MEDICAL MALPRACTICE AND INSTITUTIONAL LIABILITY

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I. HOSPITALS ARE DANGEROUS PLACES

For over 40 years, study after study has confirmed the existence of a medical malpractice epidemic in the United States. Current research demonstrates that just under 200,000 people die every year in hospitals as result of medical mistakes.[1] It is roughly equivalent to two jumbo jets full of passengers colliding in midair each day of the year.[2] In the last four years, approximately twenty percent more people have died in hospitals from medical errors than the total of all U.S. battle deaths from all wars in the history of the United States[3]. This is not simply as a result of medical and nursing mistakes. Instead, it stems from institutional carelessness at many hospitals throughout the country. To be sure, we need to make certain our doctor and nursing negligence cases are strong. But we need to also focus on the institutional liability.

The total national economic cost, including lost income, lost household production, disability and healthcare costs for these preventable adverse events approaches, if not, exceeds $60 billion per year.[4] Not included in this figure are the costs for pain, suffering, disfigurement or loss of enjoyment of life. And it does not in anyway account for the patients who survive the mistakes made. Rather than address the problem, politicians have spent hundreds of millions of dollars to misdirect analysis of the epidemic. Nonetheless, the epidemic continues. The topic is particularly relevant because recent legislative reforms do nothing to cure the epidemic. They do not even address it. The concept that limiting a patient's right to

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[1] *HealthGrades, Patient Safety In American Hospitals* 1 (July 2004), available at http://www.Healthgrades.com (last visited February 2, 2006); *see also, Health: Study: Hospital errors cause 195,000 deaths*. July 28, 2004, available at http://cnn.com.2004/HEALTH/07/28/health.mistakes.reut/index.html; *see also, HealthGrades, HealthGrades Quality Study: Third Annual Patient Safety in American Hospitals Study* (April 2006). *See also,* Healthgrades, Healthgrades Quality Study; Fourth Annual Patient Safety in American Hospitals Study (April 2007).

[2] Kohn, Linda T., *et al, To Err is Human: Building a Safer Health System* Washington D.C.: National Academy Press, 2000 at 1 *citing* Centers for Disease Control and Prevention (National Center for Health Statistics). "Births and Deaths: Preliminary Data for 1998." NATIONAL VITAL STATISTICS REPORTS. 47 (1999): 27. *See also,* Andrews, Lori B., *et al*, "An alternative strategy for studying adverse events in medical care." 349 THE LANCET 309-313 (1997); Chaundry, Sarwat I., M.D., *et al*, "Detection of Errors by Attending Physicians on a General Medicine Service' 18 J GEN INTERN MED 595-600 (2003), Schimmel, Elihu M., M.D., "The Hazards of Hospitalization" 60, No. 1 ANNALS OF INTERNAL MEDICINE 100-110 (1964).

[3] American Revolution (4,435); War of 1812 (2,260); Indian Wars (1,000); Mexican War (1,733); Civil War (214,938); Spanish-American War (385); World War I (53,402); World War II (291,557); Korean War (33,741); Viet Nam War (47,410); Gulf War (147); Iraq (2,543 as of February 19, 2007) equals 653,651. *See,* http://www.infoplease.com/ipa/a0004615.html and http://www.antiwar.com/casualties/index.php (last visited February 19, 2007). 195,000 x 4 = 780,000. 780,000 – 653,651 = 126,349. 126,349 ÷ 653,651 = 19.3%.

[4] *Supra* notes 2 and 3.

sue or that denying full recovery to those most injured will somehow reduce the number of errors that kill and injure patients does not comport with logic or history. Indeed logic and history show the opposite.[5]

A. CALIFORNIA MEDICAL INSURANCE FEASIBILITY STUDY

The Medical Insurance Feasibility Study, one of the first large hospital records' studies looking at hospital errors, was done in the 1970's[6]. The study was sponsored by the California Hospital Association and the California Medical Association in an effort to support their tort reform efforts. At the time, California was in the midst of a perceived medical malpractice insurance crisis. The idea behind the study was to test the feasibility of going to a no-fault system of compensation for injuries and death as a result of medical malpractice. The expectation was that the frequency and severity of malpractice would be shown to be a minor problem. They further expected to be able to show that the cost of a no-fault system would be substantially less than the premiums the doctors and hospitals were paying for medical malpractice insurance.[7]

The study revealed quite the opposite and the results were striking. The Medical Insurance Feasibility Study found that doctors and hospitals injured one out of every twenty hospitalized patients. Of those, one out of ten patients died from the injury. Extrapolated, that meant that in California in 1974 some 140,000 patients were injured, 14,000 of whom died as a result. The study also concluded that one out of every six of the medical injuries, over 23,000 cases, was the result of malpractice. The authors found that there was a positive correlation between the severity of the injury and malpractice. Four-fifths of the most seriously injured patients were injured by medical malpractice.[8]

The California Hospital Association and California Medical Association correctly concluded that a no-fault system was not the way to lower their malpractice insurance premiums. They shelved the study

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[5] *The Great Medical Malpractice Hoax:*
NPDB Data Continue To Show Medical Liability System Produce Rational Outcomes, Public Citizen, Congress Watch (January 2007)

[6] Mills, Don Harper, M.D., J.D.. "Medical Insurance Feasibility Study," 128 WEST J MED 360-365 (1978).

