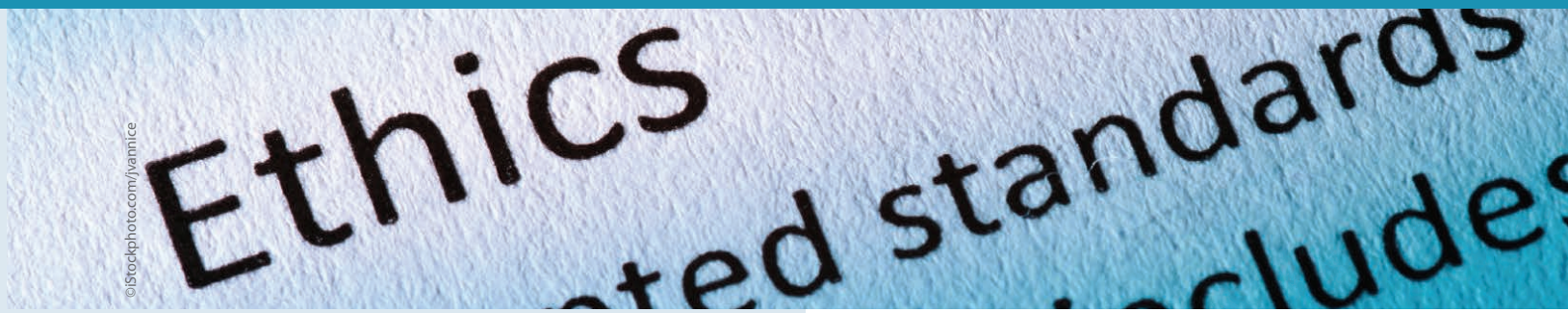
Oh, Doctor, Where Art Thou? The $1.2 Million Lawsuit Settlement

What WERE they thinking?

By Marianne M. Jennings, JD



The University of California Irvine Medical Center agreed to pay $1.2 million to settle fraud allegations that resulted from the whistleblower disclosures of a former professor of anesthesiology at UCI medical school. Dr. O'Connor filed a 2008 false claims lawsuit alleging the following:

- Nurse anesthetists or residents were administering anesthesia to patients without a supervising anesthesiologist being present.
- Patients were still billed as if the anesthesiologists were present.
- In some cases, the anesthesiologists listed as being in the room and supervising or administering anesthesia were actually in other buildings.
- The paperwork required for surgery and procedure records listed anesthesiologists as being present.
- In some cases, the surgery paperwork was completed in advance, complete with the conditions of the patient ("stable" and "comfortable") even before the anesthesia was administered.

This is the kind of headline case that makes us all hit our foreheads in V-8 style and ask: "What WERE they thinking?"

Peter Breen, the doctor who was the head of UCI anesthesiology was disciplined through a public reprimand by the California Medical Board based on charges of gross negligence and incompetence. He was required to successfully complete board-approved courses in ethics and medical recordkeeping. He remains at UCI. UCI has changed to electronic recordkeeping to prevent such false entries.

The indefinite solution

Disciplining the physician involved, changing internal controls and recordkeeping are necessary, but they are deceptively reassuring to organizations. It is a simple task to label one physician a rogue and sally forth with smug reassurance that the problem is solved. Sometimes we even add a good dose of ethics training for everyone just to show how serious we are about 'never again.'

These types of responses will fix the problems in the anesthesiology department and drive home honesty in paperwork, but may not fix the next problem in another area that will not involve either the anesthesiology department or falsification of paperwork. In fact, these dashboard fixes of ethics courses, changes in leadership and new types of recordkeeping provide a false sense of security.

These fixes elude the next ethical issue because they stop short of two simple generic questions that should be asked:

- Why did so many people go along with this?
- What made them believe this was appropriate conduct in our organization?

What lies beneath?

The answers to those questions require deeper thought, cultural exploration and organization-wide changes that are never easy to implement and even more difficult to measure in terms of their effectiveness. Without this deeper analysis, organizations constantly chase the tiger by the tail.

Dashboard fixes with ethics courses, changes in leadership and new types of recordkeeping provide a false sense of security.

For example, as we in academia looked at Penn State and the failure of that organization to respond quickly to allegations of child molestations on campus, we were prompt in taking action. Everyone on campus received training and information on reporting, and we all reviewed our policies, paperwork and procedures on having minors on campus. Check! Problem addressed! Nothing to worry about here!

