Risk Rx

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HSC Self-Insurance Program

Managing Disclosure Of Adverse Events

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Introduction

There are two groups affected by adverse medical incidents, and historically, we have not done a good job of helping either. *The first group is patients and their families; the second is the health care providers involved in the incident.*

Patients and families, who are most obviously affected by and adverse event need several things from their caregivers.

- First, they need to know what happened. All too often, once things start going wrong, caregivers become unavailable or uncommunicative with patients and families. The resulting uncertainty itself is painful, and silence is easily interpreted as lack of respect and compassion.
- Second, they need an apology. They need to hear someone say that they are truly sorry for what they have suffered. Unfortunately, while communication after an adverse event is often technically correct, it may not convey the deep sense of sorrow and regret felt by caregivers who have been involved.
- Third, some will need medical and financial assistance and compensation to help them deal with their loss.
- And finally, they need to know that something is being done to prevent similar tragedies in the future. For many, knowing that some good may come despite their tragedy helps mitigate their suffering.

Health care professionals involved in the incident also need help as well.

They cannot experience the horror of the patient or family, but their pain and devastation are no less real. Initially, they need emotional support and empathy; but professional culture and training does not support disclosure, even to peers. Feelings of shame and fears of appearing less than competent prevent open exchange. While we are generally noncritical of colleagues after an error, our reassurance is often grudging, and the unconditional support that is needed is uncommon. The opportunity to explore the incident in safety is important to their accepting responsibility, which can be necessary for constructive change.[1] Importantly, they need to be able to talk to the patient and, when appropriate, to apologize. Finally, they, too, need to know what can be done to prevent future tragedies.

Interestingly, both groups can be helped by the same actions – disclosure and apology – but despite a clear ethical duty to disclose,[2-4] and sometimes legal requirement, it does not happen as often as it should.[1] Why is disclosure so hard? There are several reasons: the discomfort we feel in dealing with failure; a lack of knowledge of how best to proceed in addressing these sensitive issues; and, by no means least, fear of litigation. The goal of this article is to review methods for dealing with the second of these issues – not knowing what to say or how to say it. This is not the only barrier to effective disclosure: organizational policies and resources must be aligned, and legal issues must be acknowledged and

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addressed, but those issues are too strongly contextual to be addressed in a general article.

A Strategy for Disclosure

Buckman[5, 6] and others[7-9] have developed a general strategy for guiding these and other difficult discussions. While written strategy cannot substitute for experience, it can still be useful, as experience will be gained over time. The specific strategy here uses the mnemonic **C-O-N-E-S** as a guide (**C**ontext, **O**pening shot, **N**arrative, **E**motions, and **S**ummary).

1. **C – CONTEXT**. The first step is to ensure the context of the discussion is appropriate. This means getting both the physical and the emotional environment right.
    a. *Physical environment*. The conversation should take place in a private area, away from distractions and interruptions. The seating should be arranged so there are no barriers between you (and other health professionals, if present) and the patient or family. In particular, this means that you should not be seated on opposite sides of a desk or table. Your eyes should be on the same level as theirs, or lower – never higher.
    b. *Emotional environment.* First, "take your own pulse;"[10] take a deep breath and identify your own emotional state, which is likely to be a mixture of fear, discomfort, distaste, and embarrassment. It is good to make eye contact unless there is strong anger or emotion in the air, when it might seem either aggressive or intrusive. Discipline yourself to focus on listening. You will often know what the patient or family members are going to say, but do not interrupt – plan to keep quiet and allow them to say it.
2. **O – OPENING SHOT**. Begin with an initial statement that sets both agenda and tone for what is coming, for example, "I have something difficult and important to discuss with you…." If the circumstances warrant, now is an appropriate point to insert the "S" word: "I'm sorry to say that…." (Sometimes in the immediate aftermath of an adverse event, it will not be known exactly how it happened, whether there was an error, etc. It is just as important not to fall on your sword prematurely as it is to apologize sincerely when an apology is due.) There are many alternative formulations of this warning shot (e.g., "I've discovered something I have to talk to you about….") and it is important not to try to memorize a set speech; find a way to express this content in words that sound natural coming from you. It is often useful to pause here to allow some response.
3. **N – NARRATIVE**. Set out events in order, as best you know them at this time. Go slow! This material will be difficult for the patient or family to understand and absorb, given the circumstances. It may need to be repeated several times. Explain the uncertainties, thinking, and decisions at each important juncture. Sit close and talk softly. Remember that often the initial theories of how things went wrong are borne out by a fuller analysis, so be careful not to speculate or leap to conclusions. Stick closely to the facts and admit knowledge gaps and uncertainties, but assure the patient or family that you will update them with more information as the analysis proceeds.