[7] Baker, Tom. *The Malpractice Myth*, Chicago: University of Chicago Press, 2005 at 25-27, *see generally*, Medical Insurance Feasibility Study, *supra* note 5.

[8] *Id*.

and moved their legislative initiatives in a different direction.[9] In 1975 the California legislature passed the Medical Injury Compensation Reform Act ("MICRA"). MICRA capped non-economic damages for pain and suffering at $250,000. There is no evidence to suggest that MICRA did anything to decrease the frequency or severity of medical injuries or medical malpractice in the state of California. Nor did it decrease the medical malpractice premiums for doctors and hospitals. Indeed, over the next 13 years the premiums continued to increase until California voters took matters into their own hands and passed Proposition 103, which changed the state's insurance laws. The insurance reform froze premiums, forced insurance companies to open their books and justify future increases. California voters got the right to elect their state insurance commissioner. After Proposition 103 passed, medical malpractice premiums began to decrease and stabilize.[10]

B. THE HARVARD MEDICAL PRACTICE STUDY

The next major study based upon hospital records of medical injuries caused by medical malpractice was the Harvard Medical Practice Study.[11] This study was conducted in the mid-80's during another medical malpractice insurance crisis. The Harvard Medical Practice Study was commissioned by the state of New York to evaluate medical injuries and also methods of compensating injured patients. The results of the study were published in three parts in the *New England Journal of Medicine* under special article status.[12]

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[9] *Id*.

[10] In fact, after the MICRA caps and until Proposition 103, thirteen years later, malpractice insurance premiums for California doctors increased by 450%. "Insurance reform required medical malpractice insurers to directly refund more that $135 million to policy holders." *See, How Insurance Reform Lowered Doctors' Medical Malpractice Rates in California and How Malpractice Caps failed* (2003) available at http://www.consumerwatchdog.org/mal-practice/rp/ 1008.pdf (last visited February 6, 2006).

[11] Harvard Medical Practice Study. *Patients, doctors, and lawyers: Medical Injury, Malpractice Litigation and Patient Compensation in New York: The report of the Harvard Medical Practice Study to The State of New York.* Cambridge: Harvard University, 1990.

[12] Brennan, Troyen A., M.P.H., M.D., J.D., *et al*, "Incidence of Adverse Events and Negligence In Hospitalized Patients: Results of the Harvard Medical Practice Study I," 324 N. ENGL. J. MED. 370-376 (1991); Leape, Lucian L., M.D., *et al.,* "The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study II," 324 N. ENGL. J. MED. 377-384 (1991); Localio, Russell, J.D., M.P.H., M.S., *et al.,* "Relation Between Malpractice Claims and Adverse Events Due To Negligence, 325 N. ENGL. J. MED. 245-251 (1991).

The methodology of the Harvard Medical Practice Study is impressive. The Harvard researchers used a two-stage sampling process to create a weighted sample of 31,000 randomly selected records of hospitalized patients from a population of 2,671,863 non-psychiatric patients discharged from non-federal acute care hospitals in 1984. Each medical record was initially screened by two people, trained nurses or medical records administrators, using eighteen screening criteria. If the screeners agreed that a record met any of the criteria, then it was reviewed independently by two physicians, almost all of whom were board certified internists or surgeons. The physicians identified adverse events. The reviewers were asked to describe each adverse event and its relation to the medical care. They estimated the degree of disability that resulted. The reviewers were also asked to indicate whether each adverse event had been caused by a reasonably avoidable error. If yes, they classified the error and then indicated the specific type of error within the class. Finally, the physician reviewers were asked to determine if there was negligence.[13]

Part One of the Harvard Medical Practice Study "estimated the incidence of adverse events, defined as injuries caused by medical management, and the sub-group of such injuries that resulted from negligent or substandard care."[14] The results showed that adverse events occurred in 3.7 percent of the hospitalizations. 27.6 percent of the adverse events were due to negligence. The researchers found that 70.5 percent of the adverse events gave rise to a disability lasting less than six months. 2.6 percent caused permanent disability, 13.6 percent caused death. Like the California Medical Insurance Feasibility Study, the study also established that the percentage of adverse events attributable to negligence increased as the severity of the injury increased. The Harvard study concluded that of 2,671,863 patients, there were 98,609 adverse events, of which 27,179 involved negligence.[15]

Part Two of the Harvard Medical Practice Study analyzed the adverse events and their relation to error, negligence and disability. The authors found that drug complications were the most common type of

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[13] Leape, *supra*, at 245-6.

