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Editor's Corner

AHRMNY's Risk Management Journal (RMJ) is the official journal of The Association for Healthcare Risk Management of New York, Inc. (AHRMNY) and is published several times a year.

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

This journal contains articles on a wide variety of subjects related to risk management, patient safety, insurance, quality improvement, medicine, healthcare law, government regulation, as well as 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.

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Article Requirements: Maximum article length 3,500 words. Photos should be high-resolution JPEGs (at least 300 dpi); AHRMNY will not publish articles promoting products or services.

The information presented in AHRMNY RISK MANAGEMENT JOURNAL is for educational purposes only.

Questions or comments to editors may be sent to ahrmny@gmail.com

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PRESIDENT'S MESSAGE

The Association for Health Care Risk Managers in New York "AHRMNY" is celebrating its forty (40) year anniversary!

Happy 40th ARHMNY!

Looking Back...

AHRMNY began in 1982 and was officially incorporated in 1985, as a Not-for-Profit Corporation, under the name, "Association of Hospital Risk Management of New York, Inc." The association changed its name to "The Association for Healthcare Risk Management of New York, Inc." in the early 1990's, and in 2011 the organization became a 501 (C) (3) charitable organization.

Since its incorporation, AHRMNY has hosted more than 200 educational programs in the New York tri-state area on risk, insurance, legal, governmental, leadership, and related topics. Our highest membership, to date, is 362 members.

Risk issues facing all organizations continue to be significant with healthcare organizations facing unrelating pressures. Organizations dealing with unprecedented challenges in treating a global pandemic which in turn has caused extreme operational pressure. Risk issues remain at the forefront for healthcare organizations, and risk professionals at healthcare organizations continue to be leading the charge in helping organizations remain safe, dependable, and resilient.

Our association continues to provide risk professionals in the New York tri-state area an outlet to learn, network, and contribute their experience and knowledge.

Our educational committee led by Dr. Victor Klein and our publication committee, led by Linda Foy continue to develop high-quality articles, webinars, and our first in-person full-day educational event on June 10th in downtown NYC. Check out this link and register for the event if you haven't already. Click Here to Register

Finally, I just wanted to thank all the board members of AHRMNY for supporting me during my time as President this past year. The association is filled with individuals who are smart, engaging, and successful. I wish Dr. Klein much success as the incoming President and appreciate his friendship.

Rob Marshall

Criminalization of Human Error and a Guilty Verdict: A Travesty of Justice that Threatens Patient Safety

By the Institute for Safe Medication Practices (ISMP)

On March 25, 2022, most of the healthcare community were shocked and dismayed after learning that RaDonda Vaught had been convicted of criminally negligent homicide and gross neglect of an impaired adult following the 2017 death of Charlene Murphey.[1] A full description of the error can be found in our January 17, 2019, newsletter (www.ismp.org/node/1326). RaDonda is a former registered nurse who was fired from Vanderbilt University Medical Center after making a fatal medication error and then stripped of her professional nursing license by the Tennessee Board of Nursing (www.ismp.org/node/26713). During her 3-day trial, RaDonda faced a charge of reckless homicide, but the 12-member jury found her guilty of a lesser charge, negligent homicide. Sentencing will occur on May 13, 2022; until then, RaDonda remains free on bond. According to sentencing guidelines, RaDonda faces 3 to 6 years in prison for felony neglect and 1 to 2 years for negligent homicide.[2]

First and foremost, our heartfelt condolences go out to the Murphey family for their tragic loss. Next, discussions about this case are dominating the healthcare community—from social media to headline-grabbing news reports.[1-7] In addition, several professional and patient safety organizations have issued statements about the negative impact of the criminalization of human error and the guilty verdict, including the:

- American Association of Critical-Care Nurses (www.ismp.org/ext/886)
- American Nurses Association and Tennessee Nurses Association (www.ismp.org/ext/866)
- American Hospital Association and American Organization for Nursing Leadership (www.ismp.org/ext/867)
- Academy of Medical-Surgical Nurses (www.ismp.org/ext/885)
- American Society of Health-System Pharmacists (www.ismp.org/ext/882)
- Institute for Healthcare Improvement (IHI) and IHI Lucian Leape Institute (www.ismp.org/ext/880)
- Outcome Engenuity and The Just Culture Company (www.ismp.org/ext/883)

Leadership at some hospitals and health systems have also issued statements to staff in response to the guilty verdict, reinforcing their commitment to stand with staff in the wake of an error, stressing the importance of transparency and error reporting, and noting their ongoing focus on learning and system redesign, not individual blame. ISMP would be remiss to not share what we perceive to be our most significant disappointments with the inadequate way the trial was handled, the unfairness of the trial and the guilty verdict, and the verdict's negative impact on the healthcare community.

INADEQUATE HANDLING OF THE TRIAL

Lack of evidence about the system failures. It appears that, in deciding to charge RaDonda, the prosecution chose to ignore the fact that the error was a culmination of multiple system failures throughout the medication-use process that contributed to Charlene Murphey's death. During the trial, the defense failed to fully educate the jury about these system failures. Examples include access to a neuromuscular blocking agent via override in an automated dispensing cabinet (ADC) after entering just the first two letters of a drug's name; inability to search simultaneously by brand and generic drug names; unsafe ADC storage of a neuromuscular blocking agent outside of a sealed box or rapid sequence intubation (RSI) kit; allowing medications to be ordered by a brand name, Versed, that has long been discontinued (2003); lack of barcode technology in the radiology unit; disallowing a family member to accompany the patient to radiology; and so many more. Instead, the prosecution singled out the individual nurse closest to the final step of the event, RaDonda, and repeatedly accused her of not following the "five rights," not reading the vial label, disregarding warnings on the vial and ADC, and abandoning the patient after administration of the drug, which the prosecution's nursing "expert" erroneously termed "conscious sedation" because midazolam (Versed) is sometimes used for that purpose, but not in this case.

While RaDonda has never once shirked responsibility for the error, she has often noted that the blame is not hers alone,[4] and ISMP fully agrees with her. But in the trial summation, the prosecution claimed that the event "is not an issue of systematic errors" and even implied that certain conditions, such as the absence of barcode technology in radiology, was not a system failure but merely a need for nurses to rely on the "five rights." There was no discussion (and likely no jury understanding) about the latent failures that allowed this error to happen—only the active failures of one nurse, RaDonda. In the end, the defense failed to educate the jury about the complexity of

healthcare errors so they could make an informed decision regarding RaDonda's conduct. This lack of critical information distorted the jury's image of RaDonda and made her a scapegoat for this tragic error.

Truthful reporting and harsh self-blame used to incriminate RaDonda. RaDonda is the poster child for event reporting, transparency, and disclosure that organizations, through their patient safety-focused transformation, have spent more than 20 years cultivating. Her immediate disclosures were made to the treatment team to help mitigate consequences to the patient. She further contributed her knowledge—sharing both her actions and her mindset—many times with her employer, investigators, and the Tennessee Board of Nursing. The notion that she should take action to protect herself did not occur to her until criminal charges were filed. Unfortunately, it seems that all the prosecution took from RaDonda's transparency was an admission of guilt. Thus, the prosecution introduced into evidence repeatedly that RaDonda admitted to every single misstep she made that led to this event.

Sadly, all practitioners involved in a fatal error hauntingly play back the event in their heads over and over again, asking what they could have done differently to avoid the tragic outcome. They are baffled how they failed to see what they now see in plain sight. So, in hindsight, of course RaDonda might have felt that she should have paid more attention, should have called the pharmacy, should have avoided using the override function to access the medication in the ADC, should have double checked the front of the label to make sure it was the right medication, should have considered it a red flag that the medication needed to be reconstituted, and so on. She also fell on the sword of guilt, remorse, self-doubt, and a wish to make amends, which are all common symptoms of the deeply personal, social, spiritual, and professional crisis experienced by those who make fatal errors (www.ismp.org/node/728). RaDonda is often quoted as saying, "I know the reason this patient is no longer here is because of me." She left no stone unturned and was quite transparent in her harsh self-analysis of every misstep that led to the tragic error. The prosecution did not appear to acknowledge the self-blame and psychological pain RaDonda is still experiencing after making a fatal error.

RaDonda's defense included testimony from only one witness. While the prosecution called 16 witnesses to testify at the trial, the defense called a single witness, a nurse educator who knew and had worked with RaDonda. RaDonda decided not to testify, but the defense showed a 2-hour video of RaDonda being interrogated by the Tennessee Bureau of Investigation (TBI). While awaiting the verdict (www.ismp.org/ext/868), RaDonda explained that she did not want to take the stand and allow the prosecution to demean her again, as the TBI investigators had done while she fully admitted and relived the missteps she took on that day.

However, we do wonder why the defense did not call Further witnesses, perhaps a human factors expert who could explain why RaDonda failed to consciously process the warnings, or perhaps a medication safety officer to testify about the many system issues that contributed to the event and why the "five rights" of medication use are merely broadly stated goals that offer no procedural guidance on how to achieve them, perpetuating the mistaken belief that nurses can be held individually accountable for achieving these goals (www.ismp.org/node/909). To be clear, nurses cannot be held accountable for achieving the "five rights;" they can only be held accountable for following the processes that organizations have designed and upheld as the best way to verify the "five rights." There was also minimal discussion about the concepts of a Just Culture and how reckless conduct differs from our natural tendency to drift into at-risk behavioral choices, which the jury should have been made to understand.

The prosecution misled the jury regarding recklessness. In the opening and closing statements, the prosecution offered an accurate definition of the term recklessness: "To consciously disregard a *substantial and unjustifiable **RISK*** that the alleged victim will be killed; a gross deviation from the standard of care that an ordinary person would exercise *under all the circumstances as viewed from the accused person's standpoint*." Yet, throughout the trial, the prosecution claimed that RaDonda was acting recklessly when she consciously disregarded certain policies, procedures, the usual standard of practice, or a safety protocol, but did **not** establish that she consciously disregarded a *substantial and unjustifiable **RISK*** associated with her choices. Policy, procedure, practice standard, and protocol violations are more often at-risk choices rather than reckless choices, where the **RISK** is not seen or mistakenly believed to be insignificant or justified. Reckless behavior requires the conscious disregard of a perceived significant **RISK**.

The prosecution kept dwelling on the fact that RaDonda was a trained nurse and knew what she was required to do to keep her patients safe. She knew how to read medical orders, safely access medications from an ADC, read vial labels, assess and monitor patients; however, the prosecution repeatedly claimed that RaDonda consciously disregarded all of her training; consciously disregarded the

label, vial, and ADC warnings; consciously disregarded that midazolam should not be reconstituted; made a knowing choice to walk away after administering the drug to the patient; and so on. Although they maliciously attacked her intent, saying that RaDonda "couldn't be bothered to pay attention," they utterly failed to prove that RaDonda consciously disregarded any substantial or unjustifiable RISK associated with her choices.

So did it creep into RaDonda's conscious thoughts that she was taking a substantial and unjustifiable risk with her patient? Likely not. RaDonda's risk monitor—that little voice that knocks on the door of our conscious thoughts and lets us know we may be endangering the lives of those around us—was likely silent as she moved through an otherwise normal day. For example, while RaDonda made a knowing choice to walk away from an otherwise stable patient after administration of what she thought was 1 mg of midazolam, the prosecution failed to prove that RaDonda saw a substantial and unjustifiable **RISK** associated with that choice. Furthermore, the jury was never asked to consider the *circumstances of those choices as viewed from RaDonda's standpoint*, particularly the conversations she had with others about not needing to monitor the patient, as well as the system vulnerabilities that led to her choices. In a Just Culture, RaDonda would have likely been consoled around the human error of administering the wrong drug to the patient and coached around a series of at-risk behaviors.

ISMP understands that the admission of policy violations in healthcare is distressing. It is one thing to publicly disclose that people make mistakes; it is wholly another to disclose that healthcare providers choose to violate rules. Too often, there is no middle ground. Thus, because RaDonda allegedly chose to violate safety policies, regardless of the underlying reason and despite not seeing a substantial **RISK** associated with that choice, she was prosecuted and convicted. But according to the tenets of a Just Culture, she was **NOT** reckless.

