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RISK MANAGEMENT JOURNAL



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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

Dear Association for Healthcare Risk Management of New York Members,

It is such an honor for me to be writing to you as President of AHRMNY! I am thrilled to have the opportunity to lead an organization comprised of such wonderful and esteemed professionals.

Since **1982**, AHRMNY has embraced the role of being a central source of information in New York State on the new developments and trends in healthcare risk management. We take immense pride in the evolution of our organization. We have done so on the heels of our presidents' past who year after year built this organization up little by little into what is now an organization comprised not only of hundreds of professionals but also a committed and ever growing sponsorship base. As we've grown, we've been able to give more to our members in the form of education, networking and overall good times!

To this end, as my first official act as President, I had the privilege to spearhead our first ever upstate conference and our first ever multi-day event! We extend gratitude to the hundreds of long-standing and new members whose collaborative spirit and commitment to excellence within our community have undeniably contributed to the resounding success of this recent conference.

I want to take a moment to commemorate this successful event. Set in the scenic upstate New York landscape of Saratoga Springs, this heavily attended conference provided an enriched comprehension of risk management best practices and a network of valuable professional connections that promises to shape the future of risk management in healthcare. Professionals from all across the State kicked off the event at a packed cocktail hour the night before the conference. Attendees then engaged in a full day of insightful discussions starting with a keynote address by the Honorable Mae A. D'Agostino who focused on decorum and respect. A national ASHRM update was provided by former ASHRM President and legend Barbara McCarthy. Esteemed speakers then workshopped topics including litigation trends and ways to reframe the issues, risks of remote patient monitoring, the important role of risk managers during trials, benefits and risks associated with increased deployment of artificial intelligence, resource challenges impacting healthcare providers, and learning the most from adverse events and innovative approaches to mitigating and handling risks. Special thanks to our speakers:



Keynote Address
by The Hon.
Mae A. D'Agostino



Nuclear Verdicts, Anchors & Reptile Theory
by Jeffrey Gerson and Katherine Buckley
Remote Patient Monitoring Devices by Judy Klein



Understanding Adverse Events
by Dr. Robert Panzer
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ASHRM Update by
Barbara McCarthy

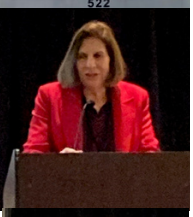


Liability Risks of AI in Healthcare by Melissa Dziak and Matthew Keris
Risk Managers in the Court Room by Terry O'Connor and Gina Kittek



Healthcare Resource Challenges by Joyce McCormack, Cody Baldwin,
Susan Starr, and Karen Tunis-Manny













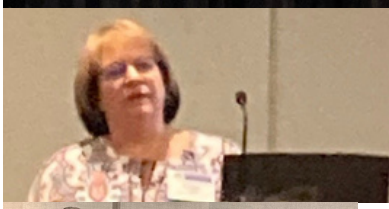
































PRESIDENT'S MESSAGE CONTINUED

As confirmed by the survey results, an overwhelming number of participants applauded every aspect of this conference and they enthusiastically voted for annual upstate conferences. To our new and current members, your passion and willingness to travel made this conference a roaring success. We are truly appreciative of your commitment and in turn we are committed to providing you with excellent events.

I want to thank Victor Klein, our immediate past President. Under his leadership, we brought the organization back to a full year of in-person events and embarked on a letter writing campaign to invite Healthcare Risk Professionals north of New York City as well as New York ASHRM members who were not AHRMNY members to join our network. As a result, our membership has reached an all-time high and continues to grow. Working with Dr. Klein, the AHRMNY board and our Executive Director, Kisha Wright, was an incredibly rewarding experience and I am forever thankful to them for their hard work and leadership.

Looking ahead, we are excited to provide more of the opportunities our members have come to rely on. We will continue to host many of our long-standing events, while rolling out innovative ways to educate and network. Please look out for invitations to our upcoming events!

To our sponsors: Healthcare Risk Professionals work tirelessly day after day and are always taking care of others. AHRMNY takes pride in offering Risk Professionals a chance to attend phenomenal educational presentations while relaxing and enjoying good food and drink, laughing and learning in beautiful venues across the State. We are incredibly grateful for our sponsors' continuous support and generosity, without which none of this would be possible. Your combined efforts reinforce the unity and strength of our community in advancing professional excellence and it makes all the difference in our ability to expand our reach throughout the State year after year. In 2023, we continued to see our dedicated, long-standing sponsor base support us while also gaining many new sponsors looking to embrace the Healthcare Risk Professional community of New York. I want to personally thank our 2023 Sponsors (page 5) and I look forward to your continued support in 2024.

More ways to be involved: We welcome you to consider joining a committee, becoming a sponsor, writing an article in our esteemed Risk Management Journal, submitting a presentation for upcoming events, helping to grow our membership and more. If interested in volunteering on a committee (By-laws; education; finance; fundraising; public relations &membership; and publications), please email ahrmny@gmail.com.

And if you have suggestions on how to make our association more valuable, you can always contact me.

Lori Shapiro

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The Grieving Families Act, Its Veto, and the State of Wrongful Death Recovery in New York

Barbara D. Goldberg, Gregory A. Cascino, and Richard Wolf

Recently, Governor Kathy Hochul vetoed Assembly Bill A6698, the Legislature's second attempt at enacting the Grieving Families Act. The Grieving Families Act, which may still be enacted if the Legislature "overrides" the Governor's veto, has the potential to substantially alter the nature of wrongful death actions in New York. While many practitioners and insurance companies have celebrated the veto of the bill, understandably concerned about the wide-ranging scope of the bill and how it may have expanded the availability of damages significantly, it is important to be aware of the legal fictions which have developed allowing plaintiffs in wrongful death actions to recover large sums of money as the law stands now. In addition, given the fact that the veto may still be "overridden," as well as Governor Hochul's continued openness to a more scaled down version of the Grieving Families Act, it is worthwhile to consider how the Act, if enacted, may alter New York's wrongful death jurisprudence.

New York's Current Wrongful Death Law

New York did not recognize a cause of action for wrongful death at common law. *See Hernandez v. New York City Health & Hosps. Corp.*, 78 N.Y.2d 687, 692 (1991). In 1847, New York enacted its first statute permitting a cause of action for wrongful death. *See id.* Currently, wrongful death actions are governed by New York Estates, Powers, and Trusts Law ("EPTL") §§ 5-4.1 and 5-4.3 through 5-4.6.

EPTL § 5-4.1 permits a duly appointed personal representative of a decedent who is survived by "distributees" to maintain an action to recover damages for a wrongful act, neglect, or default which caused the decedent's death. A "distributee" is defined as "a person entitled to take or share in the property of a decedent under the statutes governing descent and distribution," which may include a surviving spouse, children, or parents. EPTL §§ 1-2.5, 4-1.1, 5-4.4(a). A claim for wrongful death must be brought within two years after the decedent's death. *See* EPTL § 5-4.1(1).

EPTL § 5-4.3 provides that distributees may recover damages for pecuniary injuries resulting from the decedent's death. The statute specifically provides that reasonable expenses for medical aid and nursing incident to the injury causing the death, as well as reasonable funeral expenses paid by the distributees, are recoverable. The courts have found that loss of earnings, services, voluntary assistance, and possible inheritance are pecuniary injuries which also may be recovered. *See Gonzalez v. New York City Hous. Auth.*, 77 N.Y.2d 663, 668 (1991); *Freeland v. Erie County*, 204 A.D.3d 1465, 1468 (4th Dep't 2022). Interest from the date of death to the date of verdict is also part of the damages recoverable in a wrongful death action. *See Toledo v. Iglesia Ni Christo*, 18 N.Y.3d 363, 367-68 (2012). "[T]he goal of damages in a wrongful death action is to compensate the decedent's distributees for no more than their pecuniary loss." *Milbrandt v. A.P. Green Refractories Co.*, 79 N.Y.2d 26, 35 (1992).

The First Grieving Families Act Would Have Drastically Changed the Law

The Legislature initially passed the Grieving Families Act in 2022. The stated purpose of the Act was to "permit the families of wrongful death victims to recover compensation for their emotional anguish." N.Y. Senate Bill S74A, available at https://www.nysenate.gov/legislation/bills/2021/S74. Had the bill been signed into law, it would have amended, and potentially repealed significant aspects of, EPTL §§ 5-4.1 and 5-4.3.

First, the Act would have expanded the number of persons who could recover damages in a wrongful death action by replacing "distributees" with "close family members." It would have been left to the jury, or the judge in a bench trial, to determine who constituted a "close family member" of the decedent, based upon the specific circumstances relating to the person's relationship with the decedent.

Next, the Act would have amended EPTL § 5-4.3(a) to remove the limitation on damages to pecuniary damages, and specifically would have authorized recovery for "grief or anguish caused by the decedent's death, and for any disorder caused by such grief or

anguish," as well as "loss of love, society, protection, comfort, companionship, and consortium resulting from the decedent's death," none of which are compensable items of damages under the current law. *See Gonzalez*, 77 N.Y.2d at 668; *Liff v. Schildkrout*, 49 N.Y.2d 622 (1980).

Finally, the Act would have extended the time to file a wrongful death action from two years to three years and six months from the date of the decedent's death. It bears noting that this is a year longer than CPLR § 214-a's two and a half year statute of limitations applicable to medical malpractice actions and six months longer than the three year statute of limitations applicable to general negligence actions.

The initial version of the Act, had it been enacted into law, would have taken effect immediately and applied to all pending and future actions. This would have had a massive effect, particularly on actions already pending. Plaintiffs in nearly all wrongful death actions likely would have moved to amend their complaints or bills of particulars to add new categories of damages. Additional discovery would have been required to determine how "close" certain family members were to the decedent, and the extent of their "grief or anguish." Case values could have soared overnight, drastically impacting cases where insurers had already set reserves.

On January 30, 2023, Governor Hochul vetoed the Grieving Families Act. As the bill was passed during the previous Legislative Session, Governor Hochul's veto of this initial version of the Act was not subject to an "override."

In her memo vetoing the bill, Governor Hochul noted that the bill passed the Legislature "without a serious evaluation of the impact of these massive changes on the economy, small businesses, individuals, and the State's complex health care system." She noted that the bill, if enacted into law, would have increased insurance burdens on families and small businesses, and further strained healthcare workers and institutions, including hospitals in underserved communities. Furthermore, the indefinite class of beneficiaries could have resulted in confusion for judges, juries, and litigants. The bill's application to already pending cases would have resulted in new competing claims asserted by "close family members," "as well as protracted discovery and increased litigation costs, potentially upending cases far along in the judicial process." While Governor Hochul expressed her willingness to amend New York's wrongful death statute to allow parents to recover emotional damages for the loss of a young child, she found that the bill's "extraordinary departure from New York's wrongful death jurisprudence," without a serious evaluation of its unintended but potential consequences, was improper. *See* Veto Memo. 192, dated Jan. 30, 2023.

