A MONTHLY REVIEW OF EXPERT PRACTICE ATTORNEY EDITION NUMBER 1

The Vident Review



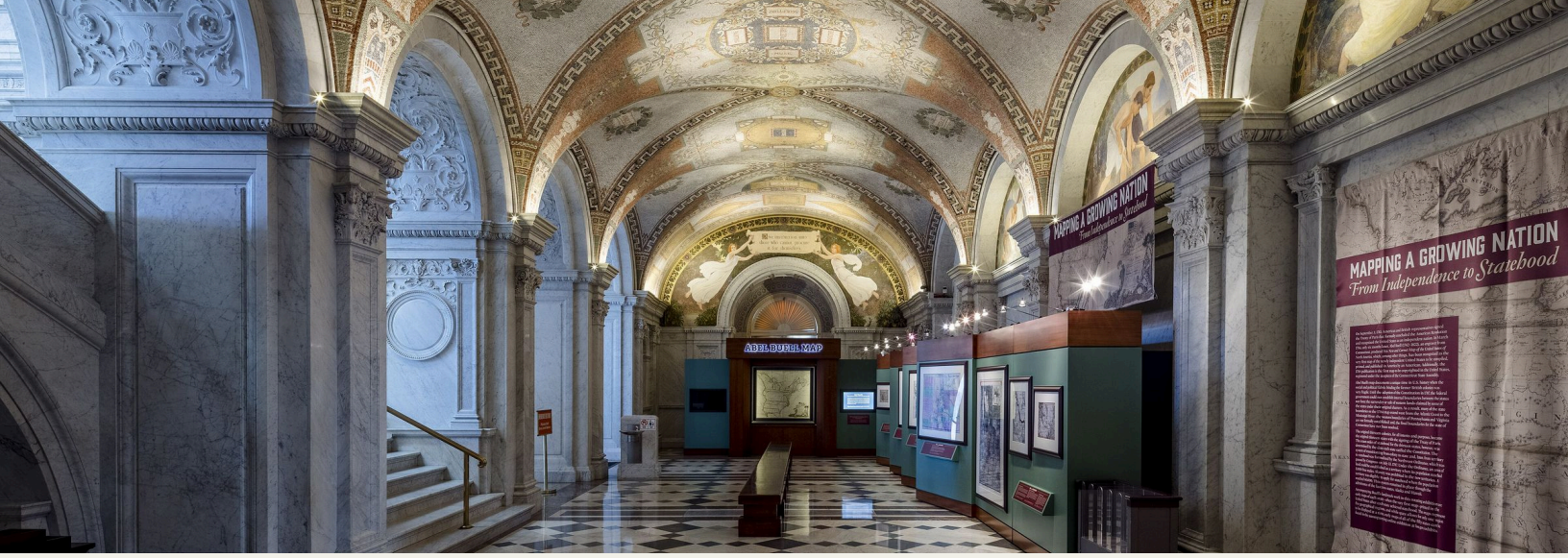
The standard, in writing

Four Centers, 37 standards and 156 primary sources, open to both sides of the v.

THE STANDARD
CANDOR's 60-minute clock

EXPERT PROFILE
Dr. Seth Krevat on what a hospital owes after harm

FOR COUNSEL
Five ways to use a Center on a live matter



NUMBER 1

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FROM THE EDITORS

One subject a month, with the sources

This is the first issue of The Vident Review, a monthly publication for the attorneys who retain experts and the experts they retain. Each issue takes one question from that work and answers it with sources you can open.

Since 2005 Vident Partners has referred consulting and testifying experts to plaintiff firms, insurance defense, government agencies and AmLaw firms. Two decades of that work teach things a CV rarely shows: how a standard gets read, how an expert holds up, what separates a strong report from a strong witness. This review writes them down.

We start where every expert case starts, with the standard. Vident now publishes four of them in full. The cover story explains why, and the pages that follow show what one looks like: a clock a hospital has to meet, and the physician who helped write the curriculum behind it.

The Vident Review is published monthly by Vident Partners, Dallas, Texas, for the attorneys who retain experts and the experts they retain. **Managing Partner** Arie S. George, J.D. videntpartners.com



COVER STORY

What was required here?

Every expert case turns on that question. The Vident Authority Network publishes the answer, with its sources, for anyone to read.

Someone has to answer it under oath. What did the school have to do before the harm? What did the nursing home owe the resident? What did the hospital owe the family the morning after?

