

The Smoldering Issue of Trustee Liability for Poor Hospital Quality: A Firestorm whose time has come

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Abstract

J. P. Kotter, in his 1996 book on leading organizational change¹ offers that the first step in a change effort is to establish a sense of urgency. The time has come to create that sense of urgency in hospital Trustees; whom almost universally, are unaware of the crisis in patient safety and preventable patient injury in American hospitals today, including those they serve in a fiduciary capacity. While Trustees are clearly responsible for the quality of care in the hospital, and ultimately liable for bad quality of care, Trustees are not receiving good information about the quality of care in their institution, and are not fulfilling their fiduciary obligation to oversee the management of quality. Without dramatic change and a focus on organizational quality, Trustees across America may expect new and dramatic exposure to liability. The purpose of this article is to create a call to action and engage hospital Trustees, medical staff leadership; and hospital administration in a positive effort to create change focused on quality. This article focuses on the pervasiveness of the quality problem from the perspective of quality professionals; the contributing factors to the quality problem; institutional resistance to change and the process of accomplishing change.

TRUSTEE LIABILITY AND THE EMERGING FOCUS

Any discussion of Trustee liability for poor quality of care provided in the hospital must include the potential for liability arising from injuries to third parties (patients) and those arising from a breach of state or federal regulation, particularly those related to billing for patients who have received poor quality care. With respect to the former, the most often cited case establishing the duty of Trustees for the care provided in the hospital is *Darling v. Charleston Community Memorial Hospital*.²

This traditional source of Trustee liability has found a new partner in the United States Government, through application of the Civil False Claims Act ("the Act"), a Civil War-era statute that prohibits the knowing submission of false or fraudulent claims to the federal government.³ Violators are subject to statutory penalties of up to \$11,000 per claim, plus treble damages,⁴ making the Act a powerful component of the federal anti-fraud arsenal. The Act also contains a *qui tam* provision, which permits a private "whistleblower" who sues on the government's behalf to retain a portion of the money recovered.⁵

¹ Kotter, J.P. (1996), *Leading Change*, Boston, MA: Harvard Business School Press.

² *Darling v. Charleston Comm. Mem. Hosp.*, 200 N.E. 2d 149, 171 (Ill. App. Ct. 1964).

³ See 31 U.S.C. §§3729-3733 (2004).

⁴ See *id.* at §3729(a)(7).

⁵ See *id.* at §3730(d).

DEFINING THE PREVALENCE OF QUALITY ISSUES

Obviously, if we are to create a sense of urgency in our call to action, we must first demonstrate that there is a hospital quality issue. It is clear, as indicated above, that there are common law negligence claims and criminal charges that can be brought against hospital Trustees based on incidents of poor care, as well as plaintiffs and prosecutors who are willing to bring them. This should be frightening to Trustees if they stop to consider the magnitude of the quality problem. It is well documented that estimates of medical error identify as many as 400,000 deaths per year and as many as 98,000 hospital deaths per year (equivalent of 1 jumbo jet crashing daily).⁶ This is compounded by the fact that one-fourth of all hospital deaths are preventable;⁷ one-third of hospital procedures expose patients to risk without improving health;⁸ and, one-third of all laboratory tests with abnormal results are not followed up by physicians; and acute care patients and 20% chronically ill patients receive care not indicated.⁹

According to the Robert Wood Johnson Foundation, the risk of death from riding on a set of recalled Firestone tires is much lower than the risk of death from avoidable hospital error. The startling contrast for risk of death is 91 per million versus 2,917 per million, or a 32 times greater risk of death in health care.¹⁰ This perspective states the magnitude of the problem in a recent and easily understandable context.

A recent RAND study further confirms the problems with quality of care based upon a study of 20,000 adults from 12 cities, 30 acute and chronic conditions, and using 439 quality indicators. The study concludes that only 55 percent of American patients receive the care recommended by experts and the most current medical science. Some of the specific problems highlighted by the study are that only 45% of those presenting with heart attacks receive beta-blockers, and only 24% of diabetics received three or more glycosylated hemoglobin tests within a two-year period.¹¹ Additional statistics on poor quality are provided in the authors' recent article published in the Journal for Health Care Finance.¹²

⁶ See Committee on Quality of Health Care in America, Institute of Medicine, *To Err is Human: a Safer Health Care System* (LT Kohn et al., editors, 2000). See also *Building a Safer Health Care System* (LT Kohn et al., editors, 2000).

⁷ See Dubois, R.W., Brook RH, "Preventable Deaths: Who, How Often, and Why?" 109 *Annals of Internal Medicine* 582-589 (1988).

⁸ See Brook, R.H., Kamberg, C.J., Mayer-Oakes, A., et al., "Appropriateness of Acute Medical Care for the Elderly: An Analysis of the Literature," *Health Policy* 225-242 (1990).