The event should have been prevented. In 2016, a full year before RaDonda's fateful error, ISMP published a feature article about errors with neuromuscular blocking agents (www.ismp.org/node/247), encouraging all healthcare organizations to reassess the safety of neuromuscular blocking agents in their facilities and offering many recommendations that likely would have avoided this error. Also in 2016, ISMP released a ***Targeted Medication Safety Best Practice for Hospitals*** that aims to promote safe storage of neuromuscular blocking agents (Best Practice 7, www.ismp.org/node/160). Regrettably, healthcare organizations tend to turn a blind eye to both risky systems and risky choices, believing patients are safe if bad outcomes—meaning harmful or fatal errors—do not happen to them. However, this type of error could happen anywhere given the current system vulnerabilities frequently found in hospitals, particularly when using ADCs. In fact, ISMP has observed many of the same system vulnerabilities in other hospitals, and they are frequently at the root of a variety of medication errors reported to the ***ISMP National Medication Errors Reporting Program*** (ISMP MERP). Make no mistake—this type of error has happened in other hospitals.

Previous to the tragic error that led to Charlene Murphey's death, events involving the inadvertent selection and administration of a neuromuscular blocking agent to an unventilated patient had been reported to ISMP, many of which were linked to practitioners overlooking or not understanding the warnings on the vial cap or ferrule. While the caps and vial ferrules note, **"WARNING: Paralyzing Agent,"** these warnings were not consistently effective and sometimes were unheeded, misunderstood, or missed altogether. In fact, errors that were eerily similar to the event that led to Charlene Murphey's death and RaDonda's prosecution were reported to ISMP before (and since) the event, including incorrectly retrieving vecuronium from an ADC after searching for Versed by entering just the first two letters, VE. It was not disclosed if similar errors had occurred at RaDonda's hospital prior to the event; allegedly, the jury was not permitted to know about any similar errors that had previously occurred at that hospital.[5]

Thankfully, many healthcare providers, including the hospital where RaDonda made the error, have now implemented risk-reduction strategies that will decrease the chance of this type of error from happening again. For example, many hospitals now place red shrink wrap warnings over the vials of neuromuscular blocking agents; they have moved the vials to a secure RSI kit; they require barcode scanning technology prior to medication administration in radiology; they changed the nomenclature by adding "paralyzing agent" before the drug name on electronic prescribing systems, ADCs, and labels; they use special break-away packaging so an extra step is required when accessing the drug; they added midazolam to their high-alert medication list with risk-reduction strategies including monitoring guidelines; and they now place much clearer auxiliary labels on storage bins and/or ADC pockets and drawers that contain neuromuscular blocking agents that state, **"Warning: Causes Respiratory Arrest – Patient Must Be Ventilated."**

In addition to the longstanding warning statements on the cap and ferrule, in 2018 the US Food and Drug Administration (FDA) asked manufacturers to add another warning statement, "**WARNING: Paralyzing Agent**" in red, bold font to the principal display panel on the carton and vial. Manufacturers were also requested to add a warning statement to the side panel in red, bold font: "**WARNING: Paralyzing Agent. Causes Respiratory Arrest. Facilities must be immediately available for artificial respiration**," and to add warnings in the prescribing information about inadvertent administration to patients for whom the drug is not intended. Also, in 2020, at least one ADC vendor made it possible for organizations to require ADC users to enter the first five letters, instead of the first two letters, of a drug name during searches via override (www.ismp.org/node/30932). But these risk-reduction strategies were implemented *after* the event. In this tragic case, Charlene Murphey is dead and RaDonda faces jail time, but the error might never have happened had hospital leadership learned from previously published, similar errors and improved or proactively redesigned their systems.

UNFAIRNESS OF THE TRIAL AND THE GUILTY VERDICT

Offensive attribution of RaDonda's behavior as "driving drunk" and "driving with her eyes closed." The prosecution used an expert witness, a legal nursing consultant with 47 years of experience, to testify that RaDonda had several chances to recognize the error but did not. At one point during her testimony, she likened RaDonda's behavior to someone who is driving drunk, perhaps not intending to kill someone but recklessly proceeding. This testimony was from a paid nursing "expert" who had never heard the term, Just Culture, in practice, knew little about the system-based causes of errors that ISMP and others have been publishing for decades, and was unaware of the investigative report from the Centers for Medicare and Medicaid Services (CMS) (www.ismp.org/ext/881) that initially drew attention to this event after an anonymous tip.

To make matters worse, the prosecution then added that RaDonda's actions were worse than "driving drunk" and more like "driving with her eyes closed." Nothing could be further from the truth! Drunk drivers and drivers who close

their eyes are making a conscious choice to disregard a substantial and unjustifiable risk of causing a harmful accident. While they might not intend to cause a harmful accident, they recklessly proceed knowing that their actions will likely result in a harmful consequence. They knowingly cause, although do not intend, the harm by driving drunk or driving with their eyes closed, which is a highly culpable and reckless behavioral choice. But in all of RaDonda's behavioral decisions on the day of the error, she likely did NOT see the risk she was taking, or mistakenly believed the risk was insignificant or justified. For example, she knew that using the override function to access medications in the ADC was allowed and used every day by nurses in her facility. Charlene Murphey had received almost two dozen medications via override from various nurses in the days prior to her death. It is highly unlikely that RaDonda (or any other nurse) perceived a significant or unjustifiable risk with obtaining medications via override. None of RaDonda's behavioral choices that day rose to the culpability level of knowingly harming her patient, so the characterization of her behavior as "driving drunk" or "driving with her eyes closed" is offensive and wrong.

Prosecution's mocking contempt for RaDonda. While ISMP knows that it is the prosecution's job to portray RaDonda as "the bad guy," the ugly words used by the prosecution to describe RaDonda's character as a person and as a nurse were disgraceful. As healthcare practitioners, it was disturbing and frustrating to listen to the demeaning, mocking contempt in the prosecutors' voices when they talked about RaDonda, which honestly felt like a slap in the face for the profession of nursing and for those working in the field of medication safety:

- "The patient is dead because RaDonda Vaught couldn't bother to pay attention to what she was doing."
- "She was driving with her eyes closed."
- "She doesn't care."
- "She disregarded all of her training and stuck that needle into Charlene Murphey's neck and killed her."
- "Charlene Murphey was a disposable person to RaDonda Vaught, who didn't care about her."
- "Nothing…would have stopped RaDonda Vaught from killing Charlene Murphey with the vecuronium bromide."
- "Her actions are unconscionable."
- "She chose to disregard common sense."
- "She ignored her duty."
- "This is not the conduct of a competent, reasonable, prudent nurse."

Additionally, the prosecutors repeatedly mocked RaDonda's honest and factual responses to prior investigative questions about the event. To cite several examples, they mocked RaDonda for not knowing to look on the patient's medication administration record for the generic name of

Versed, midazolam; and for concluding that the powder in the vecuronium vial was due to an alternative product being purchased for Versed, possibly caused by a drug shortage due to the long-lasting effects of Hurricane Maria in Puerto Rico in 2017. The prosecution mockingly said that it was "ridiculous" to think that drug shortages could be related to medication errors, even though the link between drug shortages and errors has been known for many years (www.ismp.org/node/316).

Prosecution outcome bias. In a Just Culture, the outcome or severity of an event should never determine or influence the response to individuals involved in the event. The problem with allowing the outcome to determine the course of action is that one can potentially overreact to a singular harmful event and mete out unwarranted disciplinary sanctions, as in RaDonda's case, or one can underreact to a potentially fatal system flaw simply because, by luck, it did not harm a patient. In this case, the prosecution's outcome bias led directly to the criminal charges. If the very same event had happened but had not resulted in a patient's death, it would not have resulted in criminal charges.

Recklessness of the prosecution. Throughout the trial, the prosecution focused exclusively on the missteps of one nurse, RaDonda, during the drug administration and monitoring phases of medication use, and claimed she had violated all of the safeguards for protecting patients' lives that she had learned in nursing school, thus recklessly killing Charlene Murphey. But it seems that **RaDonda was NOT reckless**—she was human, making a human error when selecting and administering the wrong drug, and making choices that turned out to be risky (at-risk behaviors) but at the time were thought to be prudent and made in good faith. On the other hand, it seems that the **prosecution WAS reckless** by bringing criminal charges against RaDonda and for their conscious disregard of the risks associated with not considering the well-known systemic causes of this medication error that were embedded in the design of systems and processes.

Even the defense failed to fully educate the jury about human fallibility, confirmation bias, inattentional blindness, alert fatigue, the normalization of ADC overrides, and why it is human to make risky choices that, at the time, seem sensible (at-risk behaviors), which would have explained some of RaDonda's exceedingly human behavior. In fact, the entire trial underscores a disappointing failure and a troubling missed opportunity to educate the jury, the public, and skeptical providers who feel this error could never happen to them, about medication safety, how medication errors occur, and how to prevent medication errors.

Negative impact on transparency, reporting, and patient safety. While our legal system allows for the criminalization of human error even in the absence of any intent to cause harm (www.ismp.org/node/30896), ISMP, along with other professional and patient safety organizations, believe the criminal charges and the guilty verdict against RaDonda set a dangerous precedent and have worrisome implications for safety, particularly for one of the key pillars of a culture of safety—reporting of medical errors. The guilty verdict will likely inhibit error reporting, undermine the creation of a culture of safety, accelerate the exodus of practitioners from clinical practice, exacerbate the shortage of healthcare providers, perpetuate the myth that perfect performance is achievable, and impede system improvements.

Of course, a small portion of nurses may assume they would never make the same mistake as RaDonda, usually because they do not realize they could.[4] But most nurses are terrified of making an inevitable human error that could tragically harm a patient and lead to their prosecution. They know this type of error could happen any day, no matter how careful they are. They think, *I could be RaDonda; something like this could happen to me*. Adding the risk of criminal prosecution for errors to the risks that nurses face every day when caring for patients (e.g., personal injury from violent patients and visitors, infecting themselves and subsequently their families with viruses) makes nursing, already one of the most dangerous professions in our country, even more fraught with risk and stress.[3]

Furthermore, by instilling the fear of severe penalties if their errors are discovered, cover-ups are sure to follow in an era when more transparency is needed. Improvements in safety by analyzing errors and making systemic changes to prevent their recurrence will not happen if practitioners think they could go to prison for factually disclosing errors and describing the workarounds that set them up to make errors.[6] For example, if an error happens when retrieving a medication via override but does not harm a patient, why would it ever be reported if the practitioner could be charged with a crime and it can easily be hidden? Even if errors are reported, effective event investigation and learning cannot occur in a culture of fear or blame, especially if the organization or licensing body is counting the frequency of individual errors (e.g., "three strikes and you are out").

Although the prosecution insisted that the trial and verdict were not a condemnation of the entire nursing community but rather just one individual woman,[7] a lot of nurses, as well as other healthcare practitioners, see it differently. Nurses and other healthcare practitioners are already at their breaking point after 2 years of caring for coronavirus disease 2019 (COVID-19) patients under extreme conditions. If healthcare practitioners now think that society, the community, and the judicial system hold them to a standard of perfection, why would they want to work in healthcare? Additionally, if they are already burdened by short-staffing, difficult patients, confusing and ever-changing technology, and complex tasks, an ongoing fear of prosecution may divert their attention even further from critical tasks and force them to focus instead on their own risk for criminal liability.[3]

CONCLUSION

ISMP pleads with those involved in prosecuting and sentencing RaDonda to reconsider their course and take actions that will be just and improve, not diminish, medication and patient safety. Likewise, ISMP implores organizations that use neuromuscular blocking agents to address all the system issues in this case, so the error is not repeated. Please refer to our 2016 article about reassessing neuromuscular blocker safety in your facility (www.ismp.org/node/247) as well as our 2019 article specific to this event (www.ismp.org/node/1326) for recommended strategies. Otherwise, the death of Charlene Murphey and the guilty verdict against RaDonda Vaught are just a heartbreaking commentary on healthcare's inability to truly learn from mistakes so they are not destined to repeat. Furthermore, ISMP encourages practitioners to continue to report medication errors, factually and completely, to their internal organization, to ISMP (www.ismp.org/MERP), and/or to a patient safety organization (PSO) to facilitate learning about the causes and prevention of medication errors.