The Revised Version of the Grieving Families Act Also Has the Potential to Substantially Change the Law

In June 2023, the Legislature passed a revised version of the Grieving Families Act, with the same stated purpose of permitting "the families of wrongful death victims to recover compensation for their emotional anguish." N.Y. Assembly Bill A6698, available at https://www.nysenate.gov/legislation/bills/2023/A6698 .

The current version of the Act, like the previous version, would expand the number of persons who may recover damages in a wrongful death action by replacing "distributees" with "close family members." The trier of fact would again determine who constitutes a "close family member." The Act expressly provides that close family members may include, but are not limited to, a spouse or domestic partner, children, parents, grandparents, step-parents, and siblings. It is possible that this amendment may open the door to aunts, uncles, cousins, or even in-laws recovering damages for the wrongful death of the decedent.

The revised Grieving Families Act also would expand the categories of damages which may be recovered in a wrongful death action. In addition to the currently available reasonable funeral expenses, reasonable expenses for medical care incident to the injury causing death, and loss of services, assistance, parental guidance, and possible inheritance, the Act authorizes recovery for "grief or anguish caused by the decedent's death," as well as for "loss of love, society, protection, comfort, companionship, and consortium resulting from the decedent's death." While the Act would permit recovery for grief or anguish caused by the decedent's death, it does not permit recovery for any disorder caused by such grief or anguish, in contrast to the prior version.

The Act would extend the time to file a wrongful death action, although not as far as the previous version of the Act. Specifically, the revised Grieving Families Act, if enacted, would extend the time to file a wrongful death action from two years to three years from the date of the decedent's death, less than the three years and six months that the prior version would have permitted but

more than the two and a half year statute of limitations applicable to medical malpractice actions.

Finally, the revised Grieving Families Act will "apply to all causes of action that accrue on or after July 1, 2018, regardless of when filed." This, like the prior version, has the potential to dramatically affect actions already pending, as Plaintiffs in all wrongful death actions where the decedent died on or after July 1, 2018 will likely move to amend their complaints or bills of particulars to add new categories of damages. As noted above, this will result in substantial additional discovery and significant increases to case values.

On December 29, 2023, Governor Hochul vetoed the revised version of the Grieving Families Act. In vetoing the Act, Governor Hochul found that it would "fundamentally alter the legal framework for wrongful death claims in New York by expanding the types of damages that may be recovered, expanding the class of persons who may recover such damages and extending the statute of limitations." She noted that the bill created "the potential for significant unintended consequences," including, like the original version, "increased insurance premiums for the vast majority of consumers, as well as risk the financial well-being of our health care facilities – most notably, for public hospitals that serve disadvantaged communities." *See* Veto Memo. 151, dated Dec. 29, 2023.

Following Governor Hochul's veto, the New York State Assembly tabled the bill. It is unclear if the Legislature will attempt to "override" Governor Hochul's veto at this time. However, greater than two-thirds of each house of the Legislature voted to pass the revised Grieving Families Act in the first instance. Accordingly, it would appear as though there may be sufficient votes to "override" the Governor's veto, if the Legislature chooses to do so, and the revised Grieving Families Act may still be enacted into law.

Plaintiffs Have Found Ways to Recover Damages for Emotional Distress Under the Current Statutory Framework

Even if the Legislature does not "override" the veto and enact the Grieving Families Act, it is important to be aware of how broad the amount of damages recoverable under the current wrongful death framework can be. One of the justifications given by the original version of the Act's sponsors for amending the law was that "[t]he law, in essence, says that the attributes of our family members that we most value," including "advice and guidance," "count for nothing." N.Y. Senate Bill S74A, available at https://www.nysenate.gov/legislation/bills/2021/S74. However, this is simply not true. The Court of Appeals has held, since the earliest days of New York's wrongful death statute, that distributees may recover compensable losses of a personal nature, such as loss of guidance, despite the statute's limiting recovery to only pecuniary injuries. *See Tilley v. Hudson River R.R. Co.*, 24 N.Y. 471, 475-76 (1862); *see also Gonzalez*, 77 N.Y.2d at 668. This often comes in the form of claims for "loss of parental guidance." *See, e.g., Freeland*, 204 A.D.3d at 1468; *Ambroise v. United Parcel Serv. Of Am.*, 143 A.D.3d 929, 932 (2d Dep't 2016). Parental guidance, however, is clearly an intangible concept and is not an economic loss. The fact that courts will look to how close a parent was to his or her children, and whether he or she was a "warm, loving" parent, demonstrates how this type of damage is really one which allows a surviving child to recover for emotional distress occasioned by the loss of his or her parent. *Phelan v. State of New York*, 11 Misc. 3d 151, 169 (Ct. Cl. 2005). Notably, the Appellate Division has sustained awards of $1 million or more per child for loss or parental guidance, depending on the evidence as to the nature of the parent-child relationship and the age of the child. *See Paccione v. Greenberg*, 256 A.D.2d 559 (2d Dep't 1998) (sustaining total of $3 million to two young children for loss of guidance of stay-at-home mother); *see also Adderley v. City of New York*, 304 A.D.2d 485 (1st Dep't 2003) (sustaining $1 million to infant plaintiff for loss of guidance of father).

An immediate family member of a decedent may also get around the limitations of the wrongful death statute by bringing a negligent infliction of emotional distress claim premised on the "zone of danger" rule. That rule allows one who is threatened with bodily harm as a consequence of the defendant's negligence to recover for emotional distress flowing only from the awareness of the death or serious physical injury of that person's immediate family member. *See Greene v. Esplanade Venture Partnership*, 36 N.Y.3d 513, 516 (2021); *Bovsun v. Sanperi*, 61 N.Y.2d 219 (1984). Accordingly, even though immediate family members may not seek damages for emotional distress directly through a wrongful death claim, they may bring their own claims for emotional damages caused by witnessing the death of their family member caused by the negligence of another, so long as they themselves were also threatened with bodily harm due to that negligence.

Another situation in which plaintiffs may evade the wrongful death statute's limitations in order to recover damages for emotional distress is when a fetus is miscarried or stillborn due to negligence. In *Broadnax v. Gonzalez*, 2 N.Y.3d 148, 155 (2004), the Court of Appeals held that, "even in the absence of an independent injury [to the mother], medical malpractice resulting in miscarriage or stillbirth should be construed as a violation of a duty of care to the expectant mother, entitling her to damages for emotional distress." *See also Brashaw v. Cohen*, 154 A.D.3d 1327, 1328 (4th Dep't 2017); *Ward v. Safajou*, 145 A.D.3d 836, 837 (2d Dep't 2016).

Accordingly, even without the Grieving Families Act, the courts have essentially permitted plaintiffs to recover the equivalent of damages for emotional distress in certain wrongful death cases.

The Current Wrongful Death Framework Has Resulted in Large Recoveries for Plaintiffs

It should also be noted that as the law currently stands, plaintiffs bringing a wrongful death action are often compensated far in excess of other similarly-situated plaintiffs. The decedent's estate may recover for the decedent's conscious pain and suffering prior to death, and courts have sustained past pain and suffering awards in wrongful death cases at a significantly higher hourly or daily rate than past pain and suffering awards where the injured person did not die. For example, in *Hyung Kee Lee v. New York Hospital Queens*, 118 A.D.3d 750, 752-53 (2d Dep't 2014), the Appellate Division sustained a jury's award of $3,750,000 for the decedent's conscious pain and suffering over the course of a three-and-a-half day hospital admission before his death. Such an award, over $1 million per day, almost certainly would not have been sustained in a similar situation where the patient ultimately lived.

Similarly, where a person dies only minutes after an accident, courts will often find some evidence of consciousness in order to sustain an award for past pain and suffering. Even where the person is alleged to have remained conscious for just a few minutes, pain and suffering awards in excess of $500,000 have been sustained. For instance, in *Vargas v. Crown Container Co., Inc.*, 155 A.D.3d 989, 993 (2d Dep't 2017), the Appellate Division found that $750,000 would constitute reasonable compensation for one-to-two minutes of conscious pain and suffering before a decedent died after being pinned between a garbage truck and dumpster. It is unlikely that a court would sustain an award of nearly $1 million for no more than two minutes of conscious pain and suffering if the plaintiff lived.

In addition, in certain circumstances, the courts have allowed recovery for preimpact terror as a separate category of damages distinct from conscious pain and suffering. *See In re 91st Street Crane Collapse Litigation*, 154 A.D.3d 139 (1st Dept. 2017) ("Crane Collapse case"). In that case, a construction crane toppled and fell 200 feet, causing fatal injuries to the crane operator, Leo, and a worker on the ground, Kurtaj, who was crushed. Both men suffered horrific, gruesome injuries as well as preimpact terror. The Appellate Division, First Department sustained $2.5 million for Leo's preimpact terror, and $2 million for Kurtaj's preimpact terror. In addition, the Appellate Division sustained $5.5 million for Leo's conscious pain and suffering, covering a period of approximately 16 minutes, and $7.5 million for Kurtaj's pain and suffering over a period of approximately four hours from the time of the crane collapse until he was taken to the operating room, after which he expired.

The Appellate Division explained that "[p]reimpact terror is a sub-category of conscious pain and suffering," and that "[d]amages for preimpact terror are designed to compensate the decedent's estate for the fear the decedent experienced during the interval between the moment the decedent appreciated the danger resulting in the decedent's death and the moment the decedent sustained a physical injury as a result of the danger." *Id*. at 153 (citations omitted).

The horrific circumstances of the Crane Collapse case are unique and may accurately be described as *sui generis.* However, the case illustrates the point that in an appropriate case, where the plaintiff can offer proof that the decedent perceived the likelihood of serious injury or death before the impact and suffered emotional distress as a result, the decedent's estate may recover substantial awards of damages.

In other contexts, awareness of impending death, which is closely analogous to preimpact terror, may be a component of conscious pain and suffering. One example is *Hyung Kee Lee, supra,* where there was evidence that, in addition to physical pain and discomfort, the decedent experienced a sense of impending death over the three day period before the series of unsuccessful intubation attempts which culminated in his death.

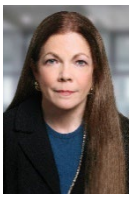
The potentially significant recoveries in cases involving preimpact terror and/or awareness of impending death were wholly ignored by the advocates for the Grieving Families Act. As the Crane Collapse case and *Hyung Kee Lee* demonstrate, provided the attorneys for a decedent's estate can prove preimpact terror or awareness of impending death, the estate (and therefore likely the close family members/beneficiaries) can already collect for the decedent's emotional damages suffered as a result of the defendant's negligence.