[14] Brennan, *supra* note 12, at 370.

[15] *Id.*

adverse event (19%); wound infections were second (14%); and technical complications, third (13%). Forty-eight percent of the adverse events were associated with an operative procedure. However, adverse events during surgery were less likely to be caused by negligence (17%) than in non-surgical events (37%). The proportion of adverse events caused by negligence was highest for non-invasive therapeutic mishaps (77%); diagnostic mishaps (75%); and mishaps in the emergency room (70%).[16]

Part Three of the Harvard study looked at the other side of the equation. The Harvard researchers identified patients who had filed claims against healthcare providers in their sample. They compared those results with their findings based on their review of those records. The researchers then matched their results with statewide data on medical malpractice lawsuits. The Harvard study concluded that the vast majority of patients injured by medical negligence did not make a claim.[17]

C. THE UTAH AND COLORADO STUDY

The Harvard Medical Practice Study stirred debate in at least some circles. As early as 1993, some healthcare safety experts extrapolated from the Harvard study to suggest that 180,000 people per year die in the United States as a result of an iatrogenic (healthcare provider caused) injury.[18] Questions were raised as to whether the findings from the Harvard Medical Practice Study might be inappropriate because they were limited to one year and to New York. And while the findings were consistent with the California feasibility study, the Harvard Medical Practice Study had not been replicated in a large-scale study in the United States. Additionally, a population based study from Australia that used the Harvard Medical Practice Study methods and a study from a Chicago teaching hospital that used observational methods found considerably higher rates of preventable medical injury than the Harvard Medical Practice Study.[19]

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[16] Leape, *supra* note 12, at 377.

[17] Localio, *supra* note 12, at 245.

[18] Leape, Lucian L., M.D., *et al*., "Preventing Medical Injury." 19 QUAL. REV. BULL. 144-149 (1993).

[19] Thomas, Eric, M.D., M.P.H., *et al*., "Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado," 38 MEDICAL CARE 261-271 (2000).

Accordingly, the Utah and Colorado study was designed to determine whether the Harvard study findings were similar to those of other states in different time periods.

The Utah and Colorado study used methods similar to the Harvard Medical Practice Study in order to estimate the incidence and types of adverse events and negligent adverse events in Utah and Colorado in 1992. The researchers selected a representative sample of hospitals from Utah and Colorado and randomly sampled 15,000 non-psychiatric 1992 discharges. Each record was reviewed by a nurse using eighteen criteria associated with adverse events. If one of the criteria was met, the record was then reviewed by a physician to determine whether an adverse event or a negligent adverse event occurred and to classify the type of adverse event. After completion of all reviews, two investigators independently reviewed each adverse event and negligent adverse event to insure that all events fulfilled the definition set forth in the study.[20]

The study concluded that the incidence and types of adverse events found in Utah and Colorado in 1992 were similar to those found by the Harvard Medical Practice Study from New York in 1984. Adverse events occurred in 2.9 percent of the hospitalizations in each state. In Utah, 32.6 percent of the adverse events were due to negligence. In Colorado, 27.4 percent were due to negligence. Death occurred in 8.8 percent of the negligent adverse events.[21]

D. INSTITUTE OF MEDICINE REPORT

The National Academy of Sciences is a private, non-profit society of distinguished scholars engaged in scientific and engineering research. Upon the authority of the charter granted to it by the U.S. Congress in 1863, the Academy has a mandate that requires it to advise the federal government on scientific matters. The National Academy of Sciences established the Institute of Medicine in 1970 to examine policy matters pertaining to the health of the public and to advise the federal government.[22] The

[20] *Id*. at 262-263.

[21] *Id*. at 261.

[22] Kohn, Linda T., *et al, To Err is Human: Building a Safer Health System, supra* note 2, at iii.

Institute of Medicine (IOM) initiated the Quality of Healthcare in America project in June of 1998. Its purpose was to develop a strategy to result in at least a threshold improvement in the quality of healthcare over the next ten years.[23] In 1999 the institute published its first report, entitled: *To Err is Human: Building a Safer Healthcare System.*[24] The IOM studied the literature on the frequency and cost of healthcare errors and the factors that contribute to their occurrence. Errors and adverse events were defined as follows:

An error is defined as the failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning).