The answer rarely sits in one place. It runs through a federal regulation, a surveyor manual, an agency toolkit, a state statute and a line of opinions, and it changes. Every Center in the Vident Authority Network gathers one of these subjects into a single reference, written so both sides can use it.

WHAT A CENTER IS

A Center is a standing reference on one area of litigation: the science, the governing law, the questions that decide matters, and the standard an expert in that field is held to. It is a section of videntpartners.com, published and funded by Vident Partners, and each one says so in the header of every page.

Four are live. The Synthetic Opioid Project covers the pharmacology, toxicology and causation questions around fentanyl. The Standard of Care in Schools covers what the law and national practice standards require of a district before, during and after harm to a child. The Long-Term Care Standards Project covers nursing homes, assisted living and memory care. The Patient Safety Standards Project covers what a healthcare organization owes after a patient is harmed.

WHY PUBLISH IT

An attorney deciding whether a case has merit needs the test before the expert. So does the defense lawyer reading a demand letter. A published standard lets either of them start with the regulation, the guidance and the case law, in order, with the citations attached, before anyone has spent an hour of an expert's time.

A published standard also holds Vident to its own work. The experts who anchor a Center list what they write there among their publications when they are retained. Opposing counsel will read those disclosures and follow the link.

> "We publish it under our own name on purpose."
>
> FROM THE EDITORIAL POLICY OF EVERY CENTER

WHO PAYS FOR IT

Vident funds every Center in full. A Center takes no advertising, no sponsorship and no third-party money. Vident is paid when an attorney engages an expert through its referral service, and each Center's About page states that plainly as the commercial interest behind the publication. Reading a Center costs nothing and obligates no one.

Anchor experts do not direct a Center's editorial content, and nothing is written to support a position in a pending matter. Appearing on a Center is no endorsement of any opinion an expert may offer in a particular case.

THE SOURCING RULES

1. **No claim without a citation.**
   If a statement cannot be traced to a primary source a reader can open, it does not go on the page.
2. **A population figure is not an individual finding.**
   A statistic about a population never stands in for a particular case.
3. **A number keeps its conditions.**
   The sampling method, the period covered, and whether the data are provisional or subject to revision travel with it.
4. **No position on any case.**
   Where the science favors neither side, the page says so. Where the literature is unsettled, the page says that too.

> "The attorney owns the decision. Vident owns the quality of the recommendation."
>
> PETER GEORGE

THE VIDENT AUTHORITY NETWORK

Four Centers, each anchored by named experts

4
Centers live, as of November 5, 2026

37
standards sections across the four

156
primary sources, each one numbered and linked

The Synthetic Opioid Project

Pharmacology, toxicology and causation, sourced to primary literature. Federal death-results prosecutions, wrongful death, emergency care and contested postmortem toxicology.

STEPHEN L. THORNTON, M.D., FACEP, AND SAADYAH E. AVERICK, PH.D.

The Standard of Care in Schools

Special education, bullying and harassment, restraint and seclusion, and student suicide, usable by a family's counsel and a district's counsel alike.

BARRY N. FELDMAN, PH.D., LICSW, AND LAURA WILK, M.ED.

The Long-Term Care Standards Project

Pressure injuries, falls, staffing and the record. 42 CFR Part 483, the surveyor guidance beneath it, federal data and the controlling case law.

NICHOLAS A. ALFONSO, M.D.

The Patient Safety Standards Project

Reporting, review, disclosure, resolution and clinician support. The Conditions of Participation, the CANDOR process, state law and the national patient safety bodies.

SETH A. KREVAT, M.D., FACP

Each Center opens with the same parts: the standards, the sources, the questions that decide matters, and the people who anchor it. Every cited link is checked before publication and rechecked whenever a page is revised. A reference that cannot be opened is not a reference.

When a dataset is revised, the figure and its citation change together, on the page. More Centers are in preparation. All four are open at videntpartners.com/network, with no sign-in and no form to fill out.

When to open a Center

Each Center lists the matters it was built for. Here they are, side by side.

