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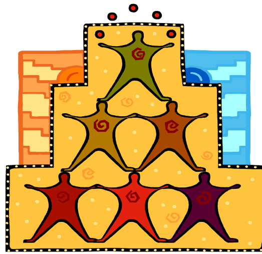

CLINICAL CARE AND THE CHAIN OF COMAND

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Whether a medical student, resident, nurse or physician extender, or attending or practicing clinician, we have all been faced with the questions of "Do I call?"…and "When should I call?"

Optimal team functioning requires the team leader to set expectations and for team members to know their roles and responsibilities and to feel comfortable communicating observations and ideas without fear of intimidation or reprisal.

Caregivers should seek out and become aware of the supervision policy pertinent to their specialty service and share this information with trainees and non-MD team members as appropriate. Trainees should talk to the senior/chief resident and attending—creating a plan by discussing an algorithm of "if/then" guidelines and parameters for action, inquiry and reporting. This kind of communication of expectations and parameters appropriate for initiating a call is also useful for communication between MDs (residents and non-residents) and nursing staff—especially at the beginning of a shift, or in facilitation of complete information at hand-offs.

Timely communication with good information builds trust! The first key in communicating is being ready with essential information for diagnosis and/or assessment of status changes. The second key is orderly presentation of information in a manner that demonstrates logical, orderly thought processes. For the resident, orderly presentation of a thoughtful plan, while being ready with rationale and pro/con analysis for management options, demonstrates further good judgment and safe, independent thought processes.

Identifying critical junctures for communicating with one's supervisor is also critical to building trust. Examples of such critical junctures include: 1) when the plan or algorithm made has been exhausted, without satisfactory patient response (i.e., the plan is not enough), 2) when the patient's condition doesn't respond in a manner expected by the current understanding of that patient's pathophysiology, and 3) when unanticipated changes occur—communicating for information only, or for further plan development.

Faculty, clinicians, and consultants should make frequent use of briefing and debriefing for teaching opportunities on what went well and what should be done differently in the future—from both clinical and communication perspectives. Part of resident and student education should involve a review and discussion of situations in which a call was made inappropriately- either too late in the course of events, or at a juncture where a consultation was not really necessary. These reviews should be conducted in a collegial, educational manner rather than a negative or punitive one.

The bottom line in reporting information up the chain of command is to build and maintain trust with the supervising physician by the timely communication of information in a clear, concise, and accurate manner.

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Chart Documentation of Patients Leaving Without Being Seen or Against Medical Advice

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Despite improvements in patient flow, the creation of "fast track" services and other quality initiatives, a significant number of patients choose to leave hospital emergency departments prior to being seen by a physician or receiving treatment.

There are no state statutes or regulations on point and case law dealing with this specific question is virtually non-existent. The federal Emergency Medical Treatment and Active Labor Act ("EMTALA") establishes requirements for processing and evaluating patients who present for care or treatment for emergency medical conditions at Medicare participating hospitals. It is one of the few Medicare provisions that pertain to all patients, not just Medicare beneficiaries. EMTALA regulations do not, however, specifically address what to do if the patient walks out of the facility's emergency department without being seen. The most relevant guidance on the issue can be found in the Medicare Interpretative Guidelines of the State Operations Manual, Appendix V-Responsiblities of Medicare Participating Hospitals in Emergency Cases ("SOM").

The SOM guidelines are used by investigators to assist them in evaluating alleged EMTALA violations. The guidelines state that EMTALA is not violated if a patient leaves against medical advice (AMA) or leaves without being seen (LWBS), as long as the patient leaves of their own free will, without suggestion or coercion. It does not matter when in the standard emergency department process the patient leaves (i.e. before or after initial triage; the performance of a medical screening examination or treatment). The medical record should reflect that screening, further examination and/or treatment was offered to the individual, if it was possible to do so. If the patient simply leaves without notice to any physician or hospital personnel, that fact should be documented in the emergency room record.

If the patient approaches anyone and states their intent or desire to leave, reasonable efforts should be made to advise the patient of the benefits of receiving appropriate examination and treatment, and the risks associated with leaving without them. Ideally, the patient should receive that information from a physician, however, it may not, always be possible to find a physician not otherwise involved in the examination or treatment of another patient. A nurse or other healthcare worker can advise the patient of the general benefits to be derived from waiting to receive medical evaluation and treatment they sought in coming to the emergency department in the first place. Any information that is conveyed to the patient should be documented in the medical record, as well as any statements the patient made prior to leaving.

Documentation should include a description of the examination or treatment that was offered and the "Refusal of Hospitalization or Medical Treatment Against Medical Advice" form should be completed whenever possible which provides a good template for recording that information.

Additional direction can be found in the Shands Healthcare Core Policy 2.23 which includes the above referenced form as an appendix.
Please feel free to contact Shands Legal Services at 733-0030 with any questions you have or any specific issues you would like to discuss.

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Learn How to Mitigate Hospital and Personal Risk by Participation in a Simulated Negligence Lawsuit

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Malpractice Claims Impact on Healthcare Organizations

The Joint Commission and healthcare facilities recognize that the failure to improve patient safety will expose organizations to significant human and financial loss. For example, "the average 250 bed hospital spends the equivalent of the cost of a new MRI unit, between $300,000 and $1 million annually, defending medical malpractice lawsuits, not including settlements and judgments" [1]. In addition to the emotional impact lawsuits have on employees and the hundreds of thousands of dollars organizations spend defending a medical malpractice lawsuit, healthcare organizations also face the harsh financial reality that juries see hospitals as a faceless entity with the ability to pay large judgments because of insurance coverage. Hospitals pay claims in 50% of court cases brought while doctors pay in 30% of cases. Jury verdict research indicates median plaintiff awards against hospitals are about $500,000 [1].

Although healthcare organizations have become more aggressive with a variety of new protocols to reduce hospital errors, such as emphasizing evidence based medicine, pharmaceutical bar coding, conducting a root cause analysis for unexpected outcomes, and using an electronic medical record, humans are imperfect by nature and mistakes happen. Research has indicated, however, that hospital injuries can still be reduced by 20-70% [2]. Hospital trial simulation provides healthcare organizations a unique, proactive, and concrete employee training tool designed to specifically help healthcare providers, administrators, and other employees reduce hospital injuries resulting from human mistakes. The goals of a