An adverse event is an injury caused by medical management rather than the underlying condition of the patient. An adverse event attributable to error is a "preventable adverse event." Negligent adverse events represent a subset of preventable adverse events that satisfy legal criteria used in determining negligence (i.e., whether the care provided failed to meet the standard of care reasonably expected of an average physician qualified to take care of the patient in question).[25]

The IOM looked at four questions:

1. How frequently did the errors occur?
2. What factors contribute to errors?
3. What are the costs of errors?
4. Are public perceptions of safety in healthcare consistent with the evidence?[26]

They concluded that between 44,000 and 98,000 Americans die in hospitals each year as a result of preventable medical errors.[27] Importantly, the IOM acknowledged that these extrapolations likely

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[23] *Id*. at xi.

[24] *Id.*

[25] *Id*. at 28.

[26] *Id*. at 29.

[27] *Id*. at 31.

underestimate the occurrence of preventable adverse events. In looking at the cost of these errors, the IOM concluded that "the national cost of adverse events to be $37.6 billion and the cost of preventable adverse events to be $17 billion."[28] It further stated "it has been estimated that for every dollar spent on ambulatory medications, another dollar is spent on new health problems caused by the medication."[29] As to public perception, the IOM concluded:

> Although the risk of dying as a result of a medical error far surpasses the risk of dying in an airline accident, a good deal more public attention has been focused in improving safety in the airline industry than in the health care industry. The likelihood of dying per domestic jet flight is estimated to be one in eight million. Statistically, an average passenger would have to fly around the clock for more than 438 years before being involved in a fatal crash. The American public may be vaguely aware that healthcare is less safe than some other environments, but to date, it has made few demands on the healthcare industry to demonstrate improvement.[30]

The IOM found that licensing and accreditation processes of healthcare providers and organizations have focused only limited attention on the safety issue. Even these minimal efforts have met with resistance from healthcare organizations and providers. The researchers found that the decentralized and fragmented nature of the healthcare delivery system contributes to unsafe conditions. The IOM also found that the context in which healthcare is purchased in the United States further exacerbates the problem. Group purchasers have made few demands for improvement in safety. The IOM concluded that a comprehensive approach to improving patient safety is needed.[31] The Institute of Medicine made a series of recommendations to that end.[32]

The IOM report created a stir. President Clinton established the Quality Interagency Coordination Task Force. He directed the Task Force to evaluate the IOM's recommendation in *To Err is Human* and to

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[28] *Id*. at 41.

[29] *Id*.

[30] *Id*. at 42.

[31] *Id*. at 3.

[32] *Id*. at 69, 87, 111, 133, and 156.

respond with a strategy to identify prevalent threats to patient safety and to reduce medical errors.[33] In February, 2000 the Task Force presented its report: *Doing What Counts for Patient Safety: Federal Actions to Reduce Medical Errors and Their Impact*.[34] The Task Force reported that medical errors were **"[a] National Problem of Epidemic Proportion."**[35] The report concluded that research documented that the rate of healthcare errors is far higher than the rate of error in other industries.[36] It looked at the epidemiology of medical errors and adverse events and medical products' use or misuse.[37] The Task Force also looked at current programs in place to prevent medical errors and found that they were insufficient.[38] The Task Force concluded that there was a general lack of awareness about the problem:

As stated earlier, the existence of medical errors has been known for some time. However, the fact that there has been very little success in reducing errors suggests that a general lack of awareness or alarm about errors is a factor in this failure.[39]

E. HEALTHGRADES QUALITY STUDY

The Agency for Healthcare Research and Quality (AHRQ) became the lead agency for the federal government on quality in healthcare. In order to better track medical errors, the agency developed and released a computer program which included a set of Patient Safety Indicators ("PSI"). These were specifically designed for screening hospital administrative data for incidents of concern related to patient safety.[40] HealthGrades took the Agency's Patient Safety Indicators software and applied it to approximately 37 million Medicare discharges. In 2004, HealthGrades, Inc. released its study:

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[33] Quality Interagency Coordination Task Force, *Doing What Counts for Patient Safety: Federal Actions to Reduce Medical Errors and Their Impact*: Report to the President (Washington: QuIC Task Force, 2000).

[34] *Id*.

[35] *Id*. at 1.

[36] *Id*. at 34.

[37] *Id*. at 37.

[38] *Id*. at 41.

[39] *Id*. at 42.

[40] *Patient Safety Indicators*, Version 2.1, Revision 1. March 2004. (Agency for Healthcare Research and Quality. Rockville, M.D.).