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4. **E – EMOTIONS.** All emotional expressions need to be acknowledged. Health professionals often feel uncomfortable with emotional responses, but failing to acknowledge them makes everyone even more uncomfortable. If no emotional response if forthcoming, it is often useful to be silent for a while. This acknowledges that you recognize it is "their turn" to speak; most people will eventually speak up to fill a long silence. If this does not work, it is permissible to probe a little, not by direct questions (e.g., "How do you feel about that?"), but rather by indirect suggestion (e.g., "You must be shocked to hear this?"). Acknowledge the emotion in an empathic response involving the following steps:
    a. Identify the emotion. Is it fear, anger, shock, embarrassment, etc.?
    b. Identify the source – is it coming from the patient or family, or is it your own emotion you are recognizing? It is okay to refer to your own feelings, especially when at a loss – "I don't know what to say…."
    c. Respond in a way that connects the two. You do not need to feel the emotion yourself or even agree with it or think it is legitimate, but you must acknowledge it: "Hearing this must be a terrible shock, be terribly frightening, disturbing, must be awful for you." Some interviewers can skillfully use a repetition technique to acknowledge what the patient or family is feeling. This involves using a word from the subject's last sentence in your next sentence, especially if you can "match up" sensory modes. (For example, if the patient says that they cannot see how this happened, you might respond that you see what they mean, and so on.) It should go without saying that you should never say something like, "I know how you feel." Even if you do (which is unlikely), the patient or family will not know that and will not believe you.
    d. Talking is an important way, but not the only way, to acknowledge emotion. Simple gestures, such as offering a tissue for crying, also acknowledge and legitimize emotional distress.

   The goal in all this is to legitimize the emotion and to make it possible to talk about shock, disappointment, and anger. Now the conversation has turned to talking about feelings rather than the facts of the case.

5. **S – SUMMARY/STRATEGY.** Begin closing the conversation by preparing a plan for the future. Establish a time for the next contact and ways to get in touch when new information (e.g., results of an autopsy or further investigation into the mishap) becomes available. The next contact should be reasonably soon, even if there is not likely to be any substantive new information at that point. This will allow the patient or family to digest the information they have been given and raise questions that do not need to wait for further results. Plans for future care, if required, are especially important at this point. The patient and family should be given your contact information and also a contact for the institution's representative. This should be convenient for the patient and family – it should NOT be the main switchboard number or the pager of the

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resident on call! Finally, elicit questions in a way that does not make the patient or family feel that this is their last chance to ask. For example, "Any questions *for now*? We will talk again later, but anything for now?" Many people will not be able to formulate the questions that are most important to them at the initial disclosure meeting, so it is important to leave the door open. Sometimes, the questions "for now" will lead you to recapitulate the narrative and emotion steps of the strategy again. Several iterations may be required until the conversation can be closed.

Conclusion

There are a great many additional issues surrounding disclosure that have not been discussed here, including things like what should or must be disclosed, who should be present at these sessions, and who should take the lead in disclosing. Institutions should develop their own internal guidance to assist in making decisions on these issues.

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How Is Your Bedside Manner?

