

Medical Malpractice Implications of “Never Events”

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On October 1, 2008, Medicare stopped reimbursing hospitals for additional costs associated with 11 “never events”, or specific hospital-acquired conditions that the Centers for Medicare and Medicaid Services (CMS) deems preventable through use of evidence-based guidelines. State Medicaid systems and private insurers are also developing their own non-payment policies.

Plaintiffs’ attorneys may well try to use Medicare or other organizations’ decisions not to pay for “never events” as proof that a hospital committed medical malpractice. Hospitals and their attorneys should therefore consider how they will respond if a plaintiff argues that non-payment for these events constitutes evidence that the hospital violated the standard of care.

This article is in two parts. The first describes the various non-payment rules promulgated by Medicare and other payers. The second discusses the potential arguments that plaintiffs may make to support their malpractice claims, and our thoughts about responding to those arguments. Please keep in mind that these are only our

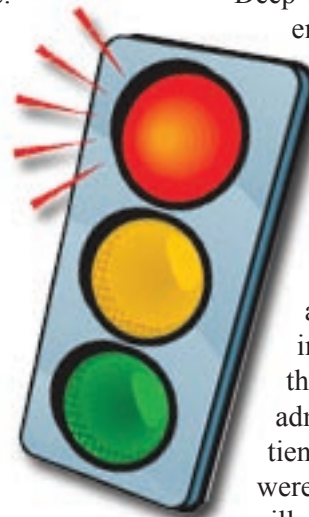
thoughts, however. Hospitals should have their own attorneys review their specific circumstances, since Marsh cannot give legal advice.

The Non-Payment Policies
CMS Medicare Rule
Effective October 1, 2008, CMS stopped paying hospitals for additional costs associated with treating 11 hospital-acquired conditions that CMS asserts are reasonably preventable through use of evidence-based guidelines.

CMS selected these matters in response to the Deficit Reduction Act of 2005, Section 5001, which required CMS to identify at least two such conditions for which CMS would no longer reimburse. The 11 events are:

- Foreign object left in after surgery
- Air embolism
- Blood transfusion incompatibility
- Stage 3 and 4 pressure ulcers
- Falls, burns, electric shock, or other trauma resulting in serious injury
- Catheter-associated urinary tract infection
- Vascular catheter-associated infection
- Surgical site infection following coronary artery bypass graft

- Surgical site infection following certain orthopedic and bariatric surgeries
- Deep vein thrombosis or pulmonary embolism following total hip or total knee replacement
 - Certain manifestations of poor control of blood sugar levels



CMS will determine whether these matters were hospital acquired, and therefore non-reimbursable, by seeing whether they were coded as “present on admission” (POA) when the patient arrived at the facility. If they were not identified as POA, CMS will deem them hospital acquired. CMS is considering adding additional items to the list in 2009.

Significantly, different organizations have different definitions of “never events”. CMS has a list of 11 non-reimbursable conditions. On the other hand, the National Quality Forum (NQF) has a list of 28 Serious Reportable Adverse Events that NQF says should never occur because they are largely preventable through appropriate care and implementation of appropriate policies and procedures.

While there is some overlap between the CMS list and the NQF list, they

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are not identical. For example, urinary tract infection and surgical site infections are on the CMS list, but are not on the NQF list. Conversely, the NQF list includes several “never events” that are not on the current CMS list, such as surgery on the wrong patient or on the wrong body part.

Medicaid, Private Insurers and State Hospital Associations’ Policies

State Medicaid agencies and private insurers are also developing their own non-payment policies. Notably, however, their “never event” lists may be different than the CMS list.

For example, New York Medicaid has identified 14 items as avoidable hospital errors that will not be reimbursed; at least two of those, medication errors and disability from use of contaminated drugs, are not on the CMS list. Massachusetts Medicaid will not pay for injury from a contaminated medical device, although that adverse event is not on the CMS list. A recently enacted Maine law prohibits hospitals from billing the patient or any insurer for 28 preventable adverse events that are caused by the hospital and are within the hospital’s control to avoid; that list includes sexual assault of a patient within the hospital, which is not on the CMS list.