HealthGrades Quality Study: Patient Safety in American Hospitals.[41] This was the first study to look at the potentially avoidable mortality and cost impact of patient safety incidents using the PSI's across all U.S. hospitals among the most concentrated at-risk patient population, Medicare patients.[42] The report was shocking. The authors concluded that their data clearly supported the Institute of Medicine's report and the findings from other studies which showed that medical errors and injuries from them are epidemic in the United States.[43] They found that even though there were "shocking and widely publicized" statistics on preventable deaths due to medical errors, there had not been improvements in patient safety since the publication of the Institute of Medicine's report five years earlier. Indeed, they found the previous studies had underestimated the number of deaths caused by preventable medical errors. HealthGrades also looked at some of the economic consequences of the medical errors.[44] The results are staggering. The 16-PSI's studied accounted for $8.54 billion in excess inpatient costs to the Medicare system over the three years studies.[45] They concluded:

> To extrapolate to the nation as a whole, we calculated that Medicare hospital discharges represented 45% of all short-term acute hospital discharges from 2000-2002 period. Using this finding and excluding obstetric patients, we calculated that an extra $19 billion was spent and over 575,000 preventable deaths occurred, as a direct result of the 2.5 million patient safety incidents that occurred in U.S. hospitals from 2000 through 2002.[46]

These costs are additional costs to the Medicare system as result of preventable errors. They do not account for the other economic and non-economic losses suffered by those hurt by the errors. And they are increasing.

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[41] *HealthGrades Patient Safety In American Hospitals*, *supra* note 1.

[42] *Id*. at 7.

[43] *Id*.

[44] *Id*. at 1.

[45] *Id*. at 6.

[46] *Id*.

In April 2006, HealthGrades published its *Third Annual Patient Safety in American Hospitals Study*.[47] It found:

▪Approximately 1.24 million total patient safety incidents occurred in almost 40 million hospitalizations in the Medicare population. These incidents were associated with $9.3 billion of excess cost during 2002 through 2004. For the second year in a row, patient safety incidents have increased--up from 1.14 and 1.18 million reported in HealthGrades' First and Second Annual Patient Safety in American Hospitals studies, respectively.

▪Of the 304,702 deaths that occurred among patients who developed one or more patient safety incidents, 250,246 were potentially preventable.

▪Medicare beneficiaries that developed one or more patient safety incidents had a one-in-four chance of dying during the hospitalization during 2002-2004 . This rate remains unchanged since our first study released July 2003.[48]

II. INSTITUTIONAL NEGLIGENCE

Traditionally, when looking at these cases, the issue is whether the physician and/or nurses were negligent. Hospital liability is premised on vicarious liability for the nursing conduct. The problem with that is that jury sympathy will often favor the healthcare provider. And the attribution bias against your client is real. But most importantly, by focusing only on physician and nursing conduct, you are leaving a large part of your case on the table.

A. CREDENTIALLING

In addition to the negligence of the physicians and nurses, it is important to look at the institutional negligence that set in motion the structural problems that put your client in jeopardy. For example, in most states, the hospital will have an affirmative duty to hire competent staff, to periodically test core competencies and retrain and retest staff, and to develop and enforce appropriate policies and procedures.

[47] H*ealthGrades Quality Study: Third Annual Patient Safety in American Hospitals Study, supra* note 1.
[48] *Id.* at 3.

See, e.g., AirShields, Inc. v. Spears, 590 S.W.2d 574 (Tex. Civ. App. – Waco 1979, writ ref'd n.r.e.) In Arkansas, the AMI specifies that hospital's duty includes, to "[determine the mental and physical condition of a patient] [and][to furnish a patient the care and attention reasonably required by his/her mental and physical condition]." Plainly this includes providing competent, trained staff. Negligent credentialing, or negligent peer review, is a well recognized common law claim. A cause of action for negligent credentialing is an independent cause of action arising out of a health care institution's direct responsibility to its patients to take reasonable steps to ensure that medical care providers are qualified. *Wellstar Health Systems, Inc. v. Green*, 258 Ga. App. 86, 572 S.E.2d 731 (2002), cert. denied, (Jan. 27, 2003). Indeed Georgia specifically held that **"We do not believe that the General Assembly has indirectly eliminated, through peer review immunity, a hospital's responsibility to its patients to exercise reasonable care in ensuring that medical care providers are qualified."** *McCall v. Henry Medical Center, Inc.*, 250 Ga.App. 679, 682, 551 S.E.2d 739, 742 (2001). In Texas the peer review immunity statute has been interpreted to raise the standard needed for credentialing/peer review cases to malice, rather than ordinary negligence, but not to do away with the claim. *St. Luke's Episcopal Hosp. v. Agbor*, 952 S.W.2d 503, 505-507 (Tex.1997).