SUPPORT FOR RADONDA

Chaunie Brusie, a nurse writer, and *Nurse.org*, a non-profit organization that publishes content and initiatives for nurses and nursing students, have compiled a list of ways to support RaDonda,[5] including the following:

- **Sign a Change.org petition** https://chng.it/wwVbTdRnn2) to grant RaDonda clemency (nearly 200,000 signatures so far)
- **Write a letter to the Tennessee Governor Bill Lee** (address: Bill Lee, Tennessee Governor, State Capitol, 1st Floor, 600 Dr. Martin Luther King Jr. Blvd., Nashville, TN 37243)
- **Write a letter to Judge Jennifer L. Smith** of the Davidson County Criminal Court Division IV (address: Judge Jennifer L. Smith, P.O. Box 128, Bethpage, TN 37033); include RaDonda Vaught's Case Number (2019-A-76); explain what your job is and how this verdict impacts you
- **Attend the sentencing hearing** to support RaDonda on May 13, 2022, at 9:00 am at The Justice A.A. Birch Building, Courtroom 6D (must go through security), 408 2nd Avenue North, Nashville, TN 37122

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Editor's Note:

Following publication of the above article Davidson County criminal court Judge Jennifer Smith granted Vaught a judicial diversion on May 13th, which means her conviction will be expunged if she completes a three-year probation. Smith said the Murphey family suffered a "terrible loss" and "nothing that happens here today can ease that loss. "Miss Vaught is well aware of the seriousness of the offense," Smith said. "She credibly expressed remorse in this courtroom."

The judge noted that Vaught had no criminal record, has been removed from the health care setting, and will never practice nursing again. The judge also said, "This was a terrible, terrible mistake and there have been consequences to the defendant."



ASHRM American Society for Health Care Risk Management HRM WEEK JUNE 20-24, 2022

Join the American Society for Health Care Risk Management in celebrating HRM Week, June 20-24, 2022. This annual event, held in the third week of June, is the time to show your appreciation for health care risk management professionals in your organization and your community. Visit ASHRM.ORG for more details and resources

Workers' Compensation Implications of Telecommuting

By Ruth B. Kraft, Mamie Stathatos-Fulgieri, and Angela Bonica

The Covid-19 pandemic altered the landscape for so many and accelerated the practice of remote work raising new questions with respect to the consequences of working from home in the context of workers' compensation and other employer liability issues. On March 28, 2020, by executive order, New York businesses were required to reduce their in-person work force by 100 percent save for essential services.[1] Since that time, employees have continued to work from home in epic proportions. Accordingly, what can be called the "new normal" in business operations has increased the propensity for injuries arising in work scenarios outside business premises, raising new and interesting questions on the legal and management levels. What commenced as temporary, emergency measures have developed into potentially enduring changes in the structure and location of employment. This alteration of the work environment may prove particularly problematic because the non-traditional setting may not be appropriately suited to work over the long term. Therefore, the potential for accidents on a much higher scale than heretofore imagined must be evaluated by employers as part of their risk assessment and management protocols.

Background of the New York State Workers' Compensation Law

New York State can trace its workers' compensation system back to the time of the Triangle Shirtwaist Fire in New York City in which 146 people died. It was the greatest workplace disaster in New York prior to the World Trade Center attacks. In March 1911, one day prior to the devastating fire, the New York Court of Appeals had declared New York's compulsory workers' compensation law unconstitutional. Absent a workers' compensation structure, family members and dependents were required to seek redress in the courts to force Triangle to compensate the injured and the families of the deceased. The owners were tried and acquitted of manslaughter. As a consequence, massive reforms in safety, health and labor laws were implemented in such a way as to withstand constitutional challenges.

New York's law is "no-fault" in nature such that an employer is prohibited from raising objections that the worker had assumed the risks of employment, was partially or wholly culpable in causing or aggravating his own injury or that the injury was caused by the negligence of a co-worker.

The workers' compensation statute is premised on compensation for injuries and illnesses arising out of and in the course of covered employment.[2] Injuries sustained outside the workplace would not generally be compensable. However, when a worker engages in a specific assignment for the benefit of the employer or works at home as part of a pattern and practice, the home then may be considered to be a place of employment.[3]

The home office exception to the principle that covered employment should take place at business premises has permitted coverage under certain circumstances, although such claims have always been scrutinized narrowly for obvious reasons. Often, this limitation arose from the question of whether an employee had elected to work from home for his own convenience.[4]

A crucial determinant when employees work from home is how to differentiate personal from business endeavors, particularly given a lack of active supervision or oversight outside the conventional workplace.

Legal Precedent

It is axiomatic that a commute between one's residence and the workplace is not covered by the workers' compensation statute as a general principle; a corollary to this concept is that work commences upon arrival at the workplace. However, the case law demonstrates exceptions to the rule. For example, when an employee was driving home from his regular placement of employment but had been permitted to work from home with the knowledge and consent of the employer, a death from myocardial infarction during the commute was deemed to have been within the scope of employment by New York's highest court.[5] The Court noted therein that an employee's home could achieve the status of a workplace under circumstances in which the employee either performs a specific work assignment for the employer's benefit or if a regular pattern of work at home exists.

However, in a later case, the Appellate Division concluded that an employee struck by a car while stopping to purchase a pen for work was ineligible.[6] Noting that it had then become routine for professional and managerial employees to take work home, the Court articulated a series of criteria:

- The quality of the work performed at home;
- The regularity of that work;
- The ongoing presence of work equipment in the home; and
- The specific circumstances of employment making it necessary, not convenient, for the employee to work at home.

More recently, the Appellate Division has supported a ruling by the Workers' Compensation Board that a death did not arise in the scope of employment despite the presence of work equipment in the home when telecommuting had occurred only three days per month and the employer's specific preference was for on-site work. The facts therein disclosed that the deceased had worked from home one day prior to her demise for personal and not business reasons.[7]

Thereafter, the Workers' Compensation Board disallowed a claim made by an employee who sustained an injury when he slipped on ice while going from his home office, above his garage, into his kitchen to prepare a cup of tea. The home office contained a computer purchased by the employer which was routinely brought home by the claimant. Furthermore, the employer had purchased a monitor and docking station for home use. It expected employees to work on-site but it was routine practice for employees to work from home in the evenings. The claim was disallowed on the basis that the employee did not work from home routinely and did so only once each month.[8] Similarly, in a claim in which an employee was working while preparing dinner for her family, during which she dropped a can, fracturing several toes, the Board denied the claim.[9]

Even more instructive was the Board's decision in a case in which a claimant was injured while assembling furniture purchased at his own expense in an authorized home office during working hours. Although the Board recognized that injuries occurring while an employee is performing his regular work duties would be compensable, it opined that actions arising from personal activities outside the scope of employment are not. This would include activities during breaks, lunch periods, or restroom use. As furniture installation was not an element of claimant's job description as an insurance claims adjuster, the injury was insufficiently related to his work duties.[10] Therefore, the Board distinguished the case from another in which a customer service[11] employee working from home tripped over a bag adjacent to her desk when the purpose of rising from her chair was to remove food from her oven, deeming that activity a momentary and reasonable deviation, which arose out of and in the course of employment.

The Current Work Environment

The case law typically addresses limited work from home scenarios. However, in the post-Covid environment, a different rubric has emerged, specifically, one in which an employee may operate from home entirely or for the overwhelming majority of his work week. In that scenario, new issues become evident:

- The ergonomics of the home work environment;
- Differentiating between work and break periods;
- The obligations of the employer to provide equipment including chairs, desks, and assistive aids; and
- The propensity for repetitive stress injuries arising out of inadequate or inappropriate conditions in the home.

It is widely believed that an uptick in back, shoulder and neck injuries has occurred based on employees working remotely on their couches, at kitchen tables, and other non-traditional environments. Questions arise as to whether an employer, having authorized work from home, has rendered the home office or other home work site subject to the requirements of the Occupational Safety and Health Administration agency (OSHA) with respect to workplace safety. OSHA applies not only to the foregoing criteria but, with equal force, to safety issues arising from deleterious environmental and other conditions.

In a non-ergonomic work location, the need to alleviate eye strain would be present, raising question as to whether an employee who takes a break to rest her eyes is engaged in work activities, rendering activities during that time compensable in the event of injury, or is engaged in a sojourn. This becomes highly problematic for workers such as data entry operators, information management, customer-focused jobs, technical support, human resources, and comparable positions.

Benefits of Telecommuting

Telecommuting offers benefits to both employees and employers including the potential for increased productivity, deceased workforce turnover, decreased absenteeism, a broader labor pool, improved morale, increased flexibility in work schedules, and reduced rental expense. Additionally, telecommuting provides a return-to-work strategy for injured employees, mitigating workers' compensation costs to the employer.

Risk Mitigation

For an employer to achieve the potential benefits of telecommuting and mitigate against its workers' compensation risks, it must address practical, technical and legal issues, establishing guidelines surrounding the terms of employment operations and put policies in place to mitigate against risk. Telecommuting involves a relationship of trust and reduction of hierarchical control between management and employees; a successful remote work protocol necessitates planning and effective communication. However, telecommuting requires consideration of safety issues. While arguably burdensome, an employer may inspect the home offices of remote workers to ensure compliance with the safety requirements it may and should establish.

This would evaluate factors including:

- Computer monitor setup;
- Smoke and carbon monoxide detections;
- Fire extinguishers;
- Adequacy of extension cords and grounded electrical system;
- Furniture and equipment fulfilling ergonomic specifications;
- Portable heating equipment;
- "Tripping factors" and cleanliness of the home office.

Additional factors of importance to employers, although beyond the scope of the workers' compensation statute, would include computer and information security measures as well as confidentiality and privacy concerns. An effective employer policy should also take into account matters typically contained in an employee policy manual, such as limitations on visitors to the home office.

To mitigate against risk, employers should provide training to assist remote workers in setting up and maintaining safe work environments.

Expectations Moving Forward

Although OSHA has not yet published a policy regarding work at home employees, it is reported to be developing draft guidelines for telecommuting safety which are anticipated to include an articulation of employer responsibility for employees in both traditional and non-traditional work settings. The lines of demarcation between covered and non-covered injuries remains amorphous and the specific circumstances of each claim will determine coverage.

Employers should establish control measures including guidelines to be used in evaluating whether an injury is work related. Employers may require a separate or designated office area; conversely, they may be obligated to provide appropriate equipment and furniture in compliance with ergonomic standards to reduce the risk of repetitive stress injuries as well as to delineate proposed work schedules including breaks. Education of employees and recommendations for optimal positioning of the body and equipment would represent appropriate risk mitigation measures. Additionally, employers may consider a "remote work contract" to address these measures and articulate its standards.

Conclusion

Notwithstanding proactive steps undertaken by an employer to mitigate against the workers' compensation exposure engendered by remote work, some degree of risk is inherent in any employment scenario. Well-constructed policies and effectively communicated expectations are essential tools for risk mitigation which, additionally, lay a foundation for safe and productive work environments benefiting both employers and employees.

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About the Authors





Hon. Ruth Bogatyrow Kraft, Mamie Stathatos-Fulgieri, Esq. are partners of Vigorito, Barker, Patterson, Nichols & Porter, LLP. Angela Bonica is an associate of the firm. Ruth is the chair of the firm's employment law practice and Mamie is the chair of the compliance practice.

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The Omnipresent Eye – An Analysis of the Connecticut "Granny Cam" Law

By Mario Giannettino and Megan Bryson

An Analysis of Connecticut's Virtual Monitoring Statute

Connecticut is one of a handful of states permitting the use of remote monitoring in long term care and assisted living centers. While the use of such technologies has grown over the years, the visitation lockout due to the coronavirus pandemic thrust remote technology to the forefront of the Connecticut State Legislature. This article aims to use the Connecticut law as the lens in which to view the larger risk management enterprise picture presented by remote monitoring.