To allow additional damages for the beneficiaries' emotional distress beyond these potentially significant recoveries would serve no legitimate compensatory purpose. As noted by the Governor in vetoing both versions of the Grieving Families Act, these additional damages would greatly increase insurance burdens on numerous classes of defendants, including hospitals, physicians, and other healthcare workers, as well as small businesses, families, and individuals. Indeed, it is not an exaggeration to suggest such expanded and duplicative recoveries might force financially distressed hospitals, as well as other defendants, into bankruptcy.

Conclusion

While Governor Hochul's veto of the revised Grieving Families Act has, for now, prevented a drastic expansion of the damages available in wrongful death actions, it is important for practitioners to be aware of how expansive the amount of damages available in such actions already are. Furthermore, the veto is subject to an "override," if the Legislature decides to pursue that route, and Governor Hochul has expressed her willingness, in both her veto memos and an op-ed published in the New York Daily News, to sign into law a bill expanding the damages permitted in wrongful death cases. Accordingly, it will be important to continue monitoring developments in the law related to wrongful death claims. In addition, insurance trade groups and healthcare associations may be well advised to renew and/or increase their lobbying efforts against the Legislature attempting to "override" the Governor's veto.

About the Authors



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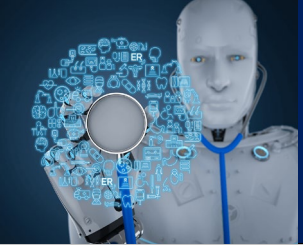


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HOW AI WILL IMPACT HEALTHCARE RISK MANAGEMENT: An Interview with AI Expert

Bonnie Boone and Meghan Anzelc, PhD

There seem to be new headlines every day about how Artificial Intelligence (AI) is impacting our work and lives. Industries are being disrupted and AI is transforming how people do their work. As Bill Gates says, "no one has all the answers on AI." Healthcare risk management will surely be impacted as well. Our conversation about AI will center on some thoughts that Healthcare risk managers can use. To help us better understand the current landscape and what the future may hold for AI in healthcare, I sat down with Dr. Meghan Anzelc, a physics PhD whose career has been in using AI to help companies perform better.

Bonnie: Meghan, to get us started, how do you define artificial intelligence, also called "AI"?

Meghan: The term itself has been around a long time, coined by John McCarthy[1] in 1956, but for today's use of the term the Encyclopedia Britannica's definition is a good one. It states, "artificial intelligence (AI) is the ability of a digital computer or computer-controlled robot to perform tasks commonly associated with intelligent beings."[2] And intelligent beings are those that can adapt to changing circumstances, like ourselves.

You've probably also heard the terms "machine learning" and "generative AI" and these are both under the umbrella of AI. Machine learning (called "ML" for short) is a subset of AI that applies algorithms to data to uncover patterns. Your email provider's spam filtering uses machine learning and so do many other common applications we interact with, like recommended products on a shopping website or the price we pay for airline tickets. Generative AI is a branch of AI that creates new content based on a set of training data. ChatGPT is a specific generative AI tool that outputs sentences and paragraphs based on a prompt question from the user. Other generative AI tools create images or video as well as tools that create different types of sound like music and voice.

Bonnie: We've seen a lot in the news about these capabilities and some of it sounds pretty scary. What are your thoughts on the risks of AI? In my opinion those risk managers that do not consider AI as a risk are missing the boat.

Meghan: We're a long ways away from some of the nightmare scenarios you may have read about. There is no sentient AI in existence. There is no AI being used today that can't be turned off if we want to get rid of it. Fundamentally, AI is applying math to data. It's just complex math and lots and lots of data.

Fear aside, there are definitely real risks with AI. Biased outcomes from AI tools is a big issue and that comes from having biased data used to train these systems. Fear aside, there are definitely real risks with AI. Biased outcomes from AI tools is a big issue and that comes from having biased data used to train these systems. As an example, back in 2018 Amazon[3] had to stop using a recruiting tool they had built because it was biased against women, and the tool was biased against women because their workforce had been predominantly male in the past. Recently, class-action lawsuits have been filed against health insurers for mis-using an AI tool to deny Medical claims.[4] In healthcare, there is a long history[5] of research showing that pulse oximeters have racial bias and don't work nearly as well for non-White patients.

Bonnie: Hopefully, Meghan, this will not add to one of our major issues in healthcare, on 'disparity of healthcare access and treatment based on race.'

Completely agree Bonnie. It's critically important we use AI to improve healthcare access and treatment for all, not inadvertently encode historical biases and disparities. Fundamentally, the risks really come from us and how we build and use these tools. We have to take a thoughtful and measured approach to ensure ethical and responsible development and use of AI that also follows regulations and best practices for ensuring privacy and security.

Bonnie: What are some of the current ways AI is used in healthcare today? I think it has been used for a number of years in diagnostic etc., however we are now focused on its universal appeal.

Meghan: There have been a number of advancements in helping identify and diagnose risks and diseases in patients. This includes a number of models[6] built to predict sepsis in patients, AI-based tools to help diagnose skin cancer,[7] and applications to help diagnose conditions that typically don't present symptoms, like left ventricular dysfunction.[8] While there are many opportunities for AI to improve diagnosis and patient outcomes, it's important to consider how best to balance deep expertise of clinicians and individual circumstance with tools that can help in many situations but aren't perfect and don't always have all of the relevant data. It's also critical to follow outcomes over time, to provide feedback to both the AI tools and those working in healthcare so that tools and people alike can continue to improve and learn.

Bonnie: What about patient safety and other risks that are specific to healthcare? Are these applications to AI to these areas?

Meghan: Yes, there are a number of areas being explored in this space. This includes predicting patients at higher risk for hospital-acquired infections, such as ventilator-associated pneumonia, as well as helping ensure better compliance with risk mitigation protocols like hand hygiene compliance.[9] Other applications Include identifying patients at higher risk

for venous thromboembolism[10] and those at higher risk for surgical complications.[11] Again, tracking of outcomes is needed to measure if, when, and how much these tools improve patient safety and when they do (or don't) perform better than existing approaches to risk management and patient safety.

Bonnie: It sounds like there are a lot of areas where AI is already being tested or used in clinical settings. What about tools we're hearing about in the news, like ChatGPT? Are there ways Generative AI is likely to be used in healthcare settings?

Meghan: Absolutely. One of the most interesting applications I've seen is to automatically generate answers to patient questions submitted online, helping cut down on the time clinicians have to spend answering straightforward or simpler questions. A recent study[12] published in JAMA Internal Medicine showed that not only can AI chatbots answer questions accurately, they can also project more empathy at times than the clinician does. We often think of empathy as a uniquely human trait, but we've all had days where we were so busy or overwhelmed or stressed that we didn't show as much empathy as we could or should have. This kind of application could be a win for everyone, cutting down on the valuable time clinicians spend answering simple questions and patients getting both the information they need and done in a way that creates a stronger relationship between the patient and their healthcare providers.

Bonnie: This is all very interesting. If readers want to learn more about AI, what would you suggest to them? I think this is like an ever-evolving topic in terms of risk and mitigation, like cyber liability was 10 years ago.

Meghan: Start wherever you're comfortable and ask lots of questions. There are lots of ways to learn, whether through articles or podcasts or short online courses. I know a lot of people who have been learning by trying out ChatGPT or Bard and finding what's helpful to them and where the boundaries are of what the tools can do - like "hallucinations" when they provide you with information that is inaccurate. Since overnight everyone is an AI "expert" I'd encourage you to start with sources that are reputable and that you trust.

I learn a lot by asking questions when I'm researching a potential vendor or learning a new tool. Much of the time, asking a handful of simple questions gives me a good sense of whether I want to keep finding out more or if I don't think the tool will be useful. I often ask about what data the AI tool was built on and whether the data representative of my use case. For example, if it was built on data from a decade ago but hospital practices have changed significantly in the past few years, the tool may not work as well in today's environment. If the data is small or focused on a different population, it may not work as well. I also ask about how the tool's outputs were validated (how do they know it works), how they checked for bias, and how it is meant to be integrated into existing workflows (does it make things more simple or does it add five additional steps to a process?).

Bonnie: Any final takeaways you'd like to leave with our readers?

Meghan: I'd say the key takeaway is to be engaged. AI isn't a fad or just hype - it's being used in many aspects of our lives today and that will only continue to grow. In fact, in January 2024 the White House announced the creation of an AI Task Force at the Department of Health and Human Services, a clear sign that AI is important for healthcare.[13] Asking questions and learning as much as you can from reputable and trusted sources will go a long way to getting more comfortable with it and finding out ways it can be helpful to you in both your personal and work lives. The deep expertise those in healthcare have developed over decades is more important than ever, and we need people to be voicing feedback on how to improve where and when AI is used and raising concerns if you're seeing potential bias or errors in the tools. There is real opportunity to make patient outcomes better and improve the ways we work and it will take all of us working together to make that a reality.

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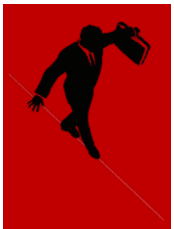
About the Authors



Bonnita (Bonnie) Boone is an insurance executive. She has recently joined J. P West Inc. of New York and Chicago as an Executive Vice President. She will work with leadership to develop markets, operational processes, sales/growth, and overall corporate strategy. Her specialty for over 39 years, has been in healthcare, hospitals, doctors, managed care, and Academic medical centers. Focusing on captives, reinsurance, professional liability, and other lines of coverage. She has worked for Gallagher, Marsh USA, Alliant, and Willis.



Meghan Anzelc, Ph.D. Is the Chief Data & Analytics Officer at Three Arc Advisory. She has two decades of experience in data and analytics, having previously served as Global Head of Data & Analytics at Spencer Stuart. She has a decade of experience in financial services, most recently as the first Chief Analytics Officer at AXIS Capital. Dr. Anzelc's global experience in data and AI have made her uniquely qualified to shape strategy at businesses adapting to new and emerging AI capabilities ethically while managing risk appropriately. She advises boards of directors and executive teams on AI, data, and digital transformation across strategy and operations, serves as an Advisor to startups, and previously served on the board and as chair of the Nom/Gov Committee of the Chicago Literacy Alliance.



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

POCUS
"Point of Care Ultrasound Testing"

By Wilhemina Nyarko

A while ago, I received a phone call from a fellow Hospital Risk Manager in the local area. (We will call her RM) She wanted to know if the organization that I was working for at the time had policies on Point of Care Ultrasound testing. (POCUS). She shared a recent event at her hospital involving an Obstetric Fellow who may have misinterpreted findings in POCUS testing on a laboring patient. Unfortunately, that mishap appeared to have adversely impacted the patient and caused harm.

I suggested to RM that perhaps the subject images could be retrieved for review by an Expert. She informed me that her organization did not have a process to secure images obtained by POCUS testing. We discussed the need to ensure that the involved Obstetric Fellow was competent to perform POCUS testing. She also relayed that her organization did not appear to have standards to ensure that competency for providers who performed POCUS testing on patients. We also discussed concerns about how hospitals and other healthcare practices ensured quality assurance with the use of POCUS. I learned shortly after my conversation with RM that the organization I was working for then also lacked those same standards. I followed up with phone calls to a few other hospitals and it became evident that the lack of robust processes for POCUS testing was not unique to just few hospitals in the New York area. It appears to be a wide spread issue across the country.