The existence of a privilege against discovery simply does not mitigate the duty. According to the ALR, states recognizing that duty are CA, FL, GA, HA, MI, NJ, NM NY, NC, OH, OK, PA, RI, TX (later limited to malice only), WA, WI, WY. Benjamin J. Vernia, J.D., *Tort Claim for Negligent Credentialing of Physician*, 98 A.L.R.5th 533 (WestLaw 2008). According to ALR, only Minnesota, of states considering the duty, rejected it.

B. JCAHO

Most hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations. This is important financially for the hospital. The Social Security Act §1881(e) and §1865(a) permit for deemed status of hospitals that are accredited by the Joint Commission. This means that they are deemed to meet all of the Medicare Conditions of Participation. It is also important because

the Joint Commission sets Accreditation Standards. And an institution's failure to follow the standards can be powerful evidence of institutional negligence.

There are no Arkansas cases dealing with the status of JCAHO or Joint Commission standards. In an Arkansas medical-malpractice action, the plaintiff must prove: (1) the applicable standard of care; (2) that the medical provider failed to act in accordance with that standard; and (3) that such failure was a proximate cause of the plaintiff's injuries. *Webb v. Bouton*, 350 Ark. 254, 264, 85 S.W.3d 885, 891 (2002). AMI 1504 describes the duty owed by hospitals as "ordinary care" to "[determine the mental and physical condition of a patient] [and][to furnish a patient the care and attention reasonably required by his/her mental and physical condition] [and][to follow the orders and directions of the patient's attending physician]…," depending on circumstances. Nothing obviously excludes evidence of Joint Commission Standards as a part of an expert's opinions regarding hospital standards of care. In fact courts in other states often look to the Joint Commission standards as guides for discerning the appropriate standard of care. Though the Joint Commission standards are not identical to the applicable standard of care, they are instructive and may be used as bases of expert opinion of the standards – along with the hospital's own policies and bylaws. See for example *Denton Regional Medical Center v. LaCroix*, 947 S.W.2d 941, 951 (Tex.App.-Fort Worth 1997, pet. denied), citing *Hicks v. Canessa*, 825 S.W.2d 542, 544 (Tex.App.-El Paso 1992, no writ); *Hilzendager v. Methodist Hosp.*, 596 S.W.2d 284, 286 (Tex.Civ.App.-Houston [1st Dist.] 1980, no writ); *Foley v. Bishop Clarkson Mem. Hosp.*, 185 Neb. 89, 173 N.W.2d 881, 884 (1970); *Darling v. Charleston Community Mem. Hosp.*, 33 Ill.2d 326, 211 N.E.2d 253, 257 (1965), cert. denied, 383 U.S. 946, 86 S.Ct. 1204, 16 L.Ed.2d 209 (1966).

In Oklahoma JCAHO guidelines "provide evidence of the appropriate standard of care even at facilities which are not accredited by JCAHO." *Gaines v. Comanche County Medical Hosp.*, 143 P.3d 203, 213 (Okla. 2006). In Michigan the JCAHO guidelines may actually establish duty owed. *Zdrojewski v. Murphy*, 254 Mich.App. 50, 63, 657 N.W.2d 721, 730 (Mich.App. 2002). If JCAHO standards are

evidence of or expert bases of opinions concerning applicable standard of care, so too are the relevant regulations and statutes, such as the nurse practice act.

While they are not definitive of the standard of care, Joint Commission guidelines, other regulations or statutes are useful bases of expert opinion, helpful to the jury, in describing the applicable standards of care.

JCAHO publishes a Comprehensive Accreditation Manual For Hospitals: *The Official Handbook (See e.g. www.JCAHO.org).* These standards set forth the standards for accreditation in several areas, including: ethics, rights, and responsibilities (R.I.); provision of care (P.C.); medication management (M.M.); improving organizational performance (P.I.); leadership (L.D.); management of the environment of care (E.C.); and management of information (I.M.).

EXAMPLES:

R.I.1.10 and R.I.1.30: Policies, procedures and performance must be in compliance with the organizational ethical code and staff members must be well informed about the content and application of the code to ensure business is conducted in an ethical manner. Care and treatment of patients must be delivered based on patient need, regardless of the organization's financial implication.

R.I.2.90: It is essential that the patient is informed regarding the outcomes of care, including unanticipated outcomes. The licensed independent practitioner or his/her designee must inform the patient, and when appropriate family members regarding any unanticipated outcome.

R.I.2.160: Policies and procedures should address the care of patients to define when pain should be screened, assessed and reassessed, and to provide for communication to patients about effective pain relief.