Private insurers and health plans such as Aetna, CIGNA, Wellpoint, and some Blues are implementing non-payment policies of their own. Again, the lists of “never events” that will not be compensated may be different from the CMS list, and approaches also vary from insurer to insurer. For example, one plan currently has only four events on its non-reimbursable list, including surgery on the wrong patient and surgery on the wrong body part, neither of which is on the CMS list. Another health plan is allowing hospitals to do

a root cause analysis to see if appropriate precautions were followed before making a decision about payment.

In addition to the non-payment policies for “never events” imposed by Medicare, Medicaid, and private insurers, members of a number of state hospital associations have voluntarily agreed not to charge for care related to preventable errors that happen in their facilities. Different associations do things differently, however. For example, Massachusetts had only nine of the 28 NQF events on its original will-not-bill list, while the Washington Hospital Association included all 28.

Objections to Non-Payment Rules

As can be seen, some matters on these lists are not always within the hospital’s control. For example, a patient may fall out of bed even though the bed rails are up and a call button is within easy reach, simply because she decides to go to the bathroom without calling for assistance. Or a patient with a fractured neck might develop a severe pressure sore because moving him might exacerbate the fracture and potentially cause paralysis. For these reasons, several hospitals, physicians, and professional associations have objected to some of the conditions on the CMS “never event” list, saying for example that they are not always preventable, or that they are not always within the hospital’s sole control, or that there are not accepted evidence-based guidelines to eliminate the condition.

Potential Medical Malpractice Litigation Implications

Plaintiffs’ Possible Arguments

Plaintiffs alleging medical malpractice must generally prove four things:

1. What the standard of care was;
2. That the hospital breached the standard of care;

3. that the breach caused the plaintiff’s injury; and
4. The damages resulting from the injury.

Typically, plaintiffs are required to use expert testimony from a properly qualified health care provider to establish the standard of care and the hospital’s violation of it.

Now, however, CMS is saying that “never events” are preventable if the hospital follows evidence-based guidelines and that they are indeed so preventable through appropriate care that Medicare will not reimburse for them. Plaintiffs’ attorneys may therefore try to argue that Medicare’s decision not to pay is evidence that the hospital violated the standard of care. Plaintiffs might try to use the CMS “never event” rule to support their malpractice claims in several ways, such as by asserting:

- The plaintiff does not need to file an expert affidavit with a complaint alleging a “never event”
- The CMS designation of certain conditions as “never events” is evidence that can be used to establish the standard of care
- Medicare’s refusal to pay for a “never event” is evidence that the hospital breached the standard of care
- A “never event” is a *res ipsa loquitur* matter (the thing speaks for itself), meaning that negligence is so clear that expert testimony is not needed to prove the plaintiff’s case
- Medicare’s decision not to reimburse for “never events” is *prima facie* evidence that medical malpractice occurred, meaning that the plaintiff’s case is proved unless the hospital can rebut it
- A “never event” constitutes negligence *per se*, or liability based on the violation of a safety statute

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- A “never event” creates strict liability, meaning that liability could be imposed on a hospital without a finding of negligence or fault

Plaintiffs’ attorneys might raise similar arguments in cases where state Medicaid or private insurers did not pay for “never events.”

Hospitals’ Possible Responses

Hospitals and their defense counsel need to discuss how they will respond, both in substance and procedurally, if a plaintiff claims that failure to reimburse is evidence that the standard of care was violated. The hospital’s response may depend on a number of factors, including the nature of the event, the facts involved, the identity of the payer, the specific wording of the non-payment rule, and the law in the state where the suit is brought. However, we offer the following comments for the hospital’s consideration. Of course, these are only our thoughts. Marsh cannot offer legal advice, and hospitals need to consult with their own attorneys about this before initiating any action.

1. As a general matter, should the CMS reimbursement rule have any place in tort litigation at all? Should it only be used to define the types of treatment that CMS will pay for and not to determine what the standard of care is for a particular case? Should a reimbursement rule issued by a federal agency be allowed to override long-standing common law principles and statutory protections that apply to medical malpractice cases?
2. If the plaintiff does not attach an expert affidavit to a complaint, based on the CMS rule, does state law set out specific requirements for an affidavit and the qualifications for the individual who signs

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it? If so, would a motion to dismiss the complaint be appropriate?