The Connecticut Statute

Unlike the concealed or hidden "granny cam", Connecticut allows for open camera use. In brief, the Connecticut law (SB-975) permits residents to have cameras installed to monitor activities in their rooms or facilitate virtual visits. Each resident must pay for installation and costs associated with the technology. Facilities are required to provide free internet access, electricity and a power source, but they have civil, criminal and administrative immunity from liability for residents' use of the technology. Additionally, the Connecticut law seeks to streamline the form of consent in that it allows the Long-Term Care Ombudsman to develop and provide standard consent and notification forms for use of remote monitoring technology.

However, this brings us to the first obstacle. Even with a consent form on file, a more elemental problem for facilities remains. Specifically, what proof should be required to permit consent to recording? If the resident is competent the answer is simple: the resident decides as competency is presumed. However, what happens when the resident is incompetent and a resident representative is in place? Connecticut broadly defines a "resident representative" as:

- A person who is the resident's legally appointed health care representative, guardian or conservator;
- Designee, as indicated in a signed written document in the resident's facility records; or
- Legally liable relative or other responsibility party who is not a facility employee or contractor.

This broad definition leaves potential gaps. Specifically, financial and medical powers of attorneys do not expressly cover the ability to consent to being recorded. Moreover, a Court is unlikely to hold that the decision to record is a healthcare decision. The consent question becomes even murkier in situations where there is no designated Power of Attorney, Health Care Proxy, agent, or when family members may disagree on what is in the resident's best interests.

Favorably, the Connecticut legislation squarely places the control of the technology, including costs of purchasing and facilitating, with the user. While these costs will be easy to determine, the unintended "cost" of employee morale is not so clear. A nurse or aide that knows they are being monitored may feel that their professionalism and dedication are being undermined if they know a camera is watching them perform their duties. Staff may be more reluctant to accept a particular resident assignment if they know they are under a microscope. This could impact staff's willingness to interact with the families or share information if they feel that they are unfairly being monitored.

The foregoing point is a critical one. In states like Connecticut where a statute or regulation on remote monitoring exists, providers must invest in training and education to staff. They may wish to implement a written policy to comply with existing laws. A written policy may serve as the "ground rules" for everyone to follow and promote transparency as to a facility's practices. Of course, a policy needs acceptance by staff and must be promoted in such a way as to eliminate any punitive elements that staff are being somehow punished by the adoption of cameras.

The Connecticut law requires facilities to place conspicuous notices in certain areas that virtual monitoring or virtual visitation technology may be in use. Again, though, facilities may find that more is needed. For example, the use of cameras in resident's rooms may be necessary to include in admission agreements, employment handbooks and union contracts in order to show a facility's adoption of and compliance with the law.

"Granny Cam" Law

Critics of cameras having long questioned their utility, mainly citing privacy concerns. In skilled nursing facilities, where congregate living situations are the norm, privacy issues are all the more apparent. The Connecticut law sought to assuage these concerns by requiring the resident or the resident's representative to provide advanced notice to the roommate or the roommate's representative, specifying the type and location of the technology, the intended use and hours of operation, and whether the device can record audio or video or be activated remotely. Consent may be withdrawn. Upon any such withdrawal, the use of virtual monitoring and/or virtual visitation technology must cease pending further consent. If consent is refused and/or withdrawn, the facility must work with the resident to provide alternative accommodations, which may include transfer of the resident seeking to use the technology to a room with a roommate who will consent to its use. Such an accommodation, however, need only be made if an appropriate room is available and the resident is able to pay any price difference as between the rooms (if and as applicable). Room transfers, though are seldom as streamlined as the Connecticut Legislature envisions. The statute is also silent as to the time frame, if any, upon which consent must be received. Thus, there can be scenarios where a resident is waiting for consent from a roommate, and for reasons beyond anyone's control, may not be forthcoming in a prompt fashion.

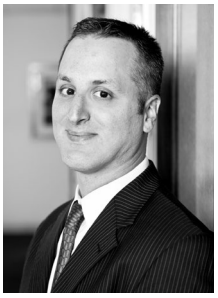
The scope and breadth of the Connecticut law aims to provide clarity as to the permitted uses and prohibitions of remote monitoring devices. Even with specifications regarding use in place, the admissibility of remote monitoring footage in legal proceedings is uncertain. State survey agencies, litigants and credentialing bodies may all have an interest in the products of remote monitoring footage, but state evidentiary rules and case law differ and will impact admissibility. Unlike security footage of a common area such as the nurse's station, which is typically maintained and kept in the ordinary course of business and controlled at the facility level, remote monitoring devices are controlled at the user end. Therefore, authenticity of the footage becomes a substantial concern, including whether it has been altered in any fashion or edited by the end-user.

Conceivably, if a facility had an interest in metadata of footage, there may be issues concerning obtaining proprietary information from the product manufacturer, including access to potential proprietary information.

The final issue is that of usability. Remote monitoring is intended to give the end-user a window into the resident's day-to-day. However, what the user does with that information is paramount. Elderly patients can have multiple interacting comorbidities that fluctuate. Using remote technology as a snapshot of health status through intermittent monitoring may be challenging as it does not account for contextual health information that is typically accessible through the chart or direct dialogue with medical staff. Thus, any insight to be gained from remote monitoring must be integrated alongside actual clinical information to provide a more realistic and holistic picture.

The whole purpose of remote monitoring is to allow families to stay involved with and monitor resident care when they are not physically present in the building. The use of such technologies will only grow. We need to take the opportunity now to apply such measures in a way that enhances the entire resident picture and promote resident health, safety and family engagement with health care providers.

About the Authors



Mario Giannettino is a Partner of Kaufman Borgeest Ryan. He is CPHRM certified through the American Hospital Association. Both Ms. Bryson and Mr. Giannettino specialize in medical malpractice and long-term care litigation. Each are licensed to practice law in and are residents of the State of Connecticut.



Megan Bryson is a Senior Litigation Counsel in Kaufman Borgeest & Ryan, LLP's Stamford, Connecticut Office. Ms. Bryson has regularly been selected as a "Connecticut Rising Star" and was recently recognized by *Best Lawyers in America: Ones to Watch* (2021-2022 edition).

MEMBER SPOTLIGHT

Join us in congratulating the following AHRMNY members for volunteering to share their achievements featured in this edition's MEMBER Spotlight

Pamela Monastero, MBA, CPHRM - NYU Langone Hospital-Brooklyn



Pamela Monastero, a long-term member of the AHRMNY Publications Committee, has advised us that she needs to step down from the board and her committees at this time. The Publications Committee would like to take this opportunity to thank Pamela for all she has done for us and the organization and share a little bit about her accomplishments with you, hoping to inspire other members to follow in her footsteps!

Pamela has over twenty-five years of experience in patient safety and risk/quality management. She has worked at what was formerly known as Beekman Downtown Hospital, New York Methodist Hospital, Physicians' Reciprocal insurers, Coney Island Hospital (part of the New York City Health + Hospitals), and now works at NYU Langone Hospital-Brooklyn. Her current responsibilities include coordination of the Patient Safety/Risk Management Department at the Brooklyn site, including investigation and development of comprehensive systematic analyses, review of incident reports and near-miss reporting, and development of educational programs for patient safety/risk management. In 2011 and 2012, she assisted in coordinating the evacuation of patients for Hurricane Irene and Super Storm Sandy. In 2015, Ms. Monastero received the Patient Safety Champion award from New York City Health + Hospitals for the development and implementation of the close call reporting system.

Ms. Monastero is a former President and Treasurer of the Board of The Association for Healthcare Risk Management of New York, Inc. (AHRMNY). She has served on the Board of AHRMNY since 1999 and has been a member since 1993. Over the years, Ms. Monastero has served on several AHRMNY Board Committee, assisting with education, nominations, and public relations. She is an active member of the Publications Committee and authors the "Risky Business" column for the Risk Management Journal on topics of relevance to risk, quality, and patient safety managers. She also served on the Legislative & Advocacy Committee of ASHRM. In 2014-15 Ms. Monastero completed a fellowship in change management with America's Essential Hospitals. She is bronze-level trained in LEAN methodology. She also holds an BBA and MBA degrees from Pace University.

Rosemary Swedenburg-Murphy, MPA, BSN, RN, LNC, CPHRM - Catholic Health



Rosemary Swedenburg-Murphy, is the Clinical Risk Manager for the Continuing Care Division of Catholic Health and Catholic Health Physician Partners. The Continuing Care Division includes three skilled nursing facilities, Catholic Home Care and Good Shepherd Hospice, inpatient and home hospice. Catholic Health Physician Partners includes over 100 physician practices across Long Island. Rosemary, along with staff from the six Catholic Health Hospitals, facilitated the development of a Pressure Injury Prevention Program which has impacted the delivery of patient care and safety and enhanced patient experience. In April 2022, Rosemary obtained the Certified Professional in Healthcare Risk Management Designation.

Linda Foy, CPHRM - Catholic Health



Linda Foy, Vice President, Risk Management and Insurance, presented with Marcos Iglesias, MD, Chief Medical Director of Travelers Insurance Company at the April RIMS Risk World 2022 held in San Francisco. The topic was “Beyond Physical: Improving Recovery for Injured Employees Requires a Holistic Approach”. The speakers examined the impact of psychosocial barriers and mitigation strategies which impact returning injured workers to the workplace.

Appellate Division Clarifies Burden on Quality Assurance Privilege for Non-Party Statements

By Christopher Simone and Lena Holubnyczyj

Introduction

On December 22, 2021, the Appellate Division, Second Department decided Siegel v. Snyder (2021 N.Y. Slip Op. 07264), which impacts discovery of recorded statements made at quality assurance meetings. The appeal focused on the scope of the quality assurance privilege and the corresponding "party-statement exception" to that privilege. The court held that a hospital defendant has the burden of demonstrating that a statement claimed to be privileged made at a quality assurance meeting derived from a person who is not a party to the action.

The Party-Statement Exception

Public Health Law ("PHL") § 2805-m(2) and Education Law § 6527(3) shield from disclosure, under CPLR Article 31, the proceedings and records relating to performance of the quality assurance review function as well as any statement of any person attending such a meeting. But both allow for the discovery of "party statements", which, in this context, are statements made by any person attending the quality assurance meeting who is a defendant in the medical malpractice action about which the subject treatment is discussed. Under this exception, the statement made by the defendant is not privileged and thus must be disclosed upon demand in the underlying action.

The Siegel Case

Critical to the discovery of recorded statements, Siegel held that it is the hospital's burden in asserting the privilege to identify "who said what at the meeting." Therefore, if the minutes of the meeting do not identify the speaker, the hospital is in no position to confirm that the speaker is not a party to the underlying action. Under those circumstances, therefore, the hospital cannot meet its burden in showing that the quality assurance privilege should apply to the statements it aims to withhold.

After Siegel's death at defendant South Nassau Communities Hospital ("SNCH") from a head injury, defendants Trauma Medical Director Dr. Kenneth Becker and Assistant Director of the Emergency Department Dr. Mathew Lurin attended a Trauma Peer Review Committee meeting. The minutes of the meeting contained statements attributed to the "committee" along with one statement attributed to the "Trauma Medical Director", i.e. Dr. Becker.

In response to plaintiff's demand for quality assurance records, SNCH moved for a protective order asserting privilege under PHL § 2805-m and Education Law § 6527(3). SNCH sought to limit discovery to only those portions of the minutes that constituted statements made by the individually named defendants. SNCH submitted to the court proposed redactions of the meeting minutes and sought a determination that the party-statement exception applied only to a notation that the two defendant physicians were present at the meeting and a single statement made by Dr. Becker. As the other statements in the meeting minutes were attributed to the "committee", they were not subject to disclosure, SNCH asserted, because they fell outside the party-statement exception.

After an in-camera review, the court denied SNCH's motion. The court found itself unable to identify who provided specific comments at the meeting when the "statements and/or information contained in the minutes [were] attributed to the committee" and, as a consequence, what statements were indeed privileged. Thus, the court ordered disclosure of the statements attributed to the "committee" as party-statements.

"To avoid disclosure beyond party statements, all quality assurance meeting minutes should identify, by full name and professional title, each person making a statement at such a meeting."

In upholding the disclosure, the Appellate Division reasoned that, by falling to properly identify each speaker, SNCH in turn failed to establish its entitlement to the quality assurance privilege. Put another way, since the speakers were not identified, the hospital necessarily could not show that it was rightfully withholding statements made by nonparties to the underlying action.