CENTER	MATTERS IT COVERS	EXPERT FIELDS
Synthetic Opioid Project	Federal “death results” prosecutions and state drug-induced homicide. Wrongful death after overdose. Emergency and EMS standard of care: naloxone dosing, observation and discharge. Correctional withdrawal and overdose. Contested postmortem toxicology.	Medical toxicology, emergency medicine, pharmaceutical chemistry
Standard of Care in Schools	IDEA due process and FAPE sufficiency. Section 504 and ADA Title II damages claims. Peer harassment and staff misconduct. Child find failures. Suicide risk identification, safety planning and postvention.	Special education administration, suicidology
Long-Term Care Standards Project	Pressure injury and wound claims. Falls and whether the mechanism described can produce the fracture found. Malnutrition and dehydration. Sepsis and failure to escalate. Medication error. Abuse, neglect and reporting timelines.	Orthopedic trauma, on injury mechanism and consequence
Patient Safety Standards Project	Claims about the safety program itself. Disclosure questions raised apart from the underlying negligence. Adequacy of an event review. Billing for care an event made necessary. What the organization did in the seventy-two hours after a serious event.	Patient safety, disclosure and event review

Each Center is written to be equally usable by both sides, because a standard only one side trusts is not a standard.

FROM THE CENTER’S STATEMENT OF PURPOSE

Five ways to use a Center on a live matter

1 Start with the standards section.

It lays out the test the expert will be held to, in the order a court or surveyor would apply it, with each claim numbered to its source.

2 Open the sources yourself.

Every citation goes to the statute, opinion, dataset or paper underneath it. Read the current edition of anything that changes between editions.

3 Date every number and rule.

Staffing, Title IX and accreditation text have all moved in recent years. The Long-Term Care Center puts it in one line: date it, do not assume it.

4 Use the case types to scope the expert.

The list can show that a matter needs a different field than the one first requested, or a second expert for causation.

5 Call before the theory hardens.

Vident's attorney-led team can talk through the question and the fit. The consultation is complimentary, often within 24 hours, with no obligation.

WHAT A CENTER WILL NOT DO

- Take a side in any case
- Say whether a particular matter has merit
- Stand in for a retained expert's review of your record
- Speak for an anchor on a pending matter

It gives both sides the same reference. The opinion in your case still comes from the expert who reads your file.

Plaintiff or defense, prosecutor or public defender, the Center is the same page.

The anchors are available to plaintiff and defense counsel alike. To talk through a matter, call (913) 257-5170 or write to experts@videntpartners.com.

THE STANDARD

A hospital's response to harm runs on a clock

CANDOR, the federal process for responding to unexpected harm, sets the sequence, the components and the time allowed.

60 minutes

The initial disclosure conversation "will occur within 60 minutes after the CANDOR event occurs."

30 to 45 days

The complete disclosure follows the investigation, which takes place "within 30-45 days after the event occurred."

12 to 18 months

"It will take at least 12-18 months to implement the CANDOR process."

CANDOR stands for Communication and Optimal Resolution. The Agency for Healthcare Research and Quality describes it as “a process that health care institutions and practitioners can use to respond in a timely, thorough, and just way when unexpected events cause patient harm,” and contrasts it with a traditional deny-and-defend approach.

The process has five components: identifying a CANDOR event, activating the system, response and disclosure, investigation and analysis, and resolution. A CANDOR event is “an event that involves unexpected harm (physical, emotional, or financial) to a patient.” Such events trigger the process “even when a cause for the event is not yet known.”

NAMED IN A POLICY, OR IMPLEMENTED

The distinction that decides matters is between an organization that has named CANDOR in a policy and one that has implemented it. The gap analysis, the disclosure communications, the event review files and the qualifications of the person running the program all show which happened.

RESOLUTION INCLUDES THE BILL

The Leapfrog Group’s Never Events Policy is voluntary, and it is the clearest written national statement of what a hospital should do after a serious reportable event. A hospital meets it only by committing to all nine lines, among them an apology, waiving the costs directly related to the event, reporting it to an external agency, a root-cause analysis, and telling the family what will change. The hospital waives those costs “so that the patient and third-party payor do not receive a bill for those costs.”

FIVE COMMITMENTS IN 2007, FOUR MORE IN 2017

The four added in 2017 were interviewing patients and families, informing them of the prevention steps, a caregiver-support protocol and an annual compliance review. The underlying list is the National Quality Forum’s 29 serious reportable events across seven categories.