3. If a plaintiff asserts that the CMS designation of something as a “never event” is itself evidence of the standard of care, the hospital might have several responses. It may want to argue that the law requires that the standard of care be established by a health care provider who meets the qualifications for experts set forth in the particular state, not by a federal agency which has been tasked with reducing payments. Also, does the fact that so many different organizations, such as NQF, state Medicaid agencies, and private payers, have different definitions of preventable adverse events and different non-payment rules show that this is not a proper way to prove the standard of care? And what specific evidence-based guidelines did CMS rely on in formulating its “never event” rule? Can the science behind the guidelines be challenged? Did any physicians or hospitals object to the rule at issue, which could weaken plaintiff’s argument that the “never event” rule constitutes evidence of the standard of care? Also, can a health care provider use clinical judgment to override the guideline if appropriate?

4. If the plaintiff tries to say that Medicare’s refusal to reimburse for a “never event” is evidence that the hospital breached the standard of care, or prima facie evidence that malpractice occurred, the hospital might want to ask whether evidence of non-payment is admissible at all. Does the state have a collateral source rule that may bar any evidence regarding payment or non-payment of the plaintiff’s medical expenses, including evidence that Medicare refused reimbursement, particularly to establish whether the standard of care was violated? Similarly, if a hospital voluntarily does not bill for an event, in accordance with its state hospital association policy, does the state have a law that says that a defendant’s paying for medical treatment shall not be considered an admission of liability? Is evidence of non-payment based on a “one-size-fits-all” rule relevant to proving liability issues which should be decided on a case-by-case basis? Should the hospital bring a motion in limine, or a motion to bar at trial, if the plaintiff tries to offer such evidence?

On a related note, did the hospital have a chance to appeal the non-payment decision or to show that the injury occurred even though it followed proper precautions? If an attending physician’s actions contributed to cause the injury, should a non-reimbursement rule be used to hold the hospital legally responsible for the non-employed physician’s conduct if there is no other basis for finding apparent agency or vicarious liability?

Also, if CMS denied payment for what it said was a hospital-acquired condition, can the hospital show at

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trial that the condition may have in fact existed at admission, even if it was not documented as being “present on admission” (POA)? For example, what if the attending physician whose notes are relied on for coding POA conditions failed to notice a pressure ulcer, but a nurse who examined the patient soon after admission did observe and note it?

5. If the plaintiff asserts that a CMS “never event” is *res ipsa loquitur*, or that expert testimony is not needed because negligence is so clear, the hospital may want to point out that *res ipsa loquitur* is rarely applicable to medical malpractice cases. While one event on the CMS list, retention of a foreign object left in after surgery, may be subject to *res ipsa loquitur*, the others involve complex medical issues which a jury cannot decide based on its own lay experience without the benefit of expert testimony.
6. If the plaintiff argues that a CMS “never event” constitutes negligence *per se*, or liability based on the violation of a safety statute, what is the state’s law regarding violation of safety statutes? Is the CMS reimbursement rule similar to a safety statute, which typically sets out specific duties and is designed to protect persons or property, such as a building code or a waste dumping law? Might it be appropriate to bring a motion to strike portions of a complaint that allege negligence *per se*?
7. If the plaintiff asserts that a CMS “never event” creates strict liability, the hospital might want to argue that a reimbursement rule should not be used to create strict liability for a hospital just because something happened in the facility. For example, if something happened that was outside the hospital’s control, such as blood incompatibility because mislabeled blood was received from an outside party, the hospital should be allowed to assert that as a defense to a negligence claim, as it has historically been able to do.
8. A hospital could make similar responses if a plaintiff asserts these arguments in cases where state Medicaid agencies or private insurers deny payment for events that are not on the CMS list. For example, if payment is denied for a medication error, can the hospital show that the error occurred because an attending physician prescribed the wrong medication or dose and not because a nurse erred in administering an appropriately ordered drug? Similarly, if injury is caused by contaminated blood, tissue, or other biologic, does the state have a “blood shield” type statute which protects the hospital from liability if it obtained the blood or tissue from a reliable outside source?
9. The hospital will also need to consider how to respond to references to “never events” and non-reimbursement rules that come up during the discovery process. Might objections need to be raised? Will witnesses, including experts, have to be prepared to deal with these topics?
10. Lastly, should the hospital consider a motion to exclude use of the term “never event” on the grounds that it is prejudicial to the defense, especially if the event could have happened even if the plaintiff received appropriate care? Many organizations now refer to these matters as “adverse events”, which is a less pejorative term.