Accounting for Siegel Going Forward

Critically, under Siegel, any recorded statements attributed only to the "committee", or presumably, to an unidentified speaker, made during a quality assurance meeting would not be entitled to the quality-assurance privilege afforded by Education Law § 6527(3) and PHL § 2805-m(2). Accordingly, to avoid disclosure beyond party statements, all quality assurance meeting minutes should identify, by full name and

professional title, each person making a statement at such a meeting. This will ensure that, upon a motion for a protective order in response to a discovery demand, the hospital can satisfy its burden of establishing that certain statements are subject to the quality assurance privilege. By identifying the speakers in the meeting minutes, the hospital can affirmatively prove to the reviewing court that certain statements were indeed made by nonparties to the underlying medical malpractice action. Upon such a showing, those statements should be deemed privileged and not subject to disclosure because they are not "party statements".





Christopher Simone is a Senior Partner and Chair of, and Lena Holubnyczyj is Of Counsel to, Shaub, Ahmuty, Citrin & Spratt, LLP's Litigation/ Appellate Strategy & Advocacy Group.

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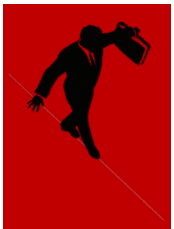
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R I S K Y B U S I N E S S

Staffing For "What If" Scenarios

By Pamela Monastero, MBA, CPHRM

WHEN COMMON SENSE IS UNCOMMON

This Risky Business column is inspired by an article about amusement/theme park safety and the far reaching impact that the Covid-19 pandemic has had on staffing and safety. Having recently returned to New York from the theme parks in Orlando, Florida, I was struck by the attention-grabbing headline "After Disney World Guest Dies, Firefighters Explain Why They Feel Park Visitors Could Be 'In Danger" Over the Holidays.[1]" The piece, which also cites a December 19, 2021 Orlando Sentinel article, is based on the emergency responder union, that represents both local firefighters and paramedics, response to staff layoffs at the theme parks as a result of the Covid-19 pandemic. The article points to a recent emergency response to a fire at Disney World's Main Street USA, as well as an event at a nearby resort, where a guest died following a cardiac arrest. The article claims that it took 13 minutes for the first medic to arrive at the resort, and 20 minutes to commence treatment of the guest. A communications director for the theme park's firefighters and paramedics union stated that short staffing of first responders causes safety issues and that "if more first responders had been on call, the (resort) guest's chance of survival would have been better." The article further notes that the park's reopening led to gaps in coverage and that "they're not worried about staffing for the 'what if' calls….but that's exactly what we're here for. We are here for those 'what if' situations, those truly traumatic incidents, and so to not staff with that in mind seems kind of foolish."

The Orlando "what if" staffing article inspired thought about how we traditionally staff our hospitals and long term care facilities, which is usually based on current census or historical data (e.g. daily volume in emergency rooms, labor and delivery and procedural suites). When facilities are staffed based on the current patient census or average daily volume, this is known as "what is" staffing, which may not be ideal in those circumstances when there is a mass casualty event or when an influx of admissions occurs during a given shift. In such circumstances, hospital administration and nursing leadership need to juggle staffing to accommodate patient needs and safety, which is extremely challenging.

Therefore, should we, and can we, staff for "what if" vs. "what is?" Even if desired and financially feasible, staffing for "what if" in the pandemic environment is further compounded by human resource logistical challenges as healthcare, and other industries struggle to find staff. Further, given the specialized training of healthcare staff (e.g. physicians, advanced practice providers, nurses, respiratory therapists, nutritionists, social workers, etc.), filling vacancies is even more challenging. A 2014 Nursing Management[2] article explores staffing models, highlighting that we "don't staff for 'what if.'" We would need to omniscient or have a crystal ball to identify the perfect staffing formula in advance to staff for 'what if' and most healthcare organizations staff for 'what is.' Overtime pay, use of per diem staff or agency staff are frequently employed to temporarily fill gaps in staffing but the associated costs can be staggering to healthcare organizations, especially for smaller facilities. How can one predict 'what if' scenarios given unknown variables such as volume, patient acuity and needs? To overstaff would be wasting precious resources and to understaff would pose patient and staff safety concerns. Seven years after this article was published, we continue to struggle for optimal solutions and are likely further from the mark, given the impact of the pandemic. Healthcare organizations do take steps to prepare for "what if" scenarios, e.g. performing emergency management drills to help identify gaps in workflows, highlight needed resources and improve response to potential mass casualty incidents; by instituting per diem and float pools; and by creating back-up call trees to help quickly staff up for "what if" scenario, although it takes time for any back-up staff to arrive at the facility and there may be associated costs with having physicians available on call 24/7. These measures, among others, can limit some of the variables inherent in 'what if' situations, but it is far from perfect.

Another consideration for "what if" staffing is the rate of healthcare worker burnout,[3] making staffing for the 'what is' environment a struggle. "The World Health Organization says it's (worker burnout) was also characterized by greater cynicism and reduced effectiveness at work. It was a huge problem in health care long before the pandemic.

But now the short staffing and the crushing and unpredictable workload is contributing to epidemic levels of burnout." In terms of gauging how much worker burnout affects patient care is very difficult and, while several studies have linked burnout to lower quality of care, these were primarily based on subjective measures (e.g. patient surveys and self-reporting by nurses and doctors). Therefore "drawing a cause-and-effect connection isn't easy." The article highlights the shrinking field of seasoned professionals in medicine, compounded by early retirements and those leaving the field as a result of Covid-19. This is true for non-clinical staff as well, e.g. registrars, housekeepers, etc. "On balance, the pandemic has made all the normal bureaucratic hassles of the medical system that much more grating." The article highlights creative methods implemented by healthcare staff members at various organizations to help address staff burnout and waste and provides examples of small, targeted fixes that can have a huge impact.

It is abundantly clear that we need to continue to be creative in our staffing and in how we do our jobs as we wade through yet the latest Covid-19 mutation—Omicron among others. We can be creative in our efforts to reduce or eliminate small, unnecessary stressors to help with staff burnout, e.g. ensuring that staff have modern and functioning equipment (e.g. electronic devices, fax and copier machines, etc.), simplified and streamlined workflows, up-to-date and easy-to-find on-call schedules and contact information, etc. While "what is" staffing will likely remain challenging for the foreseeable future and a "what if" staffing model seems impractical for the reasons cited, the actions of leadership to engage frontline staff and take action to remove unnecessary stressors is one small but important step in help mitigate staff burnout and stem the loss of our healthcare workers. As someone once told me, we all come to work expecting that there will be toilet paper and soap in the bathroom and, when there is not, this one little thing that no one really ever thinks about, becomes a HUGE issue. The pandemic has proven that the little things we once expected and took for granted are now epic in scope and we need to focus on the small changes we can make to improve our practices.

References on page 32

About the Author



Pamela Monastero is Assistant Director of Patient Safety & Risk Management at NYU Langone Hospital-Brooklyn. She has served on the Board of AHRMNY since 1999 and has been a member since 1993. Pamela is an active member of the AHRMNY Publications Committee and is author of this column, Risky Business which is designed to support both the novice and seasonal risk manager by presenting brief *pearls of wisdom* based on the experiences of our colleagues. The column is based on the contributions of our constituent members, to whom we are grateful for sharing their experiences. We continue to encourage our members to submit their experiences anonymously for inclusion in this column. Please email any suggestions to: Pamela.Monastero@nyumc.org or mail to AHRMNY utilizing the RISKY BUSINESS FORM. The form permits confidentiality.

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Telemedicine, One Step Closer to a National Standard of Care

By Lou Tassan, Robert F. Elliott, Brian E. Lee, and Robert G. Vizza



While the practice of telemedicine had already been growing steadily, recently released medical claim submission data demonstrates that the transition to telemedicine has accelerated exponentially throughout the COVID-19 pandemic which began in January of 2020. For example, FAIR Health, the nation's largest repository of private medical reimbursement claims data, reported telehealth claim submission in the Northeast region grew 15,503% in March 2020 compared to March 2019 (0.07% to 11.07% of total medical claims submitted). The growth in nationwide telehealth claim submission was also staggering with an increase from March 2019 to March 2020 of 4,3467% (0.17% to 7.52% of total medical claim lines). Just as many have found the benefits of work-from-home can outweigh the challenges, so too will many patients avail themselves of the opportunity to remotely consult with health care practitioners.

Novel legal issues will continue to surface as the practice of telemedicine proliferates. Cross-jurisdictional practice garners significant attention since conflicting federal and state laws, rules and regulations, and voluntary protocols have all struggled to keep up with demand and increasing risk and quality issues. Licensing, standard of care, parity of reimbursement, availability of insurance in cross-state practice, cyber and privacy concerns and other issues all have the potential to spawn litigation.

The following is an overview of the present and prospective risks and benefits of telemedicine. For purposes of this article, the terms telemedicine and telehealth will be used interchangeably to describe the delivery of health-related care, services, education, and information via telecommunications technology, which includes videoconferencing, remote monitoring, electronic consults, and wireless communications.

The confluence of wearable monitoring and at-home diagnostic devices, improvements in the speed and quality of image transmission, the increased availability online of the right specialists and the maturation of AI has begun and will continue to reshape the medical profession and all industries involved directly and indirectly in the health care sector.

This undeniable revolution in the field of medicine logically requires a corresponding evolution of the metrics used to assess performance both in terms of value of the service and outcomes. To be clear, the applicable fundamental legal principles remain sound. It is the underlying circumstances which have changed. To put it another way, the game is changing, and the rules certainly require some reinterpretation and adjustment. Inflexible application of pre-existing, static rules and standards to new and emerging technologies and practice models is counterintuitive. Accordingly, for example, allowance should be made for the modification of the in-person standard of care to account for care that is not, in fact, delivered "in person." Refusal to acknowledge and accommodate such changes can only serve to hinder further development and implementation. The benefits of telemedicine, along with the corresponding risks, have been well documented in and through an array of trusted sources including the federal government, private industry and innumerable medical, legal and insurance societies.

The widely acknowledged benefits of telemedicine include the following:

- Access to specialists possessing skills or offering services that might otherwise be out of reach;
- Reduced errors and improved outcomes owing to algorithm-assisted diagnosis based on patient data collection and analytics;
- Continuity of care facilitated by the ability of providers in different locations to access and communicate through a centralized medical record;

- Delivery of state-of-the-art health care to previously under-served regions nationally and worldwide;
- Faster access to health professionals;
- Increased convenience and time savings for patients;
- Ability of patients, even amidst a pandemic, to continue chronic care at home through remote monitoring and oversight for an ever-widening category of medical conditions;
- Full-scale implementation of shared care whereby patients, primary care physicians and specialists enjoy easier and more frequent "direct" communication between providers and their patients;
- Interaction of health care providers with one another and their patients from ICUs, EDs, ORs, temporary triage and care facilities, or while in transit;
- Alternatives to overburdened emergency departments or urgent care centers;
- Reduced risk, and anxiety or perceived risk, of transmission of contagious disease; and,
- Encouraging patients who might be averse to in-person care for any number of reasons including mobility, privacy, or other concerns. For example, telepsychiatry has been a boon to those who could not or would not leave their homes to appear in a therapist's office.

At the same time, the practice of telemedicine presents commonly associated risks. As a practical matter, here are some examples of the limitations of the technology itself:

- Potential for limitations or glitches in technology to result in miscommunication or interruption in treatment;
- Limitations of verbal communication, even when coupled with video, without a physical examination;
- Limited familiarity on the part of the health care provider with local resources in an unlimited number of remote locations where the patient may need in-person or urgent care;
- Likelihood that certain patients, particularly children or adolescents, may end a session by closing the laptop more readily than they would actually walk out of a therapist's office;
- The possibility of undisclosed recording of the visit by a patient, with a chilling effect on candor for both participants; and
- Limitations in the ability to secure the communication of protected health information in accordance with applicable HIPAA and HITECH privacy and security rules.