FIVE STATES REQUIRE DISCLOSURE BY LAW

Pennsylvania	Written notice within seven days of a serious event
Nevada	Notice no later than seven days after discovering a sentinel event
Massachusetts	Within seven calendar days of discovering a serious reportable event
New Jersey	No later than the end of the episode of care
Florida	In person, for adverse incidents that result in serious harm

Occurrence reports are filed by the thousand for events that harmed no one. That is the design of a reporting program.

SOURCES As published in the Patient Safety Standards Project, videntpartners.com/network/standard-of-care-after-harm, read November 5, 2026: AHRQ, CANDOR Toolkit and Implementation Guide (ahrq.gov/patient-safety/settings/hospital/candor); The Leapfrog Group, Never Events Policy and 2026 Fact Sheet; 40 P.S. § 1303.308(b); NRS § 439.855; 105 CMR 130.332; N.J.S.A. 26:2H-12.25(d), as enacted; Fla. Stat. § 395.1051. The accreditation manual and state text are revised between editions. Read the current version.

CALLED ON FOR

- Disclosure of medical error
- Adequacy of an event review
- Patient safety program design
- Billing after a serious event
- Diagnostic error and closing the loop
- Human factors in healthcare



He ran patient safety for ten hospitals

Seth A. Krevat, M.D., FACP. His subject is what an institution owes a patient after harm has already occurred.

For seven years Dr. Seth Krevat was Assistant Vice President for Safety at a ten-hospital integrated health-care system in the Mid-Atlantic. Every reported adverse event in the system came to him and his team of safety professionals: missed diagnoses, wrong-site and wrong-procedure events, falls with injury, medication errors. He was responsible for the response, which included open communication with patients and families and a systems-based review of each event.

His team worked alongside risk management, making sure bills were waived when care was found not to meet the standard. He sat on the monthly claims review committee, where serious claims were evaluated with attorneys and clinical experts.

HE HELPED WRITE THE FEDERAL CURRICULUM

The Agency for Healthcare Research and Quality names Dr. Krevat in its acknowledgments for the CANDOR toolkit as a member of the Expert Faculty. He led the toolkit's implementation across his system, one of the pilot sites.

He later served as Senior Medical Director of the system's National Center for Human Factors in Healthcare, where he led patient safety research and coauthored more than 30 additional papers. His work appears in *JAMA Network Open*, *JAMA Health Forum*, the *Journal of Patient Safety* and the *Joint Commission Journal on Quality and Patient Safety*.

HE STILL SEES PATIENTS

Dr. Krevat is an assistant professor of Clinical Medicine at Georgetown University School of Medicine and cares for critically ill patients on the palliative care team at Georgetown University Hospital. He is board certified in hospice and palliative medicine, and was board certified in internal medicine for 20 years.

He is the anchor of the Patient Safety Standards Project and is available for consulting and testifying engagements, for plaintiff and defense counsel alike. Before Georgetown he was a hospitalist and physician advisor at Virginia Mason Medical Center, trained in Lean and Toyota Production System methods. He received his medical degree from Georgetown and holds a B.A. in economics and English from Tufts.

His depth is operational: seven years directing the safety program, the event reviews and the disclosures themselves.

FROM HIS PUBLISHED WORK

"Identifying Electronic Health Record Contributions to Diagnostic Error in Ambulatory Settings Through Legal Claims Analysis," *JAMA Network Open*, 2023, first author.

"Lessons Learned from a Systems Approach to Engaging Patients and Families in Patient Safety Transformation," *Joint Commission Journal on Quality and Patient Safety*, 2020.

Full profile: videntpartners.com/experts/featured/seth-krevat

A TERM WORTH KNOWING

Anchor expert

A named expert whose published work and field knowledge ground a Center of the Vident Authority Network. Anchors are chosen on credentials and publication record in the specific question at issue, and they do not direct the Center's editorial content.

FURTHER READING ON INSIGHTS

The Demise of the "Hired Gun" Expert

Arie S. George, August 11, 2026

Why a Forensic Expert's CV Cannot Tell You What You Need to Know

Peter George, October 20, 2026

Catching the Pink Unicorn

Peter George, May 12, 2020

What are you working on?

Reply to the email this review came with and it reaches Arie George.

NEXT MONTH

The deposition and the courtroom

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PHOTOGRAPHS Cover: Main Reading Room, Library of Congress, Shawn Miller, Library of Congress. Page 2: Map Gallery, Library of Congress, Shawn Miller. Page 3: Great Hall ceiling, Library of Congress, Shawn Miller. Portrait: published on videntpartners.com.

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