Conclusion

Non-payment rules and policies are changing and evolving. Hospitals should verify the current status of reimbursement provisions with respect to Medicare, Medicaid, and other payers. Hospitals and their defense attorneys should also develop responses to plaintiffs’ possible arguments that decisions by Medicare or other payers not to reimburse for “never events” is evidence that the hospital violated the standard of care in malpractice cases.

NOTE: This article is Marsh’s summary of its impressions of the law and Medicare, Medicaid, and other regulations. Statements concerning legal matters should be understood to be general observations based solely on our experience as insurance brokers and risk consultants and should not be relied upon as legal advice, which we are not authorized to provide. All such matters should be reviewed with your own qualified legal advisors.

Reliable Remedies for Two CMS “Never Events”

By Chris Hotchkiss

Most likely, your facility is taking proactive measures to assess current trends in preventing falls and pressure ulcers – just two of the eight “preventable injuries” identified by the Centers for Medicare & Medicaid Services (CMS) in its final rule revising the Medicare Inpatient Prospective Payment Systems (IPPS). [The final rule was published in the Federal Register on September 22, 2007; a notice correcting technical errors was published in the Federal Register on October 10, 2007.] What has your analysis of those current trends revealed, and how well have your quality improvement/patient safety programs addressed the opportunities identified?

In this article, we offer additional guidance to assist you in your CMS initiatives, such as utilizing evidence-based assessment tools, supporting practitioner competencies, and correlating event data with an audit process that can verify patient assessment, intervention and documentation.

One significant challenge of the new CMS method of cost reporting that singles out “present on admission” adverse conditions is to eliminate the incidence of pressure ulcers and falls in the health care institution. The most practical and feasible vehicle to fuel the implementation engine is the admission assessment process. Prevention strategies, shown in the current literature to be effective in reducing falls and pressure ulcers, can best emanate from the results of a comprehensive nursing assessment. Furthermore, the assessment and evaluation functions are non-delegable and intrinsic to the nursing process.¹

While almost all facilities have a protocol in place for assessing a patient’s fall risk and skin integrity, these assessments are ideally based on evidence published by organizations and institutions recognized for their highly reliable, scientific approaches to patient safety, e.g., the Institute for Healthcare Improvement; The Joint Commission; the ECRI Institute; the Veterans Health Administration; the Wound, Ostomy and Continence Nurses Society; and the National Pressure Ulcer Advisory Panel. Here are more specific recommendations:

- For your fall risk assessment, your admission process ideally includes a recognized scale for predicting patient risk, as well as evidence-based action plans to facilitate appropriate and immediate interventions; good examples are the Hendrich II Fall Risk Model, the STRATIFY tool, and the Morse scale.
- For pressure ulcers, your admission process ideally includes a recognized process for predicting and preventing skin breakdown, such as the Braden Scale for Predicting Pressure Sore Risk or the Gosnell and Knoll scales

Not only are the right assessment tools a clinical imperative for reducing the risk of falls and the incidence of pressure ulcers, but the assessment nurse must have a thorough understanding of the tools, how to document the assessment, and how to effectively implement and manage established preventive interventions.

It is the responsibility of the facility to ensure that nurse orientation and practical training in the risk assessment process is provided and that ongoing skills are mentored and evaluated on

Research has shown that, in the absence of formal risk assessment, nurses tended to intervene consistently only at the highest levels of risk...

External agencies that review and accredit health care facilities find the evidence quite compelling that formal prevention and risk assessment programs improve quality of care... A facility that doesn’t have a formal program faces not only the possibility of being cited by its accrediting body but also the threat of litigation if its care practices can’t be defended in light of existing standards of care.²

an ongoing basis, with competency in clinically pertinent risk assessment and intervention verified and documented at least annually.

The next challenge in the journey of putting a stop to CMS “never events” is the measuring of performance to verify that the risks associated with falls and pressure ulcers are appropriately assessed, documented, managed and reduced. Consider the following:

- Is your event reporting process effective? Does your culture motivate occurrence and “near miss” reporting? Is the event reporting process yielding the information necessary to identify current trends for falls and pressure ulcers, and focusing your patient safety initiatives to

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significantly reduce the incidence of these “never events?”