> Exploring why there were such blatant ethical missteps is the only way to avoid future problems.

However, the next issue in academia will probably not involve minors on campus and molestation. The next issue could involve, as it has with the former Rutgers basketball coach, abuse of players. Fire the coach, get rid of the athletic director and possibly others close to the problem and remind everyone of the policies on physical and verbal abuse. Check, once again.

However, the same two questions apply at Penn State and Rutgers that applied at UCI. Why were so many who witnessed the conduct complicit? Why would they think that this kind of behavior was acceptable here?

There are similar patterns in business. Chase Bank recently lost between $6 and $8 billion (it is tough to sort out on these complex deals exactly how much is lost) because of the activities of a brilliant trader known as "The London Whale." Chase has responded by firing "The Whale" and putting new trading controls in place. Check! Wild trades? Never again!

Still, those pesky questions emerge: How did he trade for so long at those levels with others in the office saying nothing? Why did they and the Whale believe that this level of risk was appropriate at the bank?

From these examples, we can explore critical derivative questions from the two primary questions:

1. Why did no one speak up? At UCI, there were nurse anesthetists, residents, and operating room staff who knew no anesthesiologist was present but proceeded anyway.
2. What made them believe this approach was acceptable under hospital standards?
3. What barriers were there to having them speak up about their concerns?
4. What about our incentives, our billing and those other financial factors?
5. Could our emphasis on billing and revenue have overridden judgment and compliance?
6. Are there personalities and deference factors in our organization that keep employees from raising issues?

Fixes in response to these more complex questions are the things that try men's souls and keep ethics and compliance folks up at night.

> Take your dashboard steps as immediate action, but with those steps, your work is only beginning.

It is just plain wrong to not have an anesthesiologist present and then to double-down and bill as if he were there.

It is just plain wrong to falsify paperwork by filling out patient status days in advance of the procedure.

These are not ethically gray areas or close calls. The same can be said of the issues at Penn State, Rutgers and Chase. Exploring why there were such blatant ethical missteps is the only way to avoid future problems.

How does this exploration occur?

In tandem with the terminations, the training and new recordkeeping that follow as dashboard alterations to ethical missteps, leaders need thoughtful reflection on the following:

- Do we have misaligned incentives? Is there something in our compensation system that would drive employees to this kind of behavior?

- Are there physicians, managers, leaders who are immune from discipline and feedback? In other words, are there some stars (particularly in research hospitals) that are viewed as untouchable, whether through leadership's touting of them and their contributions or through lack of action when these stars cross ethical lines? Employee silence surrounds these individuals who round the corners on rules and compliance.

- How often are we out and about observing? When do we have unplanned and unscheduled interaction with employees, doctors and patients? How frequent are observations?

Answers to these questions require candid conversations with those who were in the operating room to get their thoughts on why they said nothing. The rogue you fired is one part of a complex web of psychological interaction among employees that allowed the conduct to continue to a whistle-blower stage. Explore all parts of the web by interviewing those who knew about the paperwork, those who were aware of the paperwork and the missing physician. Then move to other employees within the organization who took no part in the paperwork or procedures but were aware of the practice.

At Chase, for instance, there were folks outside the bank who were aware of The Whale's activities and were voicing questions and concerns but took no steps to throw down the flag. At one point, even the financial press was raising a question or two. Still there was no response from Chase except: "This is a tempest in a teapot." Therein lies another derivative question for Chase: Why did we think we did not need to explore an external allegation?

Those knowledge rings are where your answers lie for prevention. Take your dashboard steps as immediate action, but with those steps, your work is only beginning. Find out the answer to the overarching question we all ask in these headline cases: "What WERE they thinking?" Unless and until you know that, the next problem is coming. **NP**

Marianne M. Jennings is an emeritus professor of Legal and Ethical Studies at the W. P. Carey School of Business, Arizona State University, where she taught for 35 years. Professor Jennings has authored hundreds of articles in academic, professional and trade journals. Her latest book, Business Ethics: Case Studies and Readings*, was published in January 2011. Her book,* The Seven Signs of Ethical Collapse *(St. Martin's Press), published in 2006, has received several book awards, including recognition from* Library Journal. *You can reach Marianne at Marianne.Jennings@asu.edu.*

Satisfaction does not come with achievement, but with effort. Full effort is full victory.
~ Mahatma Gandhi