The use of Point -of-Care Ultrasound Testing by non-radiologists has significantly increased in the last 30 years. This has led to improved diagnostic accuracy in settings such as in the Emergency Department where physicians are able to make quick determinations about conditions such as abdominal aortic aneurysms, free intraperitoneal fluid, appendicitis, pneumothorax, pregnancy and Deep Vein Thrombosis. The portability of the devices also allows providers to bring enhanced diagnostic skills to the patient's bedside and explain diagnosis in real time. Use of POCUS has also become the standard of practice alongside procedures such as insertion of central lines, paracentesis, lumbar punctures and administration of nerve blocks. These procedures have been shown to have improved success rates and deceased complications when performed with guidance from POCUS.

While there has been proliferation of POCUS use at the bedside, a review of the literature suggests a lack of standardizations when it comes to archiving of the images, lack of standards for skills and competency to perform POCUS and standardized quality assurance metrics to ensure patient safety. In 2020 the Emergency Care Research Institute (ECRI), designated as an Evidence-based Practice Center providing guidance for the Agency for Healthcare Research and Quality (AHRQ) and the Joint Commission, identified POCUS as number 2 among the top 10 greatest technology hazards within healthcare. ECRI stated that "safeguards for ensuring that POCUS users have the requisite training, experience, and skill have not kept pace with the speed of adoption. The lack of sufficient oversight increases the potential that patients will be adversely affected by problems associated with use, or lack of use, of the technology."

The good news is that litigation involving use of POCUS appears to be limited and the very few cases found, derived from allegations about the lack of use of POCUS even though it was available. There is no doubt however that it is only a matter of time before we start to see claims for missed or incorrect diagnoses and or for lack of competency and negligent training of users, as well as a lack of safety metrics with the use of these devices. Consequently, it is important that Health Care Risk Managers work with stakeholders in their organizations to ensure the following:

1. POCUS Image Retention and documentation

Increased use of POCUS at the bedside has sometimes resulted in what has become known as 'phantom' or "ghost" scans (scans that are not saved or record in the patient's medical record.) This obviously increases the risk of liability for hospitals and providers, particularly in the event of an error or an adverse outcome. Archiving images should be the first necessary step in any quality assurance program and it is essential that each organization has a process to permanently record POCUS images and the ability to retrieve and review images. While this does not appear to be the standard across the country, organizations that do have such a process, typically save their POCUS images in a repository such as a Picture Archiving and Communication Systems (PACS) within their radiology departments. The good news is that the growing use of handling POCUS devices that connect to smartphones allows for the possibility of immediate secure cloud-based archiving of images which may a less expensive option to archive POCUS images.

Also imperative is the need for providers to document in the patient's medical record each time POCUS is used in to aide in clinical decision making. The documentation should include time, date, body part, findings, subsequent actions/recommendations when indicated.

2. Competency and Training of Users

There must be organizational processes to ensure that users of POCUS are appropriately trained and that they continue to maintain those skills. Some medical organizations such as

American College of Emergency Physicians (ACEP) and Society of Critical Care Medicine (SCCM) have established guidelines on how to incorporate formal competency-based educational programs for their members. Those guidelines could be emulated in other services. Competency should be achieved by a specialty-dependent curriculum and should include didactics, access to stored images, and hands-on supervised simulation training as an essential component of residency training. All POCUS exams used for clinical decision making by residents should be supervised by a POCUS competent attending physician.

3. Infection Control Process

Policies and Standards for use of POCUS should include clear guidelines to minimize cross contamination of infectious pathogens with the use of these devices. During many of these examinations, ultrasound probes may come into contact with blood and/or other potentially infectious body fluids. Infectious organisms have been cultured from ultrasound probes and gels, even when they may not be visibly soiled, and those organisms included methicillin-resistant Staphylococcus aureus, Pseudomonas aeruginosa and vancomycin-resistant enterococci. All components of POCUS device should be cleaned and disinfected in between use for different patients as outlined by manufacturer's guidelines and the organization's policy.

4. Quality Assurance Program

A quality assurance program for POCUS testing is essential to optimize patient safety. There should be an efficient means to ensure the accuracy of the POCUS scan performed in each department. This should include routine random second readings of a defined percentage of tests to ensure quality and to provide feedback to users.

Given the many advantages of POCUS, we should anticipate increasing use by providers in many specialties and so healthcare organizations have a responsibility to continuously reevaluate its role in clinical care and ensure that the appropriate practice and infection control guidelines, educational curricula and training standards have been implemented.

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About the Author: Wilhemina Nyarko, RN, JD CPHRM is currently the Senior Director of Risk Management at a NYC hospital and has extensive experience in many diverse aspects of healthcare risk management, including loss prevention and mitigation, patient safety and quality, claims and litigation management, privacy and regulatory matters. Wilhemina is admitted to both the New York and New Jersey State Bars and previously served on the Board of the New York Chapter of the American Association of Nurse Attorneys.

Please email any suggestions to: ahrmny@gmail.com or mail to AHRMNY utilizing the RISKY BUSINESS FORM. The form permits confidentiality.

MEMBER SPOTLIGHT

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

Mike Midgley, RN, JD, MPH, CPHRM, DFASHRM - Munich Re Specialty Insurance
Dawn Pignatelli, Esq. - Bartlett LLP





AHRMNY Board Members Dawn Pignatelli and Mike Midgley presented a session at the ASHRM Annual Conference in Minneapolis on October 3rd as well as the virtual session on October 18th associated with Claims and Litigation Management Strategies for Health Care Risk Professionals. The presentation focused on the key elements for a successful claims/litigation management program, the importance of having formalized policies & procedures for management of potential & actual claims, and strategies for training key aspects of the claims/litigation management program. They offered very specific recommendations on claims identification and investigation, coverage determination, setting reserves, liability investigation, damages investigation, claims file management, litigation management as well as settlement negotiations. The session touched on related policies and procedures like reporting adverse events to state/federal agenciescomplaint handling, grievance handling, disclosure and apology, service recovery, alternative dispute resolution and early intervention programs.

Mike is Head of Loss Control at Munich Re's Speciality Insurance Division and Dawn is Senior Associate within the litigation group at Bartlett LLP.

The Risk Management Implications of Insufficient Healthcare Resiliency Planning for Disability, Access, and Functional Needs Populations

Rosemary McDonnell

While all populations are exposed to certain hazards that may exacerbate their existing vulnerabilities during a major disaster, Disability, Access, and Functional Needs (DAFN) populations have a higher propensity to be at-risk and exposed to threats, and the deficiencies in providing sufficient healthcare and emergency planning for DAFN populations have effects that reach past the individual. The main focus of healthcare for these populations has been placed on their day-to-day care, and this focus has not extended past that to include emergency and resiliency planning. DAFN populations in healthcare facilities require specialized planning and more involved assistance when it comes to their personal preparedness and response activities during an emergency activation. Those with cognitive, hearing, visual, and/or language impairments have communication, transportation, evacuation, and sheltering needs that require unique considerations which must be planned for in advance. If hospitals do not devote aspects of these areas specifically and separately to these aforementioned populations, then it can be assumed that their emergency plans for preparedness and response are not sufficient/enough to address the needs of these populations in an emergency and provide them with increased assistance. This article seeks to explore the gap in healthcare emergency planning that exists when considering DAFN populations from a risk management lens. The objective of this article is to explore the risk associated with not providing sufficient/enough emergency planning for DAFN populations in healthcare, as well as not engaging risk managers in these planning efforts. Recommendations will be made for how healthcare facilities can best create a truly inclusive and accessible crisis management program.

Background of the Problem

Typically, the most vulnerable populations are those whose needs for specific planning and increased assistance are not sufficiently considered in the planning of local response and relief organizations.[1] During emergencies, for example, real-time evacuation information is not generally provided to people with no or limited English proficiency, the hearing and visually impaired, and other special needs groups, and their needs are generally not adequately addressed in most emergency operations plans.[2] In a study of vulnerable populations in hospital and healthcare emergency preparedness planning, it was suggested that medical and public health preparedness organizations, particularly hospitals, are not currently identifying the most vulnerable populations, their locations, and the number of people included as a first step in the assessment process, and they are definitely not extending this assessment beyond this to include engaging with these populations in order to understand critical health delivery barriers and opportunities for disaster planning.[3] These examples show that, as opposed to integrating their unique needs into the emergency and resiliency planning processes, the needs of vulnerable populations in emergency situations are attempted to be met after disaster strikes and their inherent vulnerabilities are brought to light. While an all-hazards approach to emergency preparedness is an acceptable form of addressing the general needs of the population, regardless of vulnerability status, each approach needs to specifically address what modifications need to be made in order to meet the needs of each at-risk population that a healthcare entity may serve. Not considering these populations in emergency planning efforts can result in a healthcare facility not meeting regulatory or legal requirements to do, and may even result in lawsuits.

Legal Requirements

In order to properly define what level of emergency planning for vulnerable populations is deemed sufficient in hospitals, the expectations from regulatory agencies and from a legal standpoint were reviewed. Following the aftermath and unequal relief efforts of Hurricane Katrina, reforms to the *Stafford Act* were made to not only ensure socioeconomic status was not a basis for discrimination in response and relief efforts following a disaster, but substantial improvements were made to ensure that the nondiscrimination mandate was more expansive and inclusive of many other types of

of vulnerable populations. Hospitals should be mirroring the efforts of FEMA in their own emergency response planning activities at their facilities. The disproportionate harm suffered by those already disadvantaged provides special reasons for concern about their plight in disasters.[4] By following the guidelines set forth by the Stafford Act nondiscrimination mandate, hospitals can ensure that their emergency planning efforts are providing for specialized care and attention to their most vulnerable patient populations in order to avoid any unnecessary and discriminatory harm to their lives or safety.

Another significant legislation issued in 2006 in response to federal government response and recovery failures during Hurricane Katrina is the *Pandemic and All-Hazards Preparedness Act* (PAHPA). PAHPA influenced emergency response planning requirements for vulnerable populations, especially in the healthcare sector. This Act gives special attention to addressing the health and medical needs of vulnerable populations in emergency preparedness and response planning. However, it is extremely vague in terms of providing sufficient guidance for how its goal should be attained. PAHPA defines "at-risk individuals" as "children, pregnant women, senior citizens and other individuals who have special needs in the event of a public health emergency, as determined by the Secretary of Health", and it allows for, but does not require, the appointment of a Department of Health and Human Services (HHS) "Director of At-Risk Individuals" for emergency preparedness purposes.[5] While the means to attain the goal of sufficient emergency planning for vulnerable populations is vague in PAHPA, the Department of Health and Human Services made credible progress towards this goal in the years following the Act's passing.