- Do you have data collection in place so that during a 24-hour time span you know where and when in your facility patient falls are most often occurring? Is there a trend?
- Have you analyzed the injuries associated with falls at your facility?
- Are you aware of the incidence of Stage 3 and 4 pressure ulcers at your facility?
- Is the record of each fall and each occurrence of a pressure ulcer not present on admission reviewed to evaluate the comprehensiveness of the admission risk assessment and

your staff’s adherence to the pre-established intervention processes?

- Were the interventions timely and consistent with your evidence-based protocols?
- Does your evaluation process provide for timely collaboration with responsible nursing managers to seize educational opportunities and improve nursing assessment techniques, documentation and risk reduction practices?
- Does your event management process support correlating outcome data with improved assessment processes and adherence to intervention protocols?

We encourage you to embrace the risk identification, data management and quality audit processes without delay. According to David van Stralen, high-reliability organizations have implemented, “a mechanism to ensure process auditing, which is an established system for ongoing checks to spot expected as well as unexpected problems.”³

For additional questions regarding initiatives in reducing CMS “never events,” or any other risk and patient safety support, please contact The Risk Management and Patient Safety Institute (RM&PSI). One particular tool available from the RM&PSI is a well-tested Tracking Software package that can efficiently point to “where you are” with respect to performance improvement needs and success in falls, pressure ulcers and other CMS “never events.”

News ‘n Notes

Congratulations to New CPHRMs

The Board of Directors, on behalf of the entire membership, would like to congratulate **Patty Pate** of Waunakee on achieving her CPHRM.

Legal Credits for Fall Conference (The Ripple Effect - 11/5/08 - 11/7/08)

WSHRM’s fall conference was approved for 6.5 continuing legal education credits for attorneys.

Introduce a Fellow Risk Manager to WSHRM

If you know of a fellow risk manager who is not a member of WSHRM, please feel free to forward a copy of this newsletter and introduce them to this great organization.

Visit the WSHRM Website

Don’t forget to visit our website at www.wshrm.org and view archived issues of *Risky Business*. If you need assistance logging in, please e-mail Matt Wahoske at mwahoske@fincorsolutions.com to obtain a copy of the “Setting up your WSHRM.org Members Account” instructions.

If your contact information has changed, go to member’s area and click on “Edit Account” and select “Edit Your Contact Details”. You will be asked for your username and password prior to receiving a screen to update your information.

The Board would like to give a big thank you to Matt for maintaining and keeping our website up-to-date. Great job, Matt!

References:

1. Michigan Nursing Association, RN Accountability for Delegation Decisions: Legal Parameters in Michigan and Professional Guidelines, n.d., quoting the National Council of State Boards of Nursing that, “The practice-pervasive functions of assessment, evaluation and nursing judgment must not be delegated.” p. 8.
2. Elizabeth A. Ayello, “Why is Pressure Ulcer Risk Assessment So Important,” Nursing, Nov. 2001.
3. Risk Management and Patient Safety Institute, (RM&PSI) Clinical Services Risk Management Manual, Section 2.1, Dec. 2006, p. 5, citing David van Stralen, “High Reliability Organizations,” May 23, 2005, www.highreliability.org/articles.html.

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President's Corner

Patti Vail

Approximately 80 people attended the WSHRM Fall Conference on November 5-7 at Stone Harbor Resort in Sturgeon Bay. We had not had the conference in Door County in some time and had many requests to return there. The conference began with a Networking Welcome Reception on Wednesday evening with about 50 attendees participating. We had almost record breaking warm temperatures for the trip to Door County.

We had a record amount of sponsor support for our Fall Conference, which enables us to continue to plan two conferences per year. Thanks to our generous sponsors again for their support.

We included more networking and vendor time for this conference because of the requests made from conference attendees in the past. Thursday morning started with a networking breakfast and chillier temperatures. There was a driving rain throughout the day but that didn't affect the ample time for visiting the sponsor/vendor exhibits. Our first presentation was "Humor Matters at Work" by Rog Bates. Rog gave us the gift of laughter to start the conference.

Mary Wolverton, an attorney with Peterson, Johnson & Murray in Milwaukee spoke about "Never Events". This topic was well received and we are

waiting to see what will happen in the future regarding any potential claims that will rise out of these events. We have overwhelming requests to do part two of this presentation at future conferences.