Joseph J. Tepas III, M.D.

1.) *A young mother of three children waits patiently to be evaluated by the community's most respected colorectal surgeon. She is beleaguered by symptomatic hemorrhoids, the residual of three pregnancies. The surgeon is very pleasant and performs a thorough examination, after which he lists all of the options available for the patient to choose as therapy for her problem. The young woman is not a doctor and has little association with the health care profession. She has no idea which of the options presented to her would be the most suitable to her situation and is left in a quandary because the physician, despite his pleasantness and obvious concern, would not commit to a specific recommendation for her care.*

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2.) *A young father looks in shock as his three-year-old son fights for life in an intensive care unit. His little boy is trying to recover from massive injuries sustained in an automobile crash that killed his wife. Many physicians, nurses, and other health care professionals are scurrying about. The child is obviously the center of an enormous amount of intensive and expensive technology, each element of which brings an expected benefit and an accepted risk. The father talks to the physicians on the health care team. He listens, but does not hear. His ability to understand and comprehend is almost completely supplanted by grief at the death of his wife.*

3. *In a busy clinic, a well-respected surgeon introduces himself to a new patient, discusses briefly the patient's concerns, examines the patient, and then informs the patient that the resident team will be arriving shortly to complete a full evaluation in preparation for the recommended surgical procedure. The busy surgeon then goes on to the next patient.*

Each of these scenarios represents a combination of good and bad. Physicians today are overwhelmed by increasing administrative stress, decreasing levels of reimbursement, and a variety of other factors, all of which compete effectively for the most valuable asset any physician possesses – his or her time. In the first case, the community surgeon, having previously encountered the uncomfortable end of litigation, is not willing to commit to a specific recommendation for fear that his recommendation would not be agreeable to the patient and that any adverse results would result in litigation or at least complaint. That physician, despite his obvious care and compassion and the respect that he enjoys from patients and peers alike, has not really met his patient's needs. What his patient needs is the benefit of his expertise to make a recommendation based on his professional assessment.

The second scenario is even more challenging. There are many physicians, all of whom are distracted by a variety of different issues, attempting to provide integrated, multi-disciplinary care while maintaining some degree of liaison with the family. This circumstance represents a very common problem in increasingly sophisticated health care facilities where multiple specialists co-manage patients and provide varied insight to family members from differing physiologic and anatomic perspectives. This case, like the first, needs a lead physician who combines compassion and comprehensive understanding to provide a central source of information to families who are, by definition, in crisis. Consultants bring special expertise to the bedside but must remember that their input should complement, rather than contradict, the message of the rest of the health care team. Adding more confusion to families in crisis does nothing but undermine confidence, exacerbate fear, and increase frustration. Regardless of clinical outcome, these become the building blocks of patient dissatisfaction.

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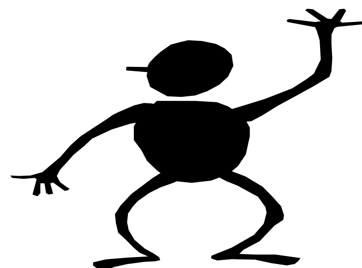
The third case is all too common in academic health care environments. Effective graduate medical education requires that trainees have an opportunity to interact with the patients of attending clinical faculty. At the same time, the attending faculty member must remain fully identified and involved as the leader of the health care team. The patient must be assured that an accomplished and experienced attending physician is responsible for the patient's care, and that care will be in concert with the physician trainees. Remember, most patients have absolutely no idea how doctors are trained!