P.C.2.20, P.C.2.120 and P.C.2.130: The patient assessment and reassessment policies and procedures must be defined in writing. The standards are for performing a thorough initial assessment and reassessment in specified time frames of the patient care needs. Information collected on patients entry into the emergency department may indicate the need for further assessments. Triage, used to determine the order in which patients will be treated, does not meet the criteria of patient assessment.

P.C.2.150: These standards concern the reassessment of patients to meet their continuing care needs. The assessment and reassessment policies must meet applicable law and regulatory requirements.

P.C.3.230: These standards concern performing tests in a timely manner to determine a patient's health care or treatment needs. Diagnostic tests and procedures require an order. Clinical information regarding the reason for the test is submitted with the order based on organization policy and applicable law and regulation. Testing that requires clinical interpretation must have appropriate information supplied with the order.

III. ESTABLISHING INSTITUTIONAL LIABILITY

To establish institutional liability, all levels of the organization need to be explored, from the floor nurse to the governing board. To be sure, the hospital will take the position that your case is only about whether or not some nurse was negligent and will resist discovery on institutional issues. However, you must carefully draft the pleadings and be ever vigilant in pursuing discovery.

In many cases, the corporate carelessness arises or is allowed to continue by lack of leadership at all levels in the organization. This lack of leadership is clearly shown by the healthcare industry's lack of compliance with the Joint Commission on Accreditation of Healthcare Organization's Sentinel Event policy. The Joint Commission is the accrediting organization for hospitals in the United States. Its Sentinel Event policy provides that hospitals are supposed to report unexpected bad outcomes. The Joint Commission then conducts an in-depth analysis of the event to determine its "root cause." The concept is that in a non-accusatory way, the Joint Commission can help the hospitals it accredits focus on patient safety and prevent future mistakes. The root-cause analysis looks for system failures in order to provide risk reduction strategies.[49] The Sentinel Event reporting, root-cause analyses and recommendations are shrouded in secrecy and not discoverable in litigation. If patient safety were indeed a concern of the healthcare industry's leadership, one would expect that hospital executives

[49] *See generally*, Joint Commission on Accreditation of Healthcare Organizations, *2003 Comprehensive Accreditation Manual For Hospitals: The Official Handbook* at SE1-10.

would be standing in line to avail themselves of theses services. However, the opposite is true. One only need look at the Sentinel Event reporting statistics to see how true.

For example, in the obstetrical arena there is debate about the number of children born with cerebral palsy as result of birth related injury. But, even taking the most conservative estimates, the gross number in the United States of these injuries is in the thousands.[50] Cases considered reviewable under the Joint Commission Sentinel Event Policy are "any prenatal death or major permanent loss of function unrelated to congenital condition in an infant having a birth weight greater than 2500 grams."[51] When such children are born, one would think their cases would be at the top of the list for hospitals to seek root cause analysis. The injury and damages to the child and family are dramatic. Future medical care costs are in the millions, if not tens of millions of dollars. These are the types of injuries responsible hospitals would want to prevent. Of the thousands of children born each year with cerebral palsy from 1996 until July 2004, a total of only seven cases were reported to the Joint Commission under the Sentinel Event Reporting Policy.[52] In July 2004 the Joint Commission published a Sentinel Event Alert. In looking at 40 cases of infant death and the seven cases involving permanent disability which actually were reported in the eight years, the Joint Commission found:

Root causes identified

In the 47 cases studied, communication issues topped the list of identified root causes (72 percent), with more than one-half of the organizations (55 percent) citing organization culture as a barrier to effective communication and teamwork, i.e., hierarchy and intimidation, failure to function as a team, and failure to follow the chain-of-communication. Other identified root causes include: staff competency (47 percent), orientation and training process (40 percent), inadequate fetal monitoring (34 percent), unavailable monitoring equipment and/or drugs (30 percent),

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[50] *See generally*, Volpe, Joseph M.D., *Neurology of the Newborn*, Saunders: Philadelphia, 2001 at 332.

[51] Joint Commission on the Accreditation of Healthcare Organizations, July 21, 2004: *Sentinel Event Issue* #30 at 1.

[52] *Id.*

credentialing/privileging/supervision issues for physicians and nurse midwives (30 percent), staffing issues (25 percent) physician unavailable or delayed (19 percent), and unavailability of prenatal information (11 percent).