Through PAHPA, the Assistant Secretary for Preparedness and Response (ASPR) acts as a leader for hospitals and encourages them to participate in emergency planning activities that support building on regional health care coalitions and better integrating public and private sector partners to improve preparedness and response. Through these federally funded preparedness programs, such as the Hospital Preparedness Program (HPP), hospitals must complete certain deliverables with guidance from ASPR. HPP has included the following language under overarching requirements for all activities: "Regarding the needs of At-Risk Populations, all goals, objectives, and activities proposed in the application should account for the public health and medical needs of at-risk individuals".[6] While this is a notable requirement, little evidence has been shown displaying the collective efforts of individual hospitals throughout the country to conform to this. HHS agency-level activities have certainly displayed their efforts to protect vulnerable populations before, during, and after public health emergencies, but the enforcement of this same requirement for individual hospitals is not prevalent in HPP programming.

Lastly, another significant legislation issued to enhance the preparation and response capabilities for certain vulnerable populations during emergencies is *Executive Order 13347*, entitled "Individuals with Disabilities in Emergency Preparedness." This Presidential Executive Order also establishes the Interagency Coordinating Council on Emergency Preparedness and Individuals with Disabilities in the Department of Homeland Security, which ensures that the Federal Government appropriately supports emergency preparedness and response initiatives for disabled populations and encourage their inclusion in emergency plans.[7] To relate this legislation to the problem statement of this study regarding lack of inclusion of vulnerable populations in emergency planning, EO 13347 makes specific mentions and puts intentional focus on the implementation of emergency preparedness plans as they relate to "individuals with disabilities". While this Presidential Executive Order does not define what exact populations are included in the term "individuals with disabilities", it still legitimizes the concept that at-risk populations need specialized emergency plans to account for their unique needs in disasters. It served as an impetus for the federal government to form partnerships with state and local entities to proactively consider the needs of vulnerable populations in traditionally exclusive and non-specialized emergency planning and response activities. In the first few years after the formation of the Interagency Coordinating Council on Emergency Preparedness and Individuals with Disabilities in the Department of Homeland Security, the unique needs of vulnerable populations were beginning to be highlighted in inclusive emergency exercises, as well as integrated into certain components of key disaster planning and response strategies.[8]

Legal Precedent

A number of other relevant laws have been enacted to prevent discrimination and protect the rights of people with disabilities and others with access and functional needs, including the American with Disabilities Act of 1990 and ADA Amendments Act of 2008, Fair Housing Act of 1968 and Fair Housing Act Amendments 1988, Telecommunications Act of 1996, 21st Century Communications and Video Accessibility Act of 2010, Assembly Bill 2311 (State Law), Rehabilitation Act of 1973, Architectural Barriers Act of 1968, Civil Rights Act of 1964, Individuals with Disabilities Education Act of 1975, and Post- Katrina Emergency Management Reform Act of 2006. The ADA requires that health care entities provide full and equal access for people with disabilities, but this concept usually does not extend past program accessibility and daily care practices (e.g., making a reasonable modification or providing effective communication) into emergency planning efforts. In emergency management, incorporating access and functional needs (AFN) refers to a much larger population. AFN is different from disabilities because it refers to populations that require access and accommodations related to mobility, equipment, communication, and services to people outside of the legal definition of disability.

While not directly related to healthcare emergency planning, these laws have served as the basis for several lawsuits brought against cities across the country. Most notably, Los Angeles (Communities Actively Living Independent and Free et al. v. City of Los Angeles, 2011)[9], New York City (Brooklyn Center for Independence of the Disabled v. City of New York, 2013)[10], and the District of Columbia (United Spinal Association et al v. District of Columbia et al, 2014)[11] all faced separate federal class action lawsuits which challenged their poor emergency planning for persons with disabilities. They also each reached separate settlement agreements regarding remedial plans to improve each city's/district's emergency preparedness programs for disability, access, and functional needs populations in areas such as accessible transportation, communications, sheltering, canvassing, and evacuation. These lawsuits have set the precedent for potential class action lawsuits against other organizations, which may include healthcare facilities. While most class action ADA lawsuits against healthcare facilities have focused on lack of access to healthcare services[12], that is not to say a lawsuit for lack of sufficient disability integration in emergency planning is not possible. If an emergency or disaster activation occurs within a healthcare facility (e.g., active shooter, evacuation, etc.), and they are not able to provide DAFN populations with services such as accessible communications, transport, etc., that facility is at-risk violating ADA law, in addition to CMS and Joint Commission regulations.

Regulatory Requirements

In terms of regulatory requirements, hospitals are guided by principles, rules, and standards from various accrediting bodies. The most prevalent accreditor guiding most hospitals and healthcare facilities is the Centers for Medicare & Medicaid Services (CMS). This is because CMS accreditation is necessary in order for a hospital to be certified as a Medicare and/or Medicaid hospital provider. Currently, the CMS Emergency Preparedness Rule §484.102(a)(3) that addresses this subject reads as follows:*"[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans."*[13] As seen in this Rule, the requirements for healthcare facilities are vague in terms of immediate emergency planning actions to take when planning for at-risk populations. The Joint Commission offers bit more specification, in terms of actionable requirements for healthcare facilities, in their standards for this subject: *Standard EM 12.01.01, EP 2: "The hospital's emergency operations plan identifies the patient population(s) that it will serve, including at-risk populations, and the types of services it would have the ability to provide in an emergency or disaster event. Note: At-risk populations such as the elderly, dialysis patients, or persons with physical or mental disabilities may have additional needs to be addressed during an emergency or disaster incident, such as medical care, communication, transportation, supervision, and maintaining independence."*[14] As seen in this Rule, the requirements for healthcare facilities are vague in terms of immediate emergency planning actions to take when planning for at-risk populations. The need for more inclusive language in these standards is apparent, as well as more specific language regarding how these regulations should be met by healthcare facility emergency planners

in all areas of communication, resources and assets, safety and security, staff responsibilities, utilities management, and patient care needs.

Distinctive Emergency Preparedness and Response Planning Needs of Vulnerable Populations in Healthcare

Many studies have been beneficial in promoting the need for modifying all-hazards plans to specifically mention how an organization will address the needs of vulnerable populations, separating specific sub-groups based on their vulnerability characteristics. In a post-2005 hurricane season analysis, it was shown that combining groups too broadly translates into imprecise planning and, as a result, emergency response failures.[15] In a study of vulnerable populations in hospital and healthcare emergency preparedness planning, it was suggested that medical and public health preparedness organizations, particularly hospitals, are not currently identifying the most vulnerable populations, their locations, and the number of people included as a first step in the assessment process, and they are definitely not extending this assessment beyond this to include engaging with service populations in order to understand critical health delivery barriers and opportunities for disaster planning.[16] In a study on vulnerability and unmet healthcare needs, researchers chose to operationalize the concept of vulnerability using profiles that account for multiple risk factors that are associated with access to care. This study further demonstrates that a substantial proportion of U.S. adults (about one in five) has multiple risk factors for unmet health care needs, and that these risk factors create up to five-fold differences in rates of unmet needs (e.g., delayed medical care) between the highest and lowest profiles, regardless of race/ethnicity.[17] The literature had a consensus on the need to distinctively define and address the varying risk factors and vulnerability characteristics of separate populations in order to account for their healthcare and emergency planning needs, but they differed in their approaches to providing frameworks for improvement. While one study proposed a function-based framework built on five essential function-based needs (communication, medical needs, maintaining functional independence, supervision, and transportation),[18] another study suggested an integrated healthcare and public health preparedness framework that incorporates the need for the integration across the healthcare sector necessary for reducing individual and cultural vulnerabilities (representing both a bottom-up and top-down approach).[19] Regardless of the framework chosen, if the unique considerations to be made for vulnerable populations remains to be left unaddressed in hospitals, the effects could be debilitating on the entire healthcare system.

New York City Hospital Case Study

Various hospitals throughout New York City participated in a 2023 dissertation study that measured their sufficiency of emergency planning for vulnerable populations with communication barriers (limited English proficiency, sight limitations, and/or hearing limitations). This mixed-methods study, which used survey and interview tools to gather information from NYC hospital Emergency Preparedness Coordinators (EPC's), found that there is a relationship between the vulnerability status of an individual or population with communication barriers and their ability to receive sufficient/enough planning for emergency preparedness and response planning in New York City hospital facilities.[20] This is displayed in Table 1 and Figure 1 below. It also found that there is a relationship between the vulnerability type of a population with communication barriers (i.e., no or limited English proficiency, sight limitations, and/or hearing limitations) and their ability to receive sufficient/enough emergency planning from hospital facilities. Most planning efforts seemed to focus on limited English proficiency populations, with limited hearing populations receiving less attention and sufficient planning, and with limited sight populations receiving even less. While describing the practical implications of this study, the researcher pointed out a lack of specificity in regulatory standards, a lack of guidance on how exactly to address this issue, and a lack of intentional focus placed on emergency planning for vulnerable populations in healthcare settings from regulatory agencies, public health agencies, healthcare coalitions, and healthcare associations.

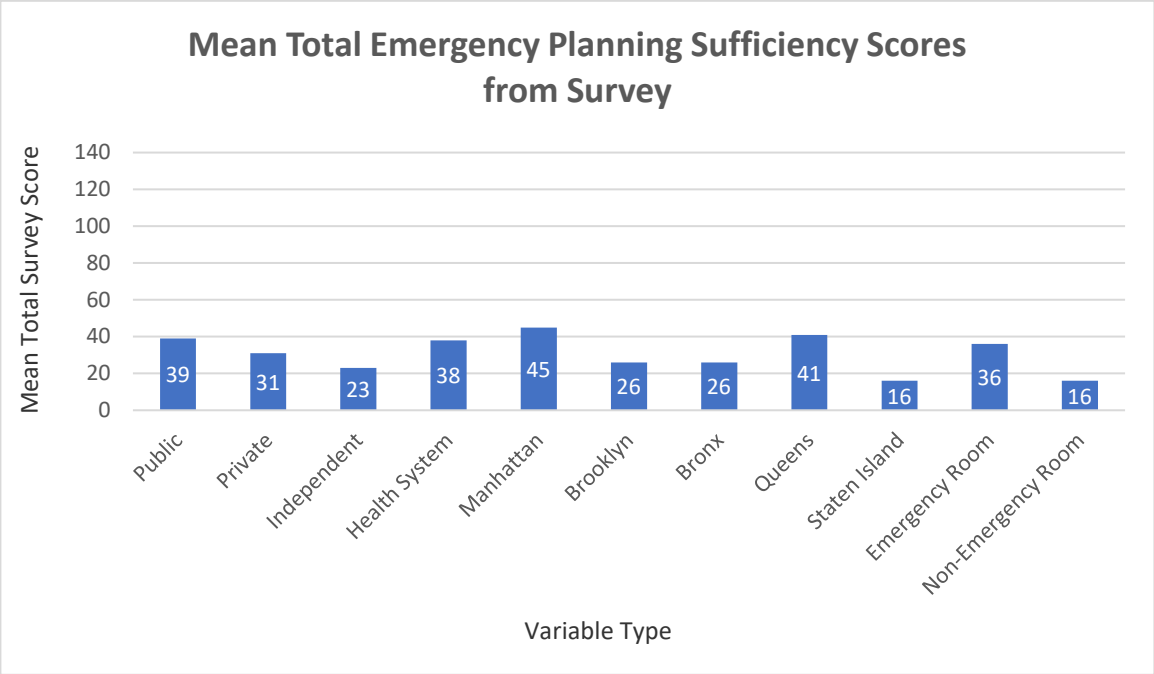
Practical Solutions and Application

While adequately addressing this issue may require a multifaceted approach from several levels of government and public health, healthcare facilities can still evaluate their specific hospital's level of sufficiency of emergency planning for vulnerable populations with communication barriers, as well as explore their demographics of these populations, applicability and