With respect to bedside manner, ***the common thread we want to exhibit is compassion, concern, and effective communication.*** Each patient is different; each scenario is different, as is the level of stress that distracts from effective communication. Thus, when one looks at the process of determining a relationship in which a physician identifies himself or herself as the individual who will be responsible for a patient's health care, one must understand that this is the establishment of a unique relationship based on confidence and communication. Good bedside manner does not necessarily mean playing the role of "best buddy" with every patient. It does mandate, however, that the physician primarily responsible for a patient's care be known to the patient, and that this physician communicates effectively with the patient. ***Demonstrating genuine concern regarding the patient's welfare and commitment to the patient's care will establish a relationship of trust and reliance that will withstand the confusion of modern health care delivery.*** Too often, the hierarchal design of academic medicine undermines this critical part of an effective physician-patient relationship.

The more complex the situation, the more likely that increasingly invasive technology may yield adverse, as well as successful, results. In these times of continued stress, the attending physician must commit enough time to identify himself or herself as the leader of the team. If nothing else, this illustrates to trainees that the practice of medicine is a combination of art and science, and that the primary goal of all practitioners is the well being of their fellow man, regardless of the adversity of the environment.



Saying "Goodbye" To A Patient Without Saying "Hello" To A Lawsuit: A Primer On Patient Dismissal

Susan B. Collingwood, Esq.
UF Associate General Counsel

Although infrequent, there can come a point in a physician-patient relationship when the physician, due to any number of good and sufficient reasons, no longer wishes to continue treating a patient. When done appropriately, ending the physician-patient relationship poses no liability risks; however, ***the practitioner must take care to ensure that he or she has not "abandoned" the patient. Be aware – poorly done patient dismissals lead to lawsuits!***

The first thing to know is that when you wish to discharge a patient, you don't have

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to go it alone – **help is available!** University of Florida Physicians has developed a ***Dismissal Policy*** that addresses the most common reasons for dismissing a patient. Clinic managers have access to the policy, which provides a standard letter template and sample language for the most common reasons for dismissal.[1] The policy also details the steps that must be taken by clinic and Family Group Practice personnel for a patient dismissal. In addition, other template letters are available for situations where the patient has completed his or her course of treatment with the physician and the physician has nothing more to offer the patient. For circumstances where the need to dismiss is urgent (i.e., there are threats of violence against physicians or staff) or where the patient's medical condition is serious or other factors make the physician or clinic manager concerned about the dismissal, help and guidance are always available from Kelly Kerr (Director, Faculty Practice Clinics, 265-7989) and from the Medical School Office of the General Counsel (392-3705). That said, the rest of this article explores in more detail some of the practical issues surrounding patient dismissal.

Patient dismissal can be risky, not only for litigation, but for public relations. *Poor public relations can sometimes hurt us more than a lawsuit in terms of real dollars!* In most cases, the clinic's or physician's first approach to the problem should be to try to talk things over and work things out with the patient. If that fails, then the process of dismissing the patient can begin. ***Patient dismissals should always be in writing.***

Although the law does not require a physician to provide care to all patients under all circumstances, ***once a physician has undertaken care of a patient the physician generally must ensure that the manner of the termination of the relationship does not put the patient at greater risk of harm.*** Generally, this means giving the patient an adequate period to secure other care for their condition. While there is no hard and fast rule about what constitutes a reasonable time to find care, the ***AMA has recommended that patients be provided with 30 days of access to emergency care before dismissal is final.*** As a result, "30-days notice" has become the standard in the industry for most cases. Be aware that there may be some circumstances where a longer period is needed, while a shorter period (or none at all) may be justified if there is a concern that the patient may become violent and injure physicians, staff, or other patients.

Even when the 30-day provision of care has been met, if the patient has been unnecessarily confronted by angry staff or physicians, the patient may feel abused by the process – and those hurt feelings can prompt litigation. Patients' memories or understanding of what is told to them can be incomplete. Thus, it is important that the dismissal be handled professionally, without undue emotion, and in a way that the patient cannot misunderstand. *This generally means notifying the patient of the dismissal in writing, not in person. Dismissal letters generally should simply stick to the facts that make the dismissal necessary and avoid emotionally laden language about those facts.* In some cases, the letter will need to be "customized" from the forms – in those cases, legal review is appropriate before the letter is sent. Finally, to ensure that the patient receives the notice, it should be sent both by regular mail (which is presumed received) and by certified mail, return receipt requested which gives proof of receipt as long as the patient will sign for it.