These limitations present new categories of allegations of professional malpractice, such as the following:

- Potential failure to recognize circumstances requiring prompt termination of a telehealth visit in favor of an in-person exam or emergency treatment;
- Failure to ensure that the patient being examined and obtaining prescriptions is the actual patient, for instance increasing the risk of inappropriate prescription of controlled substances;
- Licensing issues exposing the practitioner to claims of unauthorized practice of medicine in another jurisdiction unless they participate in a shared-credentialing program such as hub-and-spoke hospital network;
- Failure to obtain and/or properly document informed consent to the very nature of telehealth treatment;
- Failure to properly train and update staff on ever changing policies, practices, and protocols applicable to telehealth; and
- Untimely review of patient data shared through a remote device and the expectation that health care practitioners obtain and review all of the available information.

Many of the risks of telemedicine result in higher costs to operate as well as increased costs and complexity in defense of potential personal injury claims from several factors:

- Cybersecurity and shifting the risk of data breach from the technology vendor to the health care providers;
- Increased costs associated with defense counsel organizing and maintaining large data sets derived from multiple sources and devices, storing a variety of file formats (video, audio, text, digital images, film, etc.), and the costs associated with large scale discovery exchange of electronically stored information, and the need for forensic authentication of the data for evidentiary use; and
- Exposure to liability under laws of the state where the patient is located at the time of the telemedicine visit **which may have different procedural and substantive** rules, and markedly different jury verdict potential, compared to the jurisdiction where the practitioner is trained and licensed.

DISCUSSION

The Deceptively Limited Number of Reported Malpractice Claims Involving Telemedicine

To date, there have been comparatively few claims related to telemedicine. According to the Center for Connected Health Policy, "Claims of malpractice liability involving telemedicine have been few and most existing cases have been settled out of court with the final settlements sealed." In fact, a 2019 research letter published by JAMA noted that at that time its investigation revealed no "involved claims of medical malpractice against DTC [direct to consumer] telemedicine services or their health care professionals."[1]

While these findings pre-date the explosive expansion of telemedicine occasioned by the recent coronavirus pandemic, they are nevertheless encouraging. That said, claims have a lag time, and the broader use of telemedicine is a comparatively new phenomenon, so it is reasonable to predict an uptick. Indeed, one health insurance provider reported that 60% of outpatient mental health visits are currently virtual, a proportion that remains even after the easing of the social-distancing lockdown.[2]

Misdiagnosis

The telemedicine malpractice claims which have been identified tend to involve allegations of misdiagnosis and/or improper prescription of medications across state lines. As always, clinicians should be guided by their best judgment and promptly inform patients in the event it is determined that adequate evaluation requires an in-person rather than telehealth visit. Terminating a telemedicine visit by promptly and clearly explaining why it is necessary to seek in-person care may prevent a dangerous delay in care which could otherwise lead to a claim.[3]

Prescription Writing Exposures

Along with misdiagnosis, prescribing medication across state lines without conducting in-office patient exams commonly presents issues leading to malpractice and even criminal exposures.[4] Several states have local databases requiring a practitioner to make sure another doctor has not already prescribed the same controlled substance, and as a practical matter pharmacies may refuse to honor out-of-state prescriptions for fear of liability.[5]

It can even be said that prescribing controlled substances to a patient known only online is one of the likeliest scenarios to result in legal action against the physician.[6]

For example, the Florida Medical board concluded that physician review of patient questionnaires submitted over the internet was insufficient to prescribe medication absent physical examinations verifying patients' health.[7] The same medical board held that the pharmacy violated Arizona state law when it dispensed medication pursuant to such prescription orders.

According to the US Department of Justice, pursuant to the Controlled Substances Act ("CSA")[8], a prescription for a controlled substance issued by means of the internet (including telemedicine) must generally be predicated on an in-person medical evaluation. The CSA contains certain exceptions to the requirement of an in-person visit. One such exception was triggered by the COVID-19 Pandemic in January of 2020, when the U.S. Secretary of Health and Human Services declared a public health emergency under 42 U.S.C. 247d.[9] Going forward, the status of the decision to loosen those restrictions remains uncertain.

Utilization of telehealth visits has enabled providers to deliver uninterrupted care to patients in legitimate need of prescribed medications throughout the coronavirus pandemic. The experience, mainly positive, has helped highlight for public policy purposes the vast potential for more efficient delivery of services to a broader population including those previously underserved.

Fraud

Not surprisingly, the rapidly changing landscape has also presented ample opportunity for abuse.

Telehealth is on the radar of the Medicare Fraud Strike Force. In September of 2020, the Department of Health and Human Services Office of Inspector General, along with state and federal law enforcement partners, exposed a massive health care fraud ring engaged in, among other things, the prescription and distribution of controlled substances. More than 345 defendants in 51 judicial districts were charged with participating in health care fraud schemes involving more than $6 billion in alleged losses to federal health care programs. As part of the "telefraud" scam involving aggressive marketing of telehealth services, defendant telemedicine executives allegedly paid doctors and nurse practitioners to order unnecessary durable medical equipment, genetic and other diagnostic testing and pain medications, either without any patient interaction or with only a brief telephonic conversation with patients they had never met or seen.[10]

Adequate Record Keeping and the Advisability of Recording the Visit

The practice of telemedicine has created many unique information management issues for both practitioner and

staff. Health information management requires organizing and maintaining large data sets derived from multiple sources and devices such as remote monitoring and mobile health products, i.e., “wearables.” The data must be stored in a variety of file formats (video, audio, text, digital images, film); necessitating protocols for the safe transmission and access by providers and patients alike.

The additional burdens placed upon physician and staff can be daunting; the consequences of a misstep, devastating. As with traditional in-person visits, accurate documentation of all aspects of a telehealth visit is critical. The nature of the telemedicine visit, itself, generates additional items that require specific documentation. For example: whether the service was provided via technology with synchronous audio/video or by audio alone; the patients physical location; the location of the provider; the identity and location of any other providers in the event of a team meeting; the recommendations of any such additional providers; the fact that the visit was conducted virtually; explanation of the risks associated with telehealth visits; that informed consent specific to telemedicine was obtained; the patient’s history; the physical exam; recommendations; and, the amount of time spent providing services. Even before the visit occurs many practitioners have found a need for dedicated staff whose job it is to make sure that the patient is able to connect virtually.

The practitioner must also document any connectivity issues which, in the provider’s opinion, might have affected the quality of the communication. A patient must be advised of the limits of confidentiality when communicating via an electronic medium and, just as importantly, that it may be determined that telemedicine is not appropriate for the diagnosis and treatment of their condition.

The range of a responsibilities attendant to a Telehealth visit from the providing team’s perspective is, therefore, incredibly broad. The event is no less complicated from the perspective of the patient. Thus, even more-so than in the in the case of claims arising from in-person care, a laborious and costly search for the truth of what transpired during a telehealth visit will likely be at the epicenter of virtually every telemedical malpractice claim.

Were the relevant risks adequately explained to the patient? Was informed consent achieved? Were all necessary instructions clearly and adequately conveyed? Does the record created by the provider accurately reflect the visit? An exhaustive list of potential issues is unnecessary. Suffice to say that the economic cost associated with probing such issues accounts for a significant percentage of any defense litigation budget.

The stakes are at least equally high for the patient. The costs associated with the misinterpretation of instructions, or inability to firmly grasp or recall recommendations can be both financially and physically devastating. The potential for error is often compounded by the issues associated with patients own unique profile including the patients living arrangements, age, education, cognition and memory issues, vision and/or hearing loss, anxiety and stress occasioned by the visit, adequacy of available technology and ability to operate it. Unlike the physician, there is likely no team of assistants surrounding the patient in this potentially new and intimidating virtual setting - likely unfolding in a time of need - to help ensure all essential information is accurately memorialized for future use by the patient, dissemination to family or support system and to other providers, etc. The trend toward shortening hospital stays and in favor of patient driven outpatient care enhances the need of patients and their families for specific, memorialized information. Our experience has shown that the amount of information correctly recalled by patients absent memorialization can be strikingly limited.

Some health systems have concluded that these concerns may be mitigated by recording all telehealth visits. However, recordings in certain settings such as mental health care are generally thought to be counterproductive, but are otherwise recommended. We are mindful that recordings have the potential to violate patient privacy and interfere with patient care. In addition, recordings may be edited and otherwise manipulated to suit the needs of a particular party. Accordingly, recordings should only be undertaken, stored, used, and/or disclosed in compliance with state and federal law. As with the need to ease restrictions on cross-border practice, variations among the applicable state and federal laws regarding the creation, maintenance, use and dissemination of recordings pose a significant barrier to implementation.

Specifically, under federal law recording is permitted so long as one party to the conversation consents. This federal rule is also the law in only 38 states. The remaining states require consent on the part of all participants for the recording to be permitted.

While the efficacy of such recordings from the patient’s perspective may subject to a litany of patient specific variables, the benefit of having the recording at trial should

greatly assist the defense of malpractice claims. Nevertheless, support for recordings is far from universal among health practitioners. Certainly, the fear of how such recording may be used in litigation is relevant. Whether that concern is justified and/or outweighs the potential benefits is the question. Absent a recording, a patient may convincingly claim that the examination proceeded in a different manner than described by the physician, and/or that the plaintiff or physician said or did not say something notwithstanding the provider's written record. Accordingly, there is no basis to forecast a greater risk of litigation where a visit is recorded. Rather, recordings have the potential to greatly reduce the incidence of conflicting claims and the attendant time consuming and costly credibility battle. The recording, meanwhile, can help reinforce the impression that the doctor was indeed thorough and responsive, in order to counter most claimant's story that the doctor gave curt or nonexistent responses to the patient's concerns. Infinitely fallible recollections and or intentional misstatements on both sides would be resolved by the recording. Knowing that what transpired is "of record", and not wholly open for debate, should theoretically result in fewer claims.

To the extent that a recording of the visit may enhance the patient's ability to better pursue the recommended course of action, outcomes will undoubtedly improve. Improved outcomes result in fewer "legitimate" claims of malpractice. Recorded interactions should also provide a meaningful hedge against frivolous or fabricated claims. There even may be a clinical benefit if a patient can play back the doctor's instructions during a course of therapy, although we are unaware of any patient portals that presently offer this tool.

Standard of Care

The standard of care varies in certain telemedicine situations. For asynchronous "store and forward" type communications, it might not matter that the radiologist is situated remotely from the hospital or health care facility where the imaging was produced. The standard of care is no different whether the doctor is in the basement of the hospital or in a home office. The duties do not change with respect to reviewing the imaging study, and communicating the results if urgent.

On the other hand, for a virtual visit the standard of care may be altered to reflect what can and cannot be done in that context. For instance, the doctor would be adhering to the standard of care by determining that a hands-on physical examination is needed. The doctor's duty is discharged by referring the patient for follow up at a clinic, urgent care facility or emergency department. In a hospital-to-hospital ("hub and spoke" telemedicine) scenario, there may be mid-level practitioners with the patient who can provide not only vital signs but also varying degrees of physical examination, not much different than a physician on-site supervising a physician assistant or collaborating with a nurse practitioner. The time has come to modify the in-person standard of care now applicable in telehealth settings to account for care that is not, in fact, delivered "in person." Expert witnesses who have experience with telemedicine and knowledge of the geographic area will have to explain to a jury just what can, and cannot, be done in the telemedicine setting.

Privacy Concerns and Cybersecurity

Privacy concerns are not completely abated by use of HIPAA and HITECH compliant platforms during telemedicine visits. Privacy breaches in and of themselves have given rise to personal injury claims. Often a breach can result from a combination of human error, or misconduct, in order to exploit a weakness in the security protocols. This gives rise to the prospect of negligent hiring and supervision claims, as well as allegations of the failure to have sufficient security protocols in place.

Since telehealth firms typically partner with multiple vendors to deliver products and services, the prospect of shifting risk should be explored or else it is borne by the doctor or facility in the first instance. Health care providers may or may not have the negotiating power to demand that a vendor's contract provides for indemnification, or potentially for additional insurance coverage, to the health care provider. Cybersecurity insurance also can provide parallel coverage to some degree, along with professional malpractice insurance, for such claims.