Table 1: Table Displaying Mean Total Emergency Planning Sufficiency Scores from Survey for Each Variable

Variable	Total Possible Emergency Planning Sufficiency Score	Total Possible Emergency Planning Sufficiency Score Category	Mean Emergency Planning Sufficiency Score	Mean Emergency Planning Sufficiency Score Category
Public hospital	144	Excellent	39	Poor
Private hospital	144	Excellent	31	Poor
Independent hospital	144	Excellent	23	Very Poor
Health System hospital	144	Excellent	38	Poor
Manhattan hospital	144	Excellent	45	Poor
Brooklyn hospital	144	Excellent	26	Very Poor
Bronx hospital	144	Excellent	26	Very Poor
Queens hospital	144	Excellent	41	Poor
Staten Island hospital	144	Excellent	16	Very Poor
Emergency Room hospital	144	Excellent	36	Poor
Non-Emergency Room hospital	144	Excellent	16	Very Poor

Figure 1: Bar Chart Displaying Mean Total Emergency Planning Sufficiency Scores from Survey for Each Variable



feasibility of solutions and enhancements to this planning, and advocate for support and collaboration/partnerships to address this issue. A reoccurring theme in many interview responses amongst EPC's was that the response during emergencies for these vulnerable populations was thought to be more of a patient care issue than an emergency management responsibility.[21] Given this connection, it is apparent that any patient care issue or vulnerability of the hospital to provide sufficient patient care (especially during an emergency) should be considered a high priority issue of the hospital that should be addressed, supported, and given the necessary resources to ameliorate. It is paramount that EPC's and hospital Risk Managers serve as advocates for these populations in terms of their right to receive proper and sufficient pre-planning for emergencies.

Importance of Engaging Healthcare Risk Managers in DAFN Population Emergency Planning

It is equally important that this planning not be done in a silo, but as a multi-disciplinary group. EPC's and Risk Managers should work to build a support network within the hospital and/or Health System that also advocate for and/or are involved in patient care for these populations (e.g., Social Work, Case Management, ADA offices, Language Access, Deaf Health Services, Guest/Patient Experience, etc.) as well as those involved in emergency planning for the general population, all of whom should share common goals, interests, and hurdles to overcome when it comes to this topic. The involvement of risk managers is especially important in this type of endeavor, as they can provide the justification to hospital leadership to invest time, resources, and personnel into making emergency management programs accessible and inclusive. By taking a proactive stance on this topic, the risk of potential legal exposure and patient safety issues from not meeting the needs of DAFN populations within a healthcare facility during an emergency activation can be reduced. As seen in the aftermath of Hurricane Katrina, hospitals can be held liable for insufficient emergency planning that may result in the death of patients, visitors, and other constituents that might be in their facility during emergency situations.[22] While no criminal charges were ever brought against the medical staff who acknowledged that they had hastened the deaths of trapped, medically fragile patients (most were bedbound or required electric ventilators to breathe) by injecting them with drugs, Tenet Healthcare Corporation paid $25 million to patients and visitors trapped at Memorial Medical Center after Hurricane Katrina due to evacuation and backup power being inadequate.[23] This is a relevant example of how insufficient collaboration between emergency management and risk management can result not only in a horrible human toll (usually to the most vulnerable individuals within a healthcare facility), but also in disastrous financial consequences for a hospital. Risk managers should play a direct role in the development of policies and procedures related to emergency management, such as those addressing disaster-related standards of care, modification of the privileging and credentialing process, and negotiation of mutual-aid agreements with other hospitals.[24]

Conclusion

Disaster planning for disability, access, and functional needs populations in hospitals is a multifaceted issue that requires the input, guidance, and involvement from stakeholders outside of emergency management. Engaging risk managers who already advocate for the reduction of exposure to hazards in a daily care setting and barriers to patient safety can provide the necessary insight and perspectives to elicit support for bolstering equity and accessibility in emergency management programs. Risk Management should place a more intentional focus on ensuring hospitals and other healthcare facilities are aware of the risk that exists for vulnerable populations, in terms of their life, safety, and basic human needs, if they are not addressed in emergency and resiliency planning.

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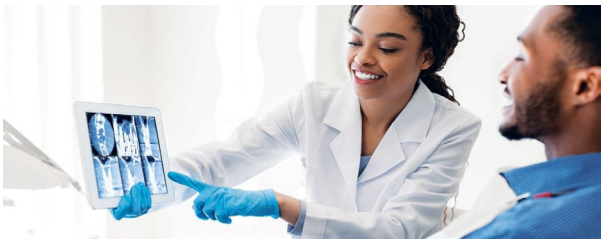


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Dental Records and Liability Protection — A Defense Attorney's Perspective

John W. VanDenburgh



As a lawyer for more than 30 years, I have represented dentists who have been sued for dental malpractice and who have been investigated by the New York State Office of Professional Discipline (OPD) for alleged misconduct. I also have the privilege of being a presenter for the New York State Dental Association Risk Management Program. In my experience, the single most important factor in successfully defending a lawsuit or protecting a dentist's license is good recordkeeping by the dentist. Legal concerns aside, good records also improve the quality and consistency of patient care.

...good records also improve the quality and consistency of patient care.

Part 29 of the Compilation of Codes, Rules and Regulations of the State of New York entitled Unprofessional Conduct (8 NYCRR 29.2) states that unprofessional conduct includes:

> **Failing to maintain a record for each patient which *accurately reflects the evaluation and treatment of the patient.* Unless otherwise provided by law, all patient records must be retained for at least six years. Obstetrical records and records of minor patients must be retained for at least six years, and until one year after the minor patient reaches the age of 21 years.**

If a dentist fails to maintain a record that accurately reflects the evaluation and treatment of the patient, that dentist has arguably engaged in unprofessional conduct. With respect to defending a lawsuit by a patient alleging dental malpractice, the issue is whether the treatment, or absence of treatment, complied with the accepted standards and practices of the dental profession.

Sometimes the treatment at issue occurred years ago and the patient was only one of many in a busy practice. If the dentist has not maintained a record that accurately reflects the evaluation and treatment of that specific patient, it will be difficult to demonstrate to a judge or jury that the treatment provided by the dentist was in accordance with the accepted standards and practices of the dental profession. That is especially true when the patient's recollection of what occurred during the treatment differs from the recollection of the dentist. Accurate and complete records, prepared at the time of the treatment, are the most objective and reliable way of establishing what happened at the time.

A few examples from my own cases of how recordkeeping can affect the outcome of a lawsuit or disciplinary proceeding are as follows:

EXAMPLE #1

A patient was seen with a complaint of redness and irritation on the lateral border of the tongue and the dentist suspected that the tongue was rubbing on the sharp edge of an adjacent tooth. The sharp edge was smoothed and, according to the dentist, the patient was instructed to call or return if the sore spot did not resolve. That instruction was not documented in the chart.

The patient was seen some months later for a routine cleaning and examination. No specific reference was made as to the appearance of the previously irritated area and there was no specific notation as to the appearance of the area or that the irritated spot resolved. Following the routine cleaning and examination, a notation was subsequently made in the chart that no further appointments should be scheduled until satisfactory arrangements were made for paying the patient's outstanding balance.

...the patient was diagnosed with oral cancer and underwent a major resection of the tongue.

Several months later, the patient was diagnosed with oral cancer and underwent a major resection of the tongue. The patient brought a lawsuit claiming that the dentist had failed to properly detect, diagnose, and/or treat the oral cancer that initially manifested itself in the red and irritated area of the tongue. The plaintiff testified that the area did not improve after the initial smoothing of the tooth and instead became larger, more painful, and chronically red, surrounded by a white border.

Factors creating difficulty in defending the case were: 1) the absence of a specific scheduled follow-up visit after the initial tooth adjustment that would have documented the patient's condition; 2) the absence of any specific reference to the area at issue during the routine cleaning and examination; and 3) the patient's testimony that she was reluctant to call or request an appointment to address her worsening condition because she knew she had an outstanding balance on her account and believed the dentist would not see her. She had obviously read her records before she testified.

It would have been helpful if the records documented a follow-up examination that revealed a resolution of the irritation; included a specific notation at the routine exam that the sore spot had resolved; and if the records reflecting treatment did not make reference to a potential refusal to treat the patient until her account balance was resolved.

EXAMPLE #2

A dentist examined a minor child, and a Panorex film was taken that demonstrated, according to the record, "…a large hole on the occlusal surface of #31." The record further stated that "patient is unaware." The note contained no further information. The patient was seen a few months later for a routine cleaning and examination, and no mention was made in the record with respect to the earlier finding.

Ultimately, the mother of the patient filed a complaint with the Office of Professional Discipline alleging that a subsequent dentist diagnosed and treated the problem with tooth #31 and that no such diagnosis had been made, or treatment recommended, by the initial dentist. The initial dentist contended that he had advised the patient and the mother of the hole on the occlusal surface of tooth #31 and had recommended treatment including, at a minimum, the need for a filling as well as the potential for root canal therapy. He recalled that the mother had declined treatment for the child, advising that she would be seeking a second opinion.

...the initial dentist did not document that discussion, the treatment recommendations, or the mother's intention to seek a second opinion.

Unfortunately, the initial dentist did not document that discussion, the treatment recommendations, or the mother's intention to seek a second opinion. In fact, the ambiguity, or poor choice of wording, in the notation "patient is unaware" could, in theory, support the contention that the patient and her mother were not told. Because the record did not document that the diagnosis as well as a plan for treatment were conveyed to the patient, the dentist was sanctioned by OPD for failure to maintain appropriate dental records.