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In some cases, after a patient has received a letter dismissing them from the clinic or from the entire Faculty Group Practice, the patient will call wanting to discuss the dismissal. If the patient does not provide new information that makes the physician or clinic want to reconsider the dismissal, then the response should be short and non-argumentative, referring the patient to the letter and encouraging them to find other care for their condition (our standard form letter refers patients to the county medical society for assistance in locating a new physician). In rare cases, the dismissed patient may make repeated or abusive calls. There is no requirement to take these calls and, if they persist for a long period or constitute a serious disruption, you should consult with the legal office to determine if court action is appropriate to stop the harassment.

This article has discussed the broad concepts related to dismissing a patient from a physician's care, but it is the specific, factual circumstances of the patient's case and behavior that govern how we should approach the dismissal. ***The Faculty Practice Group and Office of the General Counsel are happy to assist in making the dismissal decision and process as risk-free as possible – call us!***

[1] excessive no-shows, failure to meet financial responsibilities, disruptive behavior, duplicate care from another physician that contradicts/harms our care, failure to comply after warning with the physician's recommendations, breakdown in physician-patient relationship

Florida Cares & C.A.P.

Eileen Handberg, Ph.D.

In 1997, the University of Florida College of Medicine, developed an assessment center for physicians and physician assistants to aid hospitals and regulatory boards in the assessment of professional competency. This program ran successfully but closed in 2003 when it lost one of its Medical Directors. In response to university concerns about all aspects of patient safety, and the demand for the service, UF CARES, at the direction of Dr. Douglas Barrett, Vice President for Health Affairs, was re-established as Florida CARES & C.A.P. The new program reflects a change from a single university-based program to a collaborative model that involves five academic facilities: the University of Florida (Gainesville and Jacksonville campuses), the University of Miami, the University of South Florida, and Nova Southeastern University. The program also includes a Competency Advancement Program (C.A.P.). The change to a multi-centered program will allow evaluation of all specialties and more geographically centered testing and training, when appropriate. The program will initially limit its scope to those covered by the Board of Medicine and Board of Osteopathy (M.D.s, P.A.s, and D.O.s) and expects to expand to other health care practitioners, such as registered nurses and advanced practice nurses, in the future.

Referrals to the program are for the purpose of assisting organizations, such as the Board of Medicine and hospital credentialing committees, in making decisions regarding whether a physician demonstrates the abilities and attributes to practice medicine in a safe and competent manner. Some

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common circumstances where a Florida CARES referral may be of value is when a physician is:

1. *Returning to practice after treatment for chemical dependency.*
2. *Returning to practice after an extended leave of absence.*
3. *Diagnosed with a physical or mental illness that could affect his or her ability to practice medicine.*
4. *The subject of a patient care malpractice complaint before either of the boards when the knowledge or judgment of the physician is in question.*

Referral to Florida CARES & C.A.P. begins with the completion of an application that details the circumstances underlying the present concerns (e.g., administrative complaint, investigative summary, or transcripts from board meetings). The application details the physician's education, postgraduate training, and includes a listing of the physician's last 100 patients. The application is reviewed and selected additional complete medical records are obtained for the purpose of developing a practitioner-specific and specialty-specific assessment. The assessment generally requires two days onsite at the testing facility and includes psychological testing, written examinations, standardized patients, case reviews with experts from the client's specialty, and simulator-based testing, as indicated. The cost of the assessment is $8,500, but can be higher depending on the scope of the assessment. Assessments can also include reverse site visits to the practitioner's practice location. Costs of the assessments are the responsibility of the applicant.

The evaluation provides a detailed description of the deficiencies, as well as recommendations for remediation and upon completion, is provided to the referring agency.