Following lunch, we had the annual business meeting with reports from the Board chairpersons, approval of the Board of Directors and officers for 2009 and the drawing for door prizes. With the generous sponsorship we received, the organization was able to provide door prizes including two each annual memberships to WSHRM and ASHRM, WSHRM Spring Conference registration, WSHRM Fall Conference registration, gas cards and autographed books.

Paul Gouge and Brian Le Claire from CNA provided attendees with "Risk Management Techniques for Cyber-Risk". They provided information regarding weaknesses and examples that certainly will give us more to consider when protecting the electronic information that is in our everyday world.

Thursday evening's networking reception gave us another opportunity to share information, reconnect and re-energize. One newcomer stated that she had never seen a group quite like ours. She said that she could feel the friendship in the room.

Friday brought a beautiful sunny morning to wrap up the conference. Again, we had a great networking breakfast.

Diane Batten of Aurora Sinai Samaritan started off our morning with "Where is my _____? Is there a way to recover lost dentures, glasses, hearing aides and other belongings?"

Diane gave us many examples of the program she initiated at a Florida hospital to recover items. She had great stories of staff engagements and money saved using the incentive program to recover lost items. There was a lot of interest expressed by attendees who hope to institute this at their facilities.

Our final speaker was Bill Brown of Interim Healthcare Executive Solutions, Inc. regarding patient-centered care. Bill shared many wonderful experiences and tools from consulting with Ministry and other healthcare organizations. He also shared his knowledge, wisdom and humor related to this topic, which is top on the lists at many of our facilities. We hope to take his successes and improve our own patient satisfaction.

Evaluations for the 2008 WSHRM Fall Conference were favorable. Attendees expressed satisfaction overall with the program, location, food and networking. The WSHRM Board is busy planning the Spring Conference for May 1, 2009 at the Crowne Plaza in Madison and the Fall Conference for September 16-18, 2009 at The Great Wolf Lodge in the Wisconsin Dells. Please watch *Risky Business* and your e-mail for further information. The Board will continue to work hard at keeping the costs of our conferences at an affordable level, especially in these economic times.

We again would like to thank our generous sponsors for continuing to support the educational goals of our society. Without their support we would be hard pressed to provide two economical educational opportunities each year. Please consider attending if you have not been able to in the past.



Case Law Update:

Development of Post-operative Complications Did Not Require a Second Informed Consent Discussion

By: Kathleen Bonville, BSN, JD
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The Court of Appeals issued a decision in December addressing whether a patient's development of postoperative complications following gallbladder surgery constituted a substantial change in medical circumstances, necessitating a second informed consent discussion. The Court of Appeals held that, when a patient consents to surgery, acknowledges he or she understands complications may arise, and authorizes the doctor to treat these complications, the patient has consented to treatment of those complications whether they occur in the operating room or later in the recovery room. A second informed consent discussion is not necessary unless the medical conditions change such that the patient faces risks not disclosed prior to the procedure. *Hageny v. Bodensteiner*, 2008 WL 5335881 (Wis. App), Docket # 2008AP133 (recommended for publication).

Hageny arose out of a decision by the trial court not to submit the issue of informed consent to the jury. Thomas Hageny underwent surgery by Dr. Bodensteiner to remove Hageny's gallbladder. It was undisputed that before surgery, Bodensteiner and Hageny discussed the risks and potential complications of surgery, including a cardiac event or internal bleeding. Shortly after the surgery while Hageny was in the recovery room his blood pressure dropped. Administration of Ephedrine failed to raise his blood pressure. Bodensteiner requested a cardiac work-up but before that work-up could be completed, Hageny died.

At autopsy it was determined that a clip on an artery had come off and he bled to death.

... The Court of Appeals correctly refused to extend the informed consent process to cover "treatment options" for postoperative complications that were revealed to the patient as part of the initial surgery.

Hageny's widow sued and alleged that Bodensteiner was negligent in his care and treatment and that he failed to obtain informed consent. Mrs. Hageny did not dispute that a valid informed consent was obtained to perform the surgery. Instead, she argued that Bodensteiner should have obtained a second informed consent discussion when Hageny's blood pressure dropped in the recovery room. Mrs. Hageny contended that the drop in blood pressure presented Bodensteiner with three options: (1) order an EKG to rule out a cardiac event; (2) perform an ultrasound to determine whether he was bleeding; or (3) try to raise his blood pressure with fluids and Ephedrine before ordering a cardiac work-up.