EXAMPLE #3

A dentist was sued by a patient, who contended that over an approximately 15-year period of time, her periodontal condition was allowed to deteriorate such that, toward the end of her treatment with the dentist, she had significant pocket depths requiring both periodontal consultation and, ultimately, surgery. Although the dentist eventually diagnosed a periodontal issue at the tail end of the patient's treatment and referred her to a periodontist, she sued alleging that her periodontal problems should have been diagnosed and treated years earlier.

The dentist's records reflected a few scattered bite wing and periapical x-rays taken years apart and no Panorex or full mouth series films at any time during the 15 years of treatment. The records reflected no periodontal charting or screening during the same treatment period. It was the dentist's recollection that he frequently had recommended a Panorex to the patient in order to help assess her overall dental condition, but that she continually declined. In addition, both the dentist and hygienist would periodically conduct random assessments of the patient's pocket depths over the years and the random pocket depths were never concerning; otherwise, there would have been a notation made in the chart.

The x-ray recommendations and periodic pocket depth assessments were not recorded in the chart. As a result,

It was difficult to oppose the patient's testimony
It was the dentist's recollection that he frequently had recommended a Panorex to the patient...

that she never refused x-rays and was unaware of any assessment of her periodontal health ever being done. The absence of a Panorex or full mouth series, and no documentation that the patient had refused such studies, made it difficult to oppose the opinion of the patient's trial "expert" that the bone loss present at the time of diagnosis had necessarily occurred, and was undiagnosed, over many years.

Successful Defense

I have also had several other cases, however, where the dentist maintained detailed and accurate records that established proper treatment. The detailed nature of these records established the quality of the care and ultimately resulted in the voluntary discontinuance of malpractice complaints or the dismissal of disciplinary complaints. During risk management presentations, I emphasize that the most important tool for defending

...these records established the quality of the care and ultimately resulted in the... dismissal of disciplinary complaints.

malpractice claims or disciplinary actions is a quality treatment record. A quality record that accurately reflects the evaluation and treatment of the patient contains the following:

- An accurate and current patient history, including the purpose of the visit and the patient's complaints, if any.

- The nature and scope of the clinical examination, as well as documentation of any significant findings, either positive or negative.

- Documentation of any diagnostic images recommended. If the images are taken, any significant findings, either positive or negative, should be documented. If the patient refuses any images, or other treatment recommendations for that matter, including referral to a specialist, the record should document the recommendation made, the reason for the recommendation, that the recommendation was thoroughly discussed with the patient, and that the patient refused.

- The record should reflect the dentist's assessment of the patient, including any diagnosis or the identification of any conditions requiring treatment (a treatment plan).



- If the patient agrees to a treatment plan, that plan should be documented, including the fact that informed consent for such treatment was obtained. If that treatment is performed, the record should document the treatment rendered, including, among other things, the type and quantity of anesthetic. If medication is prescribed, the name and dosage of the medication should be documented. For procedures requiring x-rays taken before, during, and/or after the procedure, the taking of the x-rays should be documented. In short, the documentation should be sufficient for a dentist unfamiliar with the patient to be able to determine from a review of the record alone what treatment was provided and why.

- Referrals to any specialists such as endodontists, periodontists, or oral surgeons should be clearly documented, and the dentist should have a procedure in place to follow up with respect to the outcome of those referrals, including the determinations and recommendations made by such specialists.

- Separate records should be kept with respect to billing, and care should be taken to ensure the procedures billed for were performed and that the billing records match the patient treatment record.

In conclusion, a patient's dental chart provides strong documentary evidence, created at a time contemporaneous to the treatment and before the specter of litigation or disciplinary action ever occurred, that will support, sometimes years after the fact, a dentist's position that the treatment rendered was at all times professional in nature and comported with the accepted standards and practices of the dental profession.

About the Author



John W. VanDenburgh is a founding partner of the firm Napierski, VanDenburgh, Napierski & O'Connor, LLP, and has successfully tried numerous cases to verdict on behalf of individuals, municipalities, private sector businesses, and insurance companies. Mr. VanDenburgh is Panel Counsel to, and a Risk Management Presenter for, the New York State Dental Association and frequently lectures dental and medical societies on issues of risk management, employment practices, and liability limitation.











2023 Chapter Event

Union Rooftop Bar & Grill
Minneapolis, MN
October 2, 2023








CASE STUDY: Negligent Credentialing and Inadequate Emergency Response at Ambulatory Surgery Center Lead to Malpractice

Jeanne E. Mapes

Claims involving improper credentialing often coincide with allegations of improper and inadequate training. This case examines a failed resuscitation effort at an ambulatory surgery center (ASC) in which credentialing issues, deficient emergency response procedures, and lack of staff training all contributed to a tragic outcome.

Case Details

The patient, Ms. P., was a female in her late forties suffering from a 6 cm left thyroid mass. She had a history of morbid obesity, obstructive sleep apnea, and reactive airway disease that she controlled with a daily inhaler. The patient also had tracheal deviation to the right. A thyroidectomy was scheduled for a follicular neoplasm on the left side.

The surgery was scheduled at an ASC, which was accredited as a hospital; the facility was owned by Dr. A (an otolaryngologist) and several other physicians. Following the thyroidectomy, the patient would need to stay overnight at the facility.

The ASC had patients sign a disclosure form that stated that the facility did not have an onsite physician after normal business hours, but that staff were prepared to handle emergency situations and trained in advanced cardiac life support and pediatric advanced cardiac life support. The form also stated that the ASC's hospitalist made rounds at least once a day, and that patients' physicians would be available by phone and contacted if needed.

The patient's surgery went as planned without complications. The wound was closed with a liquid adhesive, and a Jackson Pratt drain was placed. The procedure was finished at 11:00 a.m. The surgeon, Dr. A, saw the patient in the recovery room about 45 minutes after the procedure was completed, and she was doing fine.

Shortly after the patient arrived in her room, she started to complain that her throat hurt and that it hurt to swallow. At about 1:00 p.m., the patient was offered hydrocodone-acetaminophen. She was worried that it would hurt too much to try to swallow it, so Dr. A ordered intravenous pain and antinausea medications.

The patient's O_2 saturation dropped to 84 percent and she was given a nonrebreather mask with 1 liter of oxygen flowing through it. Her oxygen level returned to normal. The next few hours were uneventful; she did not require continuous oxygen and was able to swallow ice chips. At around 6:15 p.m., the patient vomited undigested food, although she stated that she had not eaten anything since 8:00 p.m. the evening before.

A nursing shift change occurred between 6:30 p.m. and 7:00 p.m. The hospitalist, Dr. H, also arrived for his rounds around that time. The patient vomited again around 7:00 p.m.; Dr. H saw her at 7:10 p.m. and ordered ondansetron hydrochloride for nausea. Before the nurse could give the medication, the patient's family came out of her room and said that the patient was having breathing problems. The nurse noted stridor. Dr. H suctioned the patient without any return.

The nurse ran down the hall and obtained a nasal airway and a bag-valve-mask resuscitator. The patient's husband, who was a first responder, assembled the resuscitator and began ventilating the patient while the nurse inserted the nasal airway. Another nurse then took over the ventilation.

At this time, three physician owners of the ASC (an OB/GYN, an orthopaedic surgeon, and a urologist) were onsite attending a board meeting; Dr. A was attending the meeting via conference call. During the meeting, Dr. A learned from a nurse that the patient's condition was deteriorating. He interrupted the meeting and asked the onsite physicians to visit Ms. P's room and assess her. At about 7:20 p.m., as the three physicians arrived in the patient's room, she went into full cardiac arrest. A staff member called 911, and chest compressions were started. The orthopaedic surgeon tried to intubate the patient three times without success. Of note, he had not intubated a patient in 10 years. Bag ventilation continued throughout his attempts.

The nurse notified Dr. A of the evolving situation, and he began to drive to the ASC while remaining on the phone with the nurse. During the drive he learned that the onsite physicians were concerned that the patient might have a hematoma. Dr. A asked the onsite physicians to open the incision. While waiting for them to do that, he

was told that they were looking for a scalpel. Dr. A informed them that the patient had a fresh wound that was closed with liquid adhesive; thus, they could open it with their fingers. Each of the onsite physicians, with the exception of Dr. H, was qualified to open the neck. The neck was opened but no blood was found, and the patient continued to have respiratory distress. Dr. A asked whether the trachea was exposed and learned that it was. He then asked the onsite physicians to perform a tracheotomy. A scalpel was not on the crash cart, so a nurse went to find one. She had just procured one from an operating room on the other side of the small facility when the emergency medical services (EMS) crew arrived and took over the patient's care. It is unclear whether a tracheotomy kit was on the premises; if it was, no one knew where it was located.

After one unsuccessful attempt, an advanced emergency medical technician was able to intubate the patient. The patient was transported to a local hospital. There, she developed anoxic encephalopathy and died 10 days later. An autopsy was not performed, and the cause of death remains unknown.

The patient's estate initiated a malpractice lawsuit against Dr. A, Dr. H, the three physician owners who were onsite and assisted during the patient's deterioration, and the ASC. The lawsuit was settled early in the discovery phase of litigation with a payment in the midrange; defense costs were in the low range.

Discussion

Several factors converged to contribute to the devastating outcome in this case and the subsequent malpractice lawsuit. The first issue was a failure on the ASC's part to properly credential Dr. H, the employed hospitalist.

Negligent credentialing refers to a type of liability in which a patient is injured by an incompetent or unqualified healthcare provider, and the healthcare organization is directly responsible to the patient because of a failure to properly conduct the credentialing process.[1] Credentialing is not just the process of confirming a healthcare provider's degrees, certifications, and training — nor does it end with the gathering of external credentials. The information obtained during credentialing needs to be reviewed with a critical eye.

In this case, red flags should have been raised during the review of the Dr. H's credentials. Following his completion of medical school, he performed various jobs for almost a decade before entering a residency program and training as a neonatologist. Additionally, he had attempted to get board certified in neonatology numerous times without success. This information should have resulted in further questioning and review of Dr. H's education and experience to determine whether he was competent and qualified to serve in a hospitalist role treating adult patients.

Credentialing also requires professional practice review. The healthcare provider who is undergoing credentialing needs to demonstrate that he/she can provide competent care to the organization's patient population. Thus, new employees should undergo a proctoring or performance-monitoring period. No evidence was available that Dr. H's performance was ever monitored, or — if it was — what standards were used.

The ASC should have had a hospitalist on staff that could anticipate and handle postoperative complications related to all types of procedures done at the facility, including the neck procedure performed in this case. Dr. H should have been competent to open the neck, deal with postoperative respiratory complications, and intubate an adult patient with a difficult airway, as well as any other core competency for a hospitalist.[2] Interestingly, during his deposition, Dr. H said that he did not consider himself to be a hospitalist, and he confirmed that he was not qualified to open the patient's neck or trained to do a tracheotomy.

Further, the ASC's own medical staff bylaws stated that the covering physician should be board-certified or board-eligible in internal medicine. Both the ASC and Dr. H failed to recognize that he was not competent to act as a hospitalist at this facility.