Evaluation findings usually fall into one of the following categories:

1. No deficiencies
2. Minor deficiencies
3. Moderate or specific deficiencies
4. Widespread significant deficiencies
5. Global deficiencies
6. Catastrophic deficiencies

Florida CARES & C.A.P. is under the medical direction of Nikolaus Gravenstein, MD, Professor and Chair, Department of Anesthesiology, College of Medicine, University of Florida.

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Legal Case Review:

Cristina Palacio, Esq.

Case Summary: **Fernando Jimenez M.D. v. Department of Professional Regulation Board of Medicine (4th Cir. 1990)** This case involves an appeal by the above physician, of a disciplinary penalty imposed by the Board of Medicine that was more severe than the penalty recommended by the Administrative Hearing Officer of the Division of Administrative Hearing. The allegation below came to light following a medical malpractice suit where it was discovered that the plaintiff had obtained two copies of the same medical record which were found to differ. One of the copies contained added documentation that the above physician had advised the patient to have a stress test and an angiogram and that the patient had refused the recommended tests. There was no notation that this additional documentation was a late entry. After a hearing on the matter, an administrative hearing officer concluded that the above physician: (1) added the exculpatory documentation nearly a year after providing the documents to the plaintiff, subsequent to the initiation of the DPR investigation; (2) had filed false reports, because the addition was not denoted as a late entry; (3) violated statutory requirements for written records justifying the course of treatment; (4) added documentation only to forestall any criticism relating to his failure to have the patient undergo a stress test and angiogram; and finally, (5) was guilty of malpractice. The administrative hearing officer recommended to the BOM that the above physician be placed on probation for 1 year and fined $5,000, however, the Board of Medicine suspended the physician's license for one year and placed him on probation for two years in addition to the $5,000 fine. The Florida Court of Appeals affirmed the subsequent Board of Medicine action.

Allegation: Knowingly filing false medical reports, failing to keep written medical reports justifying the course of treatment of a patient by making deceptive, untrue and fraudulent representations in the practice of medicine, and failure to meet the standard of care.

Case Analysis: This case clearly demonstrates the importance of maintaining accurate medical records, not just for patient care reasons, but to avoid several bases for liability, the most damaging of which was the finding of deliberate falsification in an effort to avoid malpractice liability. Not only is such activity unethical, as noted by DPR, it is a *crime* under Florida state law. F.S. §395.302 provides that any person who fraudulently alters, defaces or falsifies any medical record commits a misdemeanor of the second degree. The fraudulent alteration finding could have been based on two separate acts. The most obvious was the fact that the above physician never advised the patient to get a stress test and angiogram. Even if the defendant had indeed properly advised his patient, his late entry, without any indication that it was a late entry, could also be considered a violation of F.S. §395.302.

Risk Reduction Strategies: Physicians have a statutory duty under F.S. §458. 331 and F.S. §459.015 to maintain medical records "that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed or administered; and reports of consultations and hospitalizations." Physicians who do not comply with the

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requirement are subject to disciplinary action. Therefore, medical record documentation should not only be accurate and timely but *complete* with all medical record entries dated to reflect when the entry was made, even if it relates to an event that occurred earlier than the documentation date. Even late entries, where clearly identified as such, and justified, can provide important documentation to support a physician's claim that appropriate care was provided.

2005 JCAHO Patient Safety Goals

The JCAHO, which accredits/certifies 16,000 facilities, has identified the following seven patient safety goals for 2005. The development of these goals is based largely on review and analysis of de-identified aggregate information from their sentinel event database:

1. Improve the accuracy of patient identification.
2. Improve the effectiveness of communication among caregivers.
3. Improve the safety of using medications.
4. Improve the safety of using infusion pumps.
5. Reduce the risk of healthcare-associated infections.
6. Accurately and completely reconcile medications across the continuum of care.
7. Reduce the risk of patient harm resulting from falls.

National Patient Safety week is March 7-11th.

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