⁹ See National Quality Forum (Forum for Health Care Quality Measurement and Reporting), "A Call to Action," at p. 2 (2001), available at www.qualityforum.org; last visited March 24, 2004. See also Institute of Medicine, *supra* note 6, at p.1.

¹⁰ See Robert Wood Johnson Foundation, "Call for Proposals: Pursuing Perfection, Raising the Bar for Health Care Performance" available at <http://www.ihf.org/pursuingperfection/>, last visited March 24, 2004.

¹¹ See Wennberg, J.E., Cooper, M.M., editors, *The Quality of Medical Care in the United States: A Report on the Medicare Program*. The Dartmouth Atlas of Health Care in the United States (1999).

¹² See Feazell, G.L., Marren, J.P., *The Quality-Value Proposition in Health Care*, *J. Health Care Finance*, 2003; 30(2), 1-29.

THE RELUCTANCE TO CHANGE: THE “IT CAN’T HAPPEN HERE SYNDROME”

Hospital boards and senior management frequently make the crucial mistake of assuming that quality problems do not exist in their organization. Or worse, they fail to look at the quality of their product – health care – and try to feel safe in the conclusion that no news is good news. When we meet with senior management, we most often hear that “we are doing fine.” “Fine” means that the bottom line is at least not too bad or even that it is favorable, and the organization is really committed to not rocking the boat. We have even heard that “there is not enough pain” for our organization to look at quality. It is important to realize if it happened at Dana Farber and at Duke University, it can and does happen everywhere.

Unfortunately, the bold and truthful role of senior management in quality “oversight” was published by a prominent medical director, as follows:

“On the surface, health care senior management appears to be engaged supporters of quality. Strong statements find their way into annual reports and corporate documents. They are often in contrast to the situation most medical directors experience as they present a “Quality Report” at a board meeting. As the medical director starts handing out the presentation, people begin looking at their watches and the walls. Indeed, the presentation needs to be handed out or it will not appear in the minutes at all. Why? In essence, senior management and quality have a love-hate relationship. On the one hand, quality is supported as a corporate value and is suspected to have a probable (but unknown) return on investment. On the other hand, frequent comments often suggest that it represents an irritating, sunk cost, a necessary evil of unknown value.”¹³

Much of the information has been available for some time, yet the problem continues. The problem is three-fold. First, in many instances the Trustees are not seeing patient safety data in a manner that allows them to actually manage the quality of care in the hospital. Second, there is a presumption that the quality of care provided in my hospital is simply good, and, third, adequate audit procedures that allow the Trustees to rely on external validation of internal reassurances about quality do not exist. ***The danger presented is that Trustees are exposed to liability and don’t even know that it exists or what to do about it.***

The ultimate “firestorm” for Trustees will become reality when malpractice litigation focuses on patterns and trends of quality defects that are known or constructively known by the organization without adequate intervention to demonstrate to the Board’s satisfaction that the deficiency is fixed. Pattern and trend litigation will be influenced by perceived solutions, such as tort reform with capitation of damages, by attorneys

¹³ Fetterolf, D., *Commentary: Presenting the Value of Medical Quality to Nonclinical Senior Management and Boards of Directors*, American Journal of Medical Quality 18(1): 10-14, at page 10 (2003).

aggregating plaintiffs. The 800 plus litigants in Northern California claiming that they received unnecessary cardiac procedures (“overuse”) is an example of such potential exposure. What may appear to be irresistible impact on the bottom line can become the end of a health care organization.

Another significant cause for concern revolves around the responsibility of Trustees for re-credentialing physicians and allied health care providers based upon demonstration of current clinical competence. The reality in most health care organizations is that there is inadequate clinical information, even including minimum threshold volumes of procedures for some specialties, much less adequate assessment of care to demonstrate such review of competence.

Our primary fear for Trustees is that courtrooms will become used to compare how Trustees deal with finance as compared to quality and patient safety. Imagine the Board chairperson being cross-examined by taking them through how there is a committee of the Board that deals with sophisticated, internal and external audits. There is no similar process for review of quality. And the question, posed as a statement, then becomes: “So is it fair for the jury to conclude that you care more about money than patients?”

Instead of engaging in finger pointing and accusation of the medical profession and hospital industry, the authors, in two previous articles offer that (1) it is necessary to address the structural, cultural and informational issues that prevent repair of the quality problems and (2) there is a direct and compelling business case for the relationship between quality and value.

The structural challenges that contribute to the problem include:

- The separation of clinicians in the hospital into distinct segments, preventing a “patient centric” focus;
- Traditional medical staff independence for peer review activities and autonomy preventing involvement in health care teams;
- Lack of Trustee commitment to quality as a business strategy and focus/support for error free care;
- Lack of Trustee information on quality and clinical performance; and
- Lack of enterprise-wide focus on quality.