In addition to negligent credentialing, other issues related to emergency response procedures and staff training also were evident in this case. The facility did not have proper equipment to handle airway emergencies, the physicians and nurses were unaware of what emergency equipment was available and where it was located, and a lack of emergency training led to a chaotic response when the patient went into full cardiac arrest.

To address the potential for medical emergencies, the facility should have had a written emergency response plan. That plan should have been based on an all-hazards risk assessment that identified the types of emergency situations that might likely occur in the facility. If an assessment had been done, airway compromise would have been identified as a recognized complication of neck surgery. In turn, the physician owners could have implemented a training and competency evaluation program to ensure that all providers and staff members were prepared for this possibility.

Beyond initial training and competency evaluation, annual training should have occurred to confirm that providers and staff members were prepared to respond quickly and appropriately to a situation involving a compromised airway. Training drills would have revealed any weaknesses in the response plan, particularly in relation to having and locating necessary emergency equipment.

Unfortunately, the staff's inability to locate a difficult airway kit, the lack of a scalpel on the crash cart, and the failure to successfully intubate the patient while waiting for EMS wasted precious minutes during the emergency response, which may have contributed to her death.

This case had many unresolved questions as a result of the settlement occurring early in the discovery process. For example, why was Dr. H hired for a hospitalist position? Did the facility lack a proper credentialing process, or was the process not followed correctly? Why were the organization's own bylaws requiring board certification or eligibility in internal medicine ignored? Without answers to these questions, understanding the full picture of this case is difficult.

In Summary

Despite the lingering questions in this case, what is known is that proper credentialing of healthcare providers and validation of competency is essential for safe patient care. Medical staff bylaws should define minimum credentialing requirements for practitioners and provide the framework for administrative procedures and processes to ensure that medical staff can provide safe and competent care.

Further, all healthcare organizations need to assess their potential risks for medical emergencies, develop thorough response plans, validate that providers are qualified to perform emergency procedures (e.g., tracheotomy), and conduct adequate emergency response drills for providers and staff members during orientation and routinely thereafter.

For more information, see MedPro's guideline titled *Credentialing and Privileging* and article titled *Managing Medical Emergencies: A Three-Pronged Approach for Healthcare Practices*.

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About the Author



Jeanne Mapes, JD, CPCU, CPHRM, is a senior risk solutions consultant at PLICO (a MedPro Group/Berkshire Hathaway company). She has more than 25 years of experience working with professional liability insurers, working first in claims and then in risk management. Jeanne currently provides services to physicians and nursing homes in Oklahoma and Arkansas.



An Uncomfortable Reality: Dealing with Domestic Violence in the Workplace

Laura M. Cascella

Violence is an undisputable issue in healthcare, and the media is rife with reports of violent acts occurring in various healthcare settings. Often, when thinking about violence in healthcare, stories in which patients or their families are the perpetrators come to mind. In some instances, disgruntled or mentally unstable employees act as the aggressors. Violence prevention programs often focus on these aspects, but sometimes overlook another crucial source of violence — domestic violence (including intimate partner violence).

Domestic violence is a substantial issue in society, and it can affect people of all gender identities, sexual orientations, races, religions, ethnicities, economic backgrounds, and so on. Despite the terminology, domestic violence is not contained within the confines of the home; it can easily move into other areas of life, including work. When domestic violence spills into the workplace, the consequences can range from subtle to catastrophic, and they may result in anything from loss of productivity and absenteeism to loss of life.

Because domestic violence is a common but sometimes under-recognized threat to safety, healthcare organizations should keep this issue in focus as they consider overall violence prevention efforts. Four ways that organizations can address this problem include raising awareness, developing a domestic violence policy, providing education and training, and working with external resources.

Raising Awareness

Domestic violence affects about 10 million people in the United States every year.[1] According to the National Coalition Against Domestic Violence, an estimated 1 in 4 women and 1 in 10 men experience sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime.[2] Domestic violence also can include threats, emotional/psychological abuse, and economic abuse.

Despite its prevalence in society, domestic violence often is viewed as a taboo topic, which may only serve to reinforce its pervasiveness. Victims might be hesitant to come forward or report threats if they feel embarrassed or ashamed, or they may fear that others will avoid them or dismiss their concerns. By shining a light on this issue, healthcare organizations can raise awareness among staff members, while also preparing them to deal with potential domestic violence scenarios that may affect them directly or indirectly.

Naming the issue and acknowledging its impact is an important first step in reducing stigma and starting conversations that support a culture of physical and psychological safety. Healthcare organizations can raise awareness in various ways and should consider multiple formats or pathways for communicating with employees, such as:

- Including information about domestic violence in orientation training, employee handbooks, and safety initiatives.
- Distributing information about the organization's violence prevention program and policies to all staff members.
- Posting information about domestic violence on the organization's intranet, on bulletin boards, in restrooms, in organizational newsletters, etc. Make sure information is posted "in places where employees can obtain it without having to request it or be seen removing it."[3]
- Providing information about support resources, including employee assistance programs, local domestic violence service providers, domestic violence hotlines, and designated human resources contacts.
- Conducting domestic violence awareness activities, including seminars, brown-bag lunches, and other trainings.[4]

Discussing domestic violence as an unfortunate but serious reality in healthcare can be uncomfortable and difficult. Yet, raising awareness — and sustaining it over time — is imperative for supporting victims and ensuring that employees understand the breadth of the

problem and the appropriate steps to take if they suspect a coworker is being abused or if they becomes victims of abuse.

Developing a Domestic Violence Policy

Policies are the bedrock of an organization's culture, and they set clear expectations for conduct and operations. Although many healthcare organizations have violence prevention policies, they may fail to include information related to domestic violence[5] — an oversight that could potentially have significant consequences.

Thus, organizations should review their policies to determine whether domestic violence information is included and whether the information is thorough and unambiguous. Key areas for consideration include:

- Developing a multidisciplinary team with representatives from various departments (e.g., human resources, communications, medical specialties, security, legal, etc.) to oversee the domestic violence policy and related initiatives.
- Working with legal counsel to ensure that the violence prevention policy complies with federal and state laws and guidance in relation to violence prevention, workplace safety, and rights for victims of domestic violence.
- Surveying employees on a periodic basis to assess their views on workplace safety and their perspectives on the domestic violence policy. Information gleaned from surveys can help the multidisciplinary team review and update the policy to address any gaps or changes that occur.
- Developing guidelines and procedures for situations in which (a) an employee/manager suspects that a staff member is a victim of domestic violence, (b) a staff member discloses to an employee/manager that they are a victim of domestic violence, or (c) the threat of violence or a violent act takes place in the workplace.
- Working with legal counsel to determine procedures for handling situations in which employees are accused of perpetrating or assisting in acts of domestic violence. Healthcare organizations should have policies related to investigating these circumstances and following up with corrective/disciplinary action.
- Establishing the organization's commitment to keeping information about victims of domestic violence confidential, and clearly delineating the situations in which the organization is compelled to disclose information (e.g., to protect worker safety or to comply with the law).
- Determining workplace flexibilities and accommodations to support victims of domestic violence, such as staggered schedules; inconspicuous work areas; phone call screening; removal of personal information from public directories; security escorts to the parking lot; and time off for injuries, moving, court dates, etc.[6]

As with other types of policies, a domestic violence policy is effective only if employees see that it was developed with purpose, is adopted across the organization, is consistently followed, and aligns with the organization's core values and priorities.
If employees do not feel that physical and psychological safety are a top concern in the facility, they will likely view any domestic violence policy as merely more bureaucracy or empty talk. To avoid this misperception, organizations should take a top-down approach that engages executives, senior leaders, and managers to help build awareness of the policy, advocate for workforce safety, and reinforce the organization's commitment to a zero-tolerance violence philosophy.

Providing Education and Training

A well-educated and trained workforce is an asset for any organization, which is particularly true when it comes to violence prevention. Responding to violence can feel unnatural, uncomfortable, and frightening — but how an individual responds might have a profound effect on the outcome of a situation.

Additionally, education and training are imperative to ensure that employees are aware of the organization's violence prevention plans, including specific guidance for situations involving domestic violence. Even the most well-devised and comprehensive domestic violence policy will be meaningless if staff members don't know it exists or are not well-versed on its guidance.

Employees should receive training on organizational violence prevention policies during orientation and periodically thereafter (e.g., yearly). In addition to policy specifics, other topics and areas of focus for a robust education and training program might include:

- The prevalence and types of domestic violence, common signs and symptoms of abuse, and how domestic violence can affect workplace productivity, culture, and safety.
- Resources available to victims or perpetrators of domestic violence, including employee assistance programs, hotlines, support groups, counseling services, local domestic violence service providers, etc.
- Appropriate methods and contacts for reporting concerns about domestic violence or known threats to the workplace.
- Privacy and confidentiality standards related to domestic violence situations, including who receives information and how it is documented.
- Appropriate steps for responding to and communicating with victims of domestic violence, including making referrals to experts who are equipped to handle these situations. Employees, managers, and human resources staff should understand their roles and limitations in assisting victims or perpetrators.
- Security policies and procedures in place at the organization as well as special accommodations available to safeguard individuals and the workplace.
- Victims' rights per legal statutes and organizational policies, including any modified workplace benefits.[7]

Organizational leaders who develop and oversee staff education and training on domestic violence prevention and response should consider various training formats and activities to keep individuals engaged and aware. Because not everyone learns in the same way, offering a variety of training options in different formats (e.g., tabletop exercises, lectures, and drills) is beneficial for participants.

Working With External Resources

Raising awareness about domestic violence, having policies in place, and offering training and education are important factors in preparing the workforce for potential exposure to this type of violence. However, expecting any individual or group of people at the healthcare organization to be experts in this area is unrealistic — and it may prove dangerous if they feel compelled to act outside of their expertise.[8]

To address these knowledge and experience gaps, healthcare organizations can forge collaborative relationships and partnerships with groups that do have specialized training and knowledge about domestic violence. For example, organizations can work with local law enforcement to conduct security vulnerability assessments of their facilities and properties and to review violence prevention policies. Additionally, community outreach can help healthcare organizations develop a network of reputable resources that can assist with domestic violence education and assistance for victims.

Having these resources in place can provide employees with a roadmap for navigating domestic violence issues and help alleviate their concerns, fears, and anxiety associated with managing these potentially high-risk situations.

In Summary

Domestic violence is a common and troubling issue in society, and it represents a serious concern for workers and workplace safety. Although discussing and responding to domestic violence can be difficult, healthcare organizations should not turn a blind eye to the problem — particularly because it can have both direct and indirect negative consequences for the organization and its workforce. Rather, by raising awareness of this issue, developing a policy to address it, providing comprehensive education and training, and establishing relationships with experts, healthcare organizations can build trust with their employees, offer vital assistance when needed, and make a good faith effort to safeguard workers from harm.

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