient's husband sued the telemedicine company and the hospital, claiming the defendants delayed in providing treatment, which resulted in a loss of opportunity to benefit from tPA. The plaintiff provided a statement from an expert who claimed the failure to timely treat resulted in a less favorable outcome. However, during deposition, the expert admitted tPA can be administered up to 4.5 hours after the onset of symptoms, and that hemorrhage is the most common risk. The expert further noted the chance

of hemorrhaging was present even if the patient received tPA early, given her hypertension.

The defendants' expert noted the risk of hemorrhage only increased by 0.1% when tPA is administered at the 4.5-hour mark compared to the three-hour mark. The expert also explained this was not a clinically significant difference, and a delay did not affect the risk of hemorrhaging.

The trial court granted summary judgment for the defendants, finding no evidence the delay in obtaining the consultation and treatment caused the hemorrhage. The patient's husband appealed, but the appellate court upheld the judgment.

What this means to you: This case confirms the importance of timely treatment and how providers can defend against claims of failure to provide such treatment. Frequently, a patient's condition requires time-sensitive treatment, and the failure to do so may constitute medical malpractice if a similar physician under such circumstances would provide that timely care. Depending on the provider's specialty, these concerns may be even more prevalent. That was the case here, as the providers were an attending ED physician and on-call neurologist.

Fortunately for the providers in this case, any delay in treating the patient was deemed immaterial based on known medical standards. In a malpractice suit, the injured patient is required to prove causation as a necessary element. If the patient cannot prove that, the case necessarily fails.

There are several methods for challenging causation. In this case, the defendants successfully demonstrated the delay did not cause the patient's injury by providing expert testimony confirming hemorrhages are a known risk of tPA treatment — and, more importantly, the risk does not increase if the patient is treated at the three-hour mark or at the 4.5-hour mark. Even the patient's expert agreed to these medical facts, concurring with the defendants' expert.

The court found it did not matter if the patient received the tPA treatment sooner because the risk of hemorrhage was the same. Thus, it was impossible for an expert to state the patient would not have suffered the hemorrhage if the tPA treatment had been administered sooner. Since the plaintiff did not prove this necessary element, the case was defective as a matter of law, and judgment was proper for the defendants.

THE COURT FOUND IT DID NOT MATTER IF THE PATIENT RECEIVED THE TPA TREATMENT SOONER BECAUSE THE RISK OF HEMORRHAGE WAS THE SAME.

When faced with a malpractice action, providers should evaluate this cause-and-effect relationship the patient alleges. If a patient claims some specific action or inaction caused the injury, other intervening or superseding causes might be responsible. If a provider can demonstrate his or her actions did not cause the harm, or the harm would have occurred regardless of the provider's actions, then there can be no malpractice liability. These are critical aspects of a case to explore in depth in discovery and to challenge if there is any doubt as to causation.

If a defendant presents such a strong defense that unequivocally confirms the plaintiff's case is defective, procedures are in place to allow early adjudication. This is commonly known as summary judgment, whereby one party can request the court determines as a matter of law based on undisputed facts the party is entitled to judgment. A jury is not used for this process since there is no factual dispute, and the court is capable of ruling based solely on the law.

Here, both experts agreed on the medical facts related to tPA administration, timing, and hemorrhage risk, so the court was not required to make any determination of such issues. Rather, the court merely had to apply those facts to the law and found the defendants were entitled to prevail. These circumstances do not occur in every malpractice action because it is quite common for fundamental, factual disputes about what happened, or when certain events happened, that affect adjudication.

However, when there is no dispute about the facts, or about a small but critical subset of those facts, it may be possible for care providers to successfully prove their defense without the need for a jury. If available, this option can be significant as it confirms the lack of liability, cuts off expensive legal fees and costs, and prevents the need for a trial and jury, which are inherently unpredictable. In this case, the defendants successfully proved their actions did not harm the patient, and did so before putting the issues in front of a jury, representing a complete and early victory. ■

REFERENCE

- Decided Aug. 25, 2022, in the Court of Appeals of Georgia, Case Number A22A0960.