It is not uncommon for a privacy breach to have been caused by a vulnerability in a device the patient has introduced into the equation no matter how secure the health care provider's platform may be. Some mobile health devices and wearables, by their nature, create a distinct privacy challenge. They live, at least in part, outside the highly regulated realm of the traditional doctor-patient relationship. The number, complexity and functionality of such devices changes on an almost daily basis. Thus far, the Federal Government has adopted a comparatively passive approach, seeking to regulate wearables only if they are classified as a "medical device." In general, digital health technology is classified as a medical device if a digital health technology is used to diagnose a disease or condition, or in

the cure, mitigation, treatment, or prevention of disease.[11] The divide becomes increasingly vague as such "gadgets" evolve into something more. That said, a more heavy-handed approach by the FDA at this stage might have the undesirable effect of curbing industry growth and delaying or negating potential health benefits. Along the way, clarity in terms of the applicability of privacy and cyber laws with respect to such devices may likely be the subject of litigation.

"Doctors [Still] With Borders"

Originally inspired by concerns of public safety and economic protectionism, states have been regulating the practice of medicine by examining and licensing practitioners since the formation of the United States.[12] Notwithstanding the wisdom originally giving rise to this practice, its present effect is to unnecessarily restrain practice across borders notwithstanding compelling the need and a recent history of the undeniable benefits derived from even a temporary waiver of such restrictions. Unanimous agreement on the part of the states to permanently simplify and expedite the licensing process permitting cross-border practice would foster the necessary maturation and improvement of the entire telehealth infrastructure.

In traditional health care, the patient and the provider are generally in the same state. With telemedicine, this is often not the case. Accordingly, the laws and licensing requirements of multiple states may be relevant since telemedicine services are mainly deemed rendered where the patient, not the provider, is located. When engaging in the practice of telemedicine, a physician must consider whether such "out of state" practice exceeds the scope of his/her medical licenses. Although federal standards govern medical training and testing, each state has its own licensing board, and doctors must procure a license for every state in which they practice medicine. A physician who violates these regulations can run the risk of exposure to criminal charges in addition to other professional and/or civil penalties.
In response to the recent pandemic, many states elected, at least temporarily, to reel in licensing requirements so that providers with equivalent licenses in other states were able to practice via telehealth. The loosening of such restrictions was facilitated through The Interstate Medical Licensure Compact (IMLC), "an agreement among participating U.S. states to work together to significantly streamline the licensing process for physicians who want to practice in multiple states. Thus, the IMLC is a critical component of the movement to improve access to care for patients and ready access to licensure for qualifying physicians. The IMLC was officially implemented in 2017. While membership growth has increased markedly throughout the pandemic, approximately 20 states have yet to join the pact.[13]

Notwithstanding the positive impact of the IMLC, significant differences in approach among states and the federal government, and inconsistent messaging from regulators, continue to create licensing issues for those seeking to provide care to patients across state lines without fear of penalty. These challenges will become more acute as states may permit certain state-level emergency declarations to expire. This remaining uncertainty may have a chilling effect on the continued growth of telemedicine since providers will likely seek to avoid non-compliance with an ever changing morass of rules, regulations, and legislation.

The waiver and/or streamlining of state licensing requirements is fundamental to the delivery of desperately needed care to areas where the health care community has been stretched to the point of breaking by the coronavirus pandemic. Given the public policy goal and proven ability of telemedicine to expeditiously deliver care and expertise where and when it is needed, notwithstanding physical proximity, any rules tending to unduly restrict the interstate practice of telemedicine warrant immediate review and clarification.

Over the past two decades, the medical professional liability insurance marketplace has been hardening in response to higher paid claims. The evolving market is putting upward pressure on premiums and downward pressure on insurance industry capacity. This is particularly true for specialists who treat high-risk patients. No doubt, the generally challenging environment has contributed to the shortage of doctors and other health care providers. In fact, according to data published in 2020 by the AAMC (Association of American Medical Colleges), the United States is projected to face an estimated shortage of between 54,100 and 139,000 physicians, including shortfalls in both primary and specialty care, by 2033.[14]
By implication, an inadequate number of providers will increasingly overburden those that remain, and generate a corresponding rise in potential malpractice. Likewise, the increasing dissatisfaction within the underserved patient population translates into ill will directed against the medical community. Parenthetically, this same population will comprise the pool of jurors which will ultimately decide those malpractice suits. Moreover, patient expectation of a suboptimal experience and/or the fundamental lack of reasonably available care has the effect of discouraging the

pursuit of timely care, or any care at all. As a result, otherwise treatable conditions worsen, requiring the type of preventable critical and/or chronic care emblematic of those in underserved communities. If we agree that preventative care is essential to better health, then it must follow that the lack of access to preventative care is responsible for otherwise avoidable consequences including chronic conditions which are far more costly to contend with.

As an industry, we justifiably bemoan "social inflation" and the proliferation of "nuclear verdicts." We bear part of the cost and dedicate tremendous resources hoping to identify the causes and craft potential solutions. While no panacea is on the horizon, there are incremental steps worthy of serious consideration. To begin, expand the partnership with organized medicine to support the nationwide trend toward easing restrictions, including as regards coverage, on cross-border practice. This will have the effect of multiplying the number of providers potentially available, in a crisis and otherwise, and improving the overall condition of underserved communities which, would otherwise be the wellspring of higher verdicts.

Telepsychiatry and Choice of Law Considerations

While the advent of the COVID-19 pandemic has facilitated a significant use of telemedicine in other specialties, telepsychiatry has long been considered the most active application of telemedicine in the United States. The specialty tends to be more interview based and less procedure based than most other specialties making it well suited to remote engagement through telemedicine. Moreover, "Research has indicated that telepsychiatry is comparable to face-to-face services in terms of reliability of clinical assessments and treatment outcome."[15]

As with any specialty, the practice of telepsychiatry is deemed to occur in the state where the patient is located. Physicians and patients are often located in states with different liability laws, statutes of limitations, standards of care or damage caps, etc. Liability claims between parties residing in different states often generate complex choice of law issues. Where more than one jurisdiction's laws could potentially apply to the issues presented, a conflict exists between the jurisdictions' laws and a choice of law determination must be made. The task of deciding that issue can be costly and time consuming. Moreover, outcomes are not readily predictable and, where divergent damages laws are involved, exposures may be significantly increased.

Likewise, conflicting coverage rulings also continue to hamper the ability of insurance carriers to forecast outcomes and assess risk.

Physicians may face liability exposure in different venues as patients may choose or be required to file any malpractice lawsuits in their own states, where the treating physician may not be licensed. This poses unique issues as to licensing, differing standards of care and malpractice insurance.

For example, if a provider's New York patient receives therapy while skiing in New Hampshire, which law will apply? The general understanding is that a patient who is temporarily out-of-state but maintains his legal residence in New York may be treated by the New York physician, even if the physician does not have a license to practice in New Hampshire. Even prior to the COVID-19 pandemic, physicians generally would be permitted to treat for a limited time on that basis.

Let's assume that this New York psychiatrist's malpractice insurance policy describes the coverage territory as "anywhere within the State of New York." Would a telepsychiatry visit with that same New York patient skiing in New Hampshire be covered?

Fortunately, several medical malpractice carriers have recently begun to expand coverage territory. In that regard, the company that insures the greatest number of psychiatrists in the US has amended its policy to cover named insured psychiatrists anywhere in the United States. The policy language for this sets forth as follows:

> **"This policy applies to Medical Incidents anywhere in the world provided the original Claim for covered Damages is brought within the United States of America, its territories or possessions, Puerto Rico or Canada."**

On the other hand, standard policy language in a typical New York malpractice policy as to the coverage territory might read as follows:

> **Territory means: (1) the State of New York and any adjoining state; and (2) anywhere in the world where you provide Professional Services in an emergency situation requiring immediate intervention.**

Thus, a typical policy would not likely extend coverage beyond New York unless the patient is in an adjoining state

at the time services are rendered. Still other policies cover only the State in which the doctor is practicing.
For many reasons made abundantly clear by recent events, as well as in order to remain competitive, serious consideration should be given to crafting endorsements extending such coverage. For instance, Florida has instituted in statute 456.47(4) a streamlined procedure for out-of-state physicians to become licensed in that state for telehealth purposes only. Included in the requirements is a provision that:

> (e) A provider registered under this subsection shall maintain professional liability coverage or financial responsibility, that includes coverage or financial responsibility for telehealth services provided to patients not located in the provider's home state, in an amount equal to or greater than the requirements for a licensed practitioner under s. 456.048, s. 458.320, or s. 459.0085, as applicable (emphasis supplied).

Predictably, insureds have increasingly begun to request this extended coverage. The trend is certainly in that direction.

The Impact of Artificial Intelligence

No doubt the confluence of wearable technologies, home monitoring and diagnostic devices, speed and quality of image transmission, increased availability online of the right specialists and the maturation of artificial intelligence ("AI") is transforming health care.

The advance of technology and the pace of its integration into the practice of medicine should be embraced not only for its potential to enhance the scope and quality of care delivered but also as a tool to dramatically mitigate the risk of malpractice. Simply put, AI will lead to better care outcomes and improve the productivity and efficiency of care delivery. Like it or not, AI is already incorporated in subtle ways into our electronic medical record systems with things as simple as choosing a template or a set of drop-down menus for a particular type of patient encounter. Better outcomes necessarily entail reduced incidents of malpractice.

That said, the march of technology brings with it a host of new issues impacting the insurance and defense industries. Just as the topic of virtual or telemedicine is almost certain to arise in any discussion of health care risk management, the issue of artificial intelligence is central to the issues around technological platforms.

In a diagnostic claim scenario, plaintiff may allege that the standard of care required the physician to utilize all available tools, including artificial intelligence where it has been implemented in that practice setting. The claimant may allege that the doctor should have, but failed to, run the clinical picture through AI. Or, in a case where the doctor did involve AI, plaintiff may allege that different information should have been elicited or considered. As we have seen historically in medical malpractice cases, the advance of technology inevitably gives rise to additional potential theories of malpractice.

Artificial intelligence, by definition, is a "black box" that not only obscures the underlying logic, but also continually changes by virtue of machine learning. Consequently, the answer you get in 2021 may be different than the one the same system will evolve to provide at some point in the future. This functional anomaly may compromise any meaningful retrospective review performed at the time the case goes to trial in the year 2024. Should the diagnosis of an impending diabetic crisis have been made if only, at the time of treatment, the patient had complained of certain symptoms such as thirst or headache? Neither side will have the ability, in 2024, to examine the "what if's" for treatment rendered in 2021. Judges and jurors tend to have a "digital hoarding" mentality, expecting that anything that can be saved should or would be available at a later date. The suspicion arises, and is sometimes encouraged by a judge's instructions to the jury, that the missing data was nefariously deleted or hidden.

We are unaware of any electronic medical record system with the capability to simulate or recreate the AI system as it operated at a prior point in time, in other words to work back from the time of trial to the time of treatment.[16] Without that capability, there will be gaps in the proof put forth by both the plaintiff and the defense when the case comes to trial.

The lone certainty is that additional expertise will be required to present medical opinion evidence at trial. This will likely entail production of a witnesses with credentials that include experience with the technology platforms involved and/or additional expert consultants. Either way, the costs associated with the undertaking are likely to be significant.

Artificial intelligence necessarily relies upon the scope of available data, and the nature of the increasing sources of

that data may result in questionable statistical analysis factoring into the diagnostic guidance of the AI algorithm. While the enormous potential of wearables continues to reveal itself, so too does corresponding concern about its accuracy and the risks and costs associated with the management of, and responsibility for, the data produced. While devices like the Apple Watch may initially have been viewed as glorified exercise and fitness trackers, they can now do things like monitor blood oxygen saturation levels, (helpful in diagnosing COVID-19) as well as blood glucose, blood pressure, and electrocardiograms to detect atrial fibrillation. More specialized devices, both implantable and wearable, are of course in use with the associated issues as to the shifting of risk from the monitoring service to the doctor.