Mrs. Hageny argued that Bodensteiner was required to have a second informed consent discussion to inform Hageny of these options, as well as the risks and benefits of each. The trial court refused to send the informed consent issue to the jury. The jury

found Bodensteiner not negligent in his care and treatment of Hageny. The patient did not appeal the jury's finding of no negligence but did appeal the decision of the trial court not to submit the informed consent question to the jury.

In analyzing whether a second informed consent discussion concerning treatment options was required, the Court of Appeals reviewed relevant Wisconsin case law and statutory provisions concerning informed consent. In Wisconsin a physician is required to inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of those treatments. The disclosure must be guided by what the reasonable person in the position of the patient would want to know. Further, after a patient's consent to treatment is given, a physician must initiate a new informed consent discussion when there is a substantial change in circumstances.

Mrs. Hageny argued that a substantial change in circumstances was presented with the emergence of the three treatment options that had not previously been discussed. Further, she argued that whether there is a substantial change in medical circumstances depends on whether the patient would have wanted to be consulted at some particular point during the treatment. In her husband's case, she claimed that the postoperative complications constituted a substantial change in circumstances because Hageny would have wanted to know about the options available to diagnose the cause of his low blood pressure.

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The Court of Appeals characterized Mrs. Hageny's test to determine if a substantial change in circumstances exists as circular and not workable. The Court stated "we conclude that a second informed consent discussion is not necessary unless the medical conditions change such that the patient faces risks not disclosed prior to the procedure." *Id.*, ¶12. The Court pointed out that Hageny's initial consent to the surgery included an

acknowledgment that internal bleeding was a possible complication. Therefore, the Court of Appeals affirmed the trial court's decision not to submit the issue of informed consent to the jury.

In conclusion, the Court of Appeals correctly refused to extend the informed consent process to cover "treatment options" for postoperative complications that were revealed to the patient as part of the initial

surgery. To adopt the alternative position would make the initial informed consent meaningless. In the author's opinion, we are likely to see arguments similar to those presented by Mrs. Hageny in the future because there is a perception that it is easier for a jury to find a physician negligent for failure to obtain informed consent than it is for that same jury to find the physician negligent in his or her care and treatment.

Welcome New Members

The Board of Directors, on behalf of the entire membership, extends a warm welcome to our new WSHRM members:

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WSHRM would like to thank our generous sponsors for the Fall Conference (November 5-7, 2008)

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- rL Solutions
- Sentry Insurance

Without their continued support, we would not have such a strong organization and would not be able to provide two conferences each year.

WSHRM Board of Directors

Welcome to new Board members Judith Cranberg, Kim Hoppe and Suzanne Soderlund. A special “thank you” to Colleen O’Connor Patzer and Betty Hove for their service to the Board and WSHRM members.

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Legislative Chair

Board Meeting Schedule

Members are welcome to attend board meetings and encouraged to contact any board member with agenda items. To reserve a spot, contact Patti Vail at 414/447-2713 or patti.vail@wfhc.org.

- January 30, 2009
Conference Call (10 a.m.)
- April 30, 2009
Crowne Plaza, Madison (evening)
- June 12, 2009
Bellin Hospital, Green Bay
(10 a.m. to 2 p.m.)
- September 16, 2009
Great Wolf Lodge, WI Dells
(Afternoon prior to Fall Conference)
- December 11, 2009
Dean Health Care Systems Business
Office, Madison (10 a.m. to 2 p.m.)

Interested in a board position? Contact Deb Ankowicz at 608-263-9202 or by e-mail at dankowicz@uwhealth.org.

Education Events

2009 & 2010 education events are scheduled as follows:

- Spring Conference
May 1, 2009
Crowne Plaza, Madison
- Annual Meeting & Fall Conference
September 16-18, 2009
Great Wolf Lodge, WI Dells
- Spring Conference
April 30, 2010
Crowne Plaza, Madison
- Annual Meeting & Fall Conference
September 22-24, 2010
Marriott West, Waukesha

If your facility or organization is interested in being a sponsor or exhibitor at WSHRM’s educational programs, please contact Judi Nelson at 715/356-8995 or nelsonj@hyhc.com.