Risk reduction strategies

As required under the Sentinel Event Policy, based on their root cause analyses, organizations develop an action plan citing the steps they will take to reduce the risk of similar future adverse events. The risk reduction strategies identified by these organizations include:

- Revise orientation and training process (70 percent)
- Physician education and counseling (36 percent)
- Revise communications protocols (36 percent)
- Reinforce chain-of-communications policy (28 percent)
- Revise competency assessment (25 percent)
- Standardize equipment and drug availability (25 percent)
- Conduct team training (25 percent)
- Revise consultation and on-call policies and procedures (23 percent)
- Revise Medical Staff credentialing and privileging process (21 percent)
- Institute changes in the patient assessment policy (21 percent)
- Standardize the evaluation and monitoring process (21 percent)
- Revise the staffing plan and process (17 percent)
- Adopt American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG) guidelines for prenatal care (13 percent)
- Institute mock OB emergency training drills (11 percent)
- Revise the conflict resolution policy (8 percent)

- Revise transfer policies and procedures (4 percent)[53]

Had more of these cases been reported and strategies been adopted, thousands of babies could have been spared the horrific damages they now suffer. Since Sentinel Event reporting began, it is unlikely that a single hospital in Arkansas has reported a single child born neurologically impaired as a result of care in labor and delivery. It is thus similarly unlikely that a single Arkansas hospital has had the benefit of the Joint Commission's specific input for risk reduction strategies or recommendations in that area. However, you can do your own root cause analysis and create your own risk reduction strategies and use them in discovery to impose institutional liability. The root causes of the injury or death in your case and the hospital's failure to have the risk reduction strategies in place can translate into an independent cause of action for institutional negligence.

IV. STANDARDS

Before filing suit, collect the literature with respect to the medical issues with which you are dealing. But, in addition, collect the standards applicable to the issue at hand. *See e.g.*, 2008 Healthcare Standards, Official Directory (ECRI 2008). ECRI serves as the Healthcare Standards and Guidelines Archive for the World Health Organization. Also, go to the internet. Some helpful sites include:

a. http://www.jointcommission.org

b. http://www.ismp.org (Institute for Safe Medical Practices)

c. http://www.fda.gov

d. http://www.qualityforum.gov (National Quality Forum)

e. http://www.ihi.org (Institute for Healthcare Improvement)

f. http://www.arsbn.org (Arkansas State Board of Nursing)

g. http://www.armedicalboard.org (Arkansas State Medical Board)

h. http://www.sosweb.state.ar.us (Arkansas Medical Practices Acts and Regulations

V. ORGANIZATIONAL STRUCTURE.

[53] *Id.*

A. STRUCTURE. Malpractice is typically not an isolated medical event. It is instead a culmination of errors that occur at various levels throughout the hospital. It is necessary to understand the organization structure and hierarchy at the hospital in order to determine who the appropriate defendants are and what standards apply. For example, at a large hospital, a typical arrangement is that the emergency department is staffed by contract with an emergency room group of physicians, physician assistants who are employed by the physician group (or the hospital) and nurses and other ancillary personnel employed by the hospital. At a small rural hospital, the emergency department is typically staffed by emergency department or other physicians under contract with the hospital and nurses employed by the hospital.

Whether the hospital is a 40 bed rural hospital or part of a large chain, early discovery efforts should be undertaken to determine the organizational structure of the institution. For example, in a typical obstetrical case, this will include the obstetrical nurse, who may be an employee of the hospital, a pool nurse or agency nurse. It will include the charge nurse, the Nurse Manager of Labor and Delivery, the Nursing Director of Women's Services, the Director of Nursing, the Administrator and the board. It will include the Nursing Education Department. If the Hospital is part of a chain, it may include national policies and procedures or reporting obligations to distant corporate entities. It is important to get a handle on the organizational structure early on. You can then begin to look for the various areas of breakdown, without which your client would not have an injured.

B. DOCUMENTATION WITH RESPECT TO ORGANIZATIONAL STRUCTURE AND DUTIES. To determine the organization structure and also the various duties amongst the health care providers, several references must be considered early on. Early discovery should include requests for institutional documents:

1. Organizational Chart;
2. Management Services Agreement;
3. Monthly Reporting to Board;
4. Annual Reports to Board;

5. Job Descriptions of everyone involved;

6. Medical staff bylaws;

7. Rules and regulations of medical staff;

8. Contract between emergency department group and hospital;

9. Contract between emergency department physician and hospital;

10. Contract between emergency department physician and emergency department group;

11. Contract between physician assistant and hospital;

12. Contract between physician assistant and emergency department group;

13. Physician personnel file;

14. Physician Assistant personnel file;

15. Nurse personnel file;

16. Supervision agreements between physician and physician assistant; and

17. Hospital policies and procedures.

C. DEPOSITIONS. Take lots of depositions.

CONCLUSION.

Hospitals are dangerous places. As a result of institutional carelessness, patients are injured or killed with alarming frequency. In order to hold hospitals accountable for their independent acts of negligence, as well as for their vicarious liability, it is important to develop theories of liability early and do the necessary discovery to develop the factual basis for recovery.