The cultural problems include:

- Care processes are not designed and provided on evidence-based best practices;

- The culture continues to tolerate errors, in stark contrast to other industries where errors (defects) are systematically eliminated;
- Feedback loops are not established to learn from clinical experience; and
- Clinical privileges for physicians are not granted based on demonstrated current clinical competence and quality.

The informational problems include:

- There is no method for monitoring of systems and processes;
- Peer review is isolated and not integrated with quality/risk data;
- Quality/risk data is not correlated with financial data;
- Integrated data is not provided to clinicians to modify behavior; and
- Clinical information to determine current clinical competence is not developed and determinative.

BOARD ACTION TO LEAD THE QUALITY INITIATIVE

There are those who believe that the health care system cannot fix itself. In *Medicine on Trial*,¹⁴ the authors conclude:

“It is simply clear that the medical care system is not capable of significant and sustained efforts to improve the quality of its services. It simply has too much at stake in preserving benefits to its own members.”

We disagree. We do believe, however, that the efforts to transform the quality of care in American hospitals require Trustees to answer the question posed by Mark Chassin, M.D., one of the nationally recognized leaders in health care quality who poses the question – who will lead? It is unreasonable, illogical, and irresponsible for Trustees to believe that physicians will lead the quality initiative in their organizations. There are simply too many disincentives and too many demands on physicians for them to engage and lead solutions to the quality challenges faced by every health care organization. The answer is that quality will be led by Trustees or not at all.

What must take place? Trustees must question their organizations’ ability to engage in a process that includes:

¹⁴ Inlander, C., L. Levin, and E. Weiner. *Medicine on Trial*. (pp. 11-12) New York: Prentice Hall, 1988.

- assessing needs and readiness of the organization;
- educating and obtaining buy-in of Trustees, senior management and medical staff;
- organizing for quality and patient safety;
- assessing quality and organizational performance;
- evaluating and improving organizational performance; and
- integrating quality functions into strategic planning.

Ultimately what needs to happen is the creation of a detailed assessment of all quality processes as well as the development of an integrated “quality/risk database” which would actually integrate, format and display data and trends in a manner that could be readily understood by all hospital leaders, including the Trustees. The process examines all sources of quality related data to identify trends, and further examines clinical areas to integrate best practice methodology, initially into high risk clinical areas and ultimately into all clinical areas. Errors are reduced and the general quality of care is increased dramatically. The key to this project is to engage the administration, the Trustees and the medical staff in a comprehensive quality effort. The result is that the hospital has a system and process for auditing its own quality assurance processes. Further, this audit system is validated on an annual basis by an external quality group to accomplish two goals: provide reassurance to the Trustees that the quality processes put in place are in fact functional and utilized, and, second, to demonstrate to the public, including insurance carriers, that the hospital has a “belt and suspender” approach to quality. This could result in reduced cost of malpractice insurance as well, on a broader scale, tort reform.

Failure to participate in such a process exposes Trustees to increased liability. It is only a matter of time before plaintiffs’ personal injury attorneys begin to focus on Trustees failure to ensure quality. Overuse, underuse and misuse have ramifications for personal injury suits against Trustees. For example, the Chubb Group of Insurance Companies, a large provider of not for profit organizational liability coverage states in their specimen policy that items that are excluded from coverage include:

- (c) any deliberately fraudulent act or omission or any *willful violation* of any statute or regulation by such Insured, if a judgement or other final adjudication adverse to such Insured establishes such a deliberately fraudulent act or omission or *willful violation*.¹⁵
(Emphasis added)

When you consider, as offered above, that there is a growing amount of public data and awareness of overuse, underuse and misuse, and that, as offered above, Trustees have no

¹⁵ The Chubb Group of Insurance Companies, Not for Profit Organizational Liability Coverage, specimen policy, on file with author.

current way of assuring the quality in their own hospitals, thereby reducing the likelihood of repeat instances of medical error, it is likely that the Trustees' failure to act effectively regarding quality may be tantamount to a "willful violation" which traditional insurance policies may not cover. If this scenario unfolds, Trustees will be personally responsible for their own defense or damages. Additionally, if the government brings an action in a criminal fashion, these cases, as well, would not be covered by insurance policies designed to protect the Trustee.

It is time for Trustees to take full and complete responsibility through direct involvement and oversight for assuring quality and patient safety. This expectation mandates creating an integrated quality/risk database, a structure to provide oversight for analysis and intervention based on the information developed, education to be capable of analysis and interpretation of the quality information, and evolving organizationally to viewing quality and patient safety as a fundamental business strategy. Quick and focused action, as outlined above is the only clear ways of assuring patient safety and protecting Trustees from unwanted liability and financial exposure.