A thorough analysis of the breadth of these transformative technologies is well beyond the scope of this article. Suffice to say that whether from an at home BP monitor, Fitbit or Apple Watch, useful information is increasingly flowing between and among patients and providers for review and incorporation into a treatment plan. In short, it is becoming increasingly clear that the future care of any one patient will involve a mix of physical, digital and asynchronous/AI-based care. The potential impact of AI in terms of speed alone cannot be overstated. There are few sectors in which speed is more important than health care. The minutes shaved off the time required to administer treatment by deploying AI's deep learning algorithms has the potential to preserve organ function, save brain cells and to save lives.

Notwithstanding the practical challenges posed by the exponential growth of patient and provider generated data, as the use of AI to interpret such data increasingly aligns with the applicable standard of care, failure to facilitate that review and follow the ensuing advice, when otherwise appropriate, may lead to exposures. Still, the medical, legal and insurance industries remain wary of the scenario whereby the decision to rely on AI tools does not end well. How will juries react to a physician finger pointed toward a computer?

Notably, according to a recent article in the Journal of Nuclear Medicine, potential jurors are growing more comfortable with the concept of providers' acceptance of AI generated medical recommendations. Consequently, clinicians may be less liable for using AI than commonly believed, particularly when following both the standard care in conjunction with AI generated recommendations.[17]

These preliminary findings should help mitigate concerns that a decision to rely upon AI might increase exposure. Indeed, juries and medical experts alike may begin to expect a doctor to use every available tool in formulating a treatment plan.

CONCLUSION

The advance of technology, and the pace of its integration into the practice of medicine should be embraced not only for its potential to enhance the scope, equitable distribution and quality of care delivered, but also as a tool to dramatically mitigate the risk of malpractice and associated liabilities.

Telemedicine provides greater, and more equitable, access to health services, cost-effectiveness, enhanced educational opportunities, improved health outcomes, enhanced quality of care, quality of life and social support. Coupled with artificial intelligence, the use of new technology is changing what patients can expect from their health care providers. We are seeing the erosion of a "local" standard of care and should soon be holding practitioners across the nation to the same standard of practice. At the same time, new challenges have presented that may shift the way we assess risk, and certainly will add to the expense of defending professional malpractice claims.

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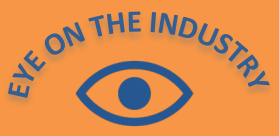
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State of the Cyber Insurance Market

By Robert Rosenzweig and Kathleen Curley

Historically cyber insurance buyers have benefitted from the continued expansion of coverage, access to capacity and stable rates, provided by a very competitive marketplace. However, in 2020 and 2021, insurers responded to skyrocketing cyber losses by tightening policy terms, increasing rates, and mandating stricter underwriting requirements. A challenging cyber insurance market is expected to continue through 2022.

How Did We Get Here?

The ongoing impact of COVID-19 has forced companies to maintain productivity through adopting new technology that can support the large shift in employees working remotely. This quick adjustment allowed threat actors to exploit a vulnerable environment through new points of entry and creative tactics. The frequency and severity of claims continues to rise, led by business email compromises and ransomware attacks.

High-profile ransomware attacks on large suppliers caused temporary distress in their respective supply chains – notably Colonial Pipeline, SolarWinds and JBS Foods. While each event was different, they revealed just how systemic and widespread one event can be in revealing the full vulnerabilities and connectivity of the economy. Ransomware attacks and those behind them are not restricted to a single industry class or organization size - ransom demands and associated busine ss interruption expenses are on the rise.

What Does This Mean for the Market?

Carriers are being far more discerning during the underwriting process about the risks they are taking onboard. They are not simply laying out terms – they want to see evidence that businesses are putting the best policies and procedures in place to prevent an attack. Average premium rate increases are nearing 100%, even for risks without claims activity and with good controls.

To mitigate their own risk, insurance carriers are utilizing many levers to make corrections, which include and are not limited to:

- Reduction in capacity deployed
- Increased premiums and retentions
- Coverage restrictions
    - Ransomware – Sublimits, Coinsurance, Removal of coverage
    - Business Interruption/Contingent Business Interruption- Sublimits, Coinsurance, Removal of coverage
- Additional information requests
    - Specific event related questions – SolarWinds, Kaseya, Log4Shell
    - Further deep dives into responses from applications

Excess carriers are seeking similar premium rate increases as they view an increased possibility of being implicated in the event of a claim. Many carriers are also taking the position to not follow terms of the primary, including any sublimits. This results in arguably less coverage for insureds than they previously secured, at a significantly higher expense.

Carriers can be hesitant to provide extensions or terms in order to mitigate the possibility of an event occurring between an extension and binding. Late stage underwriting requests and extensive reviews of submission materials, coupled with the inflexibility of extensions has led to frustration for clients.

Potential Impact to the Healthcare Industry?

Healthcare traditionally is one of the most heavily targeted industries due to the type, amount and value of personally identifiable information and personal health information. Even with the shift to ransomware as the primary attack methodology, Healthcare remains one of the targeted industries. According to the 2021 Net Diligence Cyber Claims Study, Healthcare accounts for 21% of incidents. As a result, the Healthcare industry has been highly susceptible to market corrections given the overall adverse industry experience.

Furthermore, The Office for Civil Rights (OCR), the law enforcement agency under the umbrella of the U.S. Department of Health and Human Services (HHS) continues to actively enforce privacy and security rules including HIPAA/HITECH. The robust legal landscape around privacy also continues to evolve, such as in the case of biometric data. Illinois' Biometric Information Privacy Act was passed in 2008 to regulate the collection, use and handling of biometric data by private entities. Since passing, class action litigation alleging violations and settlement figures have increased significantly; notably in 2021, a federal court approved a $650M settlement of a BIPA class action against Facebook, Inc (now Meta Platforms, Inc). Other states such as New York and California followed suit with their own laws and the National Biometric Information Privacy Act was introduced in 2020. A federal law is yet to be seen.

Essential Tools and Protocols

The following tools and protocols can significantly help businesses protect themselves against ransomware and other cyber threats.

- Multi-Factor Authentication (MFA): Also known as two-factor authentication (2FA), this is the process in which multiple barriers secure one's information. This could be in the form of a smartphone requiring a passcode in addition to a thumb print for access, or a bank account using a password as well as sending a randomly generated code to the user's cell phone via text message.
- Endpoint Threat Detection and Response Tools (EDR/EDTR): Software technology used to protect computer hardware from threats. The platform uses tools to gather and analyze data, revealing potential cyber security issues and threats. Once installed on the user's device, it continuously monitors and immediately prompts preventative actions when necessary.
- Employee Training and Awareness: Employers should make cyber security education and training a priority, as many incidents occur due to human error.
- Backups: Utilize multiple concurrent backups of essential data, either in a cloud-based system or external devices.
- Creation of Plans
  - Incident Response
  - Business Continuity
  - Disaster Recovery
- Regular Patching Cadence

2022 Outlook

We anticipate there will be continued government regulatory action intended to mitigate cyberattacks, recent actions have included:

- Ransomware Reporting: Ransomware is a top concern for clients and insurers. The number of ransomware attacks we know about is a small fraction of how many there actually are. Proposed legislation will require businesses to report attacks within 48 hours. Critical infrastructure operators will be required to report all cyber incidents within 72 hours.
- SolarWinds Probe: The Security and Exchange Commission is investigating hundreds of corporations impacted by the 2019 SolarWinds attack and requesting records on related data breaches or ransomware attacks. Those who do not disclose breaches or did not have proper controls in place could face penalties.
- The challenging conditions of the cyber insurance market are expected to continue and a stringent regulatory environment could make things worse.
- Regulatory inquiries are costly to defend and include the potential of fines and penalties.
- Strict state laws like the California Consumer Privacy Act set minimum statutory damages for what one could seek if their information were compromised. While it is helpful in protecting consumers, class action litigation is sure to rise and encourage increases in the total and average lost costs.

Impact on Insurance

Many insurance policies include minimal cyber liability coverage, however, a dedicated cyber liability policies offer more protection in the case of a ransomware or cyber security attack. Companies that are unable to demonstrate strong cybersecurity controls and a culture with cybersecurity as a top priority, will face a very difficult underwriting process where the inability to procure a cyber insurance policy is a reality.

<u>About the Authors</u>



Rob is responsible for coordinating and growing the cyber liability business across all Risk Strategies companies and offices nationwide. Rob also works directly with the firm's clients and prospects on creating comprehensive and customized coverage for their data security, privacy, and errors & omissions exposures. He has also written on cyber liability topics, has participated on panels and has led seminars on a variety of related topics. Rob currently holds a designation as a Registered Professional Liability Underwriter and he received his Bachelor of Arts Degree in Government & Economics from Hamilton College.



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The Comprehensive Insurance Disclosure Act

By Rebecca C. Kilduff

On May 26, 2021, the Comprehensive Insurance Disclosure Act (hereinafter the "CIDA"), was introduced as S7052 to the New York State Senate Committee on Judiciary and on December 31, 2021, Governor Kathy Hochul signed "CIDA" into law. The Act amended CPLR § 3101(f) and CPLR § 3122-b to require defendants to provide detailed insurance coverage information.[1] This legislation imposes a time restraint on defendants' already-existing obligation under the CPLR to provide insurance coverage information, purportedly in order to impede powerful insurance companies from ignoring and/or delaying the exchange of this information.[2] Following widespread criticism and concern, amendments to "CIDA" were presented to the New York State Senate Committee on Rules on January 18, 2022 as 7882-A and Governor Hochul signed the amended version into law. The amended version mitigates some of the more burdensome requirements of the original form of the law. For example, "CIDA," as amended, applies only to cases commenced on or after the effective date, December 31, 2021, rather than all pending actions.

As amended, "CIDA" requires the disclosure of insurance coverage information no later than ninety (90) days after service of an answer. Furthermore, defendants must disclose total limits available under the policy, which includes "the actual funds, after taking into account erosion and any other offsets, that can be used to satisfy a judgment described in this subdivision or to reimburse for payments made to satisfy the judgment." Importantly, defendants now have the option to either exchange a full copy of the relevant insurance policy or, if plaintiff's counsel consents, only the declaration page. Acceptance of the declaration page does not waive the right of the plaintiff to receive further information, and this acceptance may be revoked at any time, at which point the defendant must provide a full copy of the insurance policy. Whether a defendant submits the full policy or the declaration page, it must include "all primary, excess and umbrella policies…insofar as such documents relate to the claim being litigated." Defendants are required to disclose the name and email address of the insurance adjuster assigned to the matter.[3] This information must also be provided within 90 days after service of the defendant's answer.[4] The Act also requires the defendant and their attorney to certify that the insurance disclosures are accurate and complete, and that they have made and will continue to make reasonable efforts to ensure that the information remains accurate and complete.[5] Notably, disclosure of the policy does not constitute an admission that an alleged injury or damage is covered by the policy.

With regard to the "accurate and complete" requirement, defendants are required provide updated information "at the filing of the note of issue, when entering into any formal settlement negotiations conducted or supervised by the court, at a voluntary mediation, and when the case is called for trial, and for sixty days after any settlement or entry of final judgment in the case inclusive of all appeals." CIDA does not apply to no-fault actions or personal injury protection ("PIP") actions.

The Act has drawn criticism from attorneys that represent insurance companies as well as entities such as the New York Insurance Association (hereinafter the "NYIA").[6] The NYIA questioned the need for the Act and denied that there was significant noncompliance with the existing obligations on behalf of insurance companies and related defendants.[7] Moreover, opponents of the Act have expressed disapproval in that the obligation to provide this information imposes a heavy burden on defendants and creates unreasonable compliance standards that may expose defendants to legal sanctions.[8] For example, questions arise as to how insureds and their counsel can comply with the Act where resolutions are confidential, or instances where a policy is eroding and there are multiple lawsuits against one defendant, possibly involving multiple firms.

Furthermore, it is not uncommon that insureds and their counsel do not possess or control all information required to be disclosed, so it will be difficult if not impossible for defendants and their attorneys to certify the accuracy and completeness of the disclosed information.[9]

We hope this article will be useful to you in the defense of your insureds. We would be pleased to discuss the legislation and its impact in more detail at your convenience. Please feel free to call or e-mail Rebecca Kilduff (rkilduff@kbrlaw.com) or Kendall Pipitone (kpipitone@kbrlaw.com) for a more in-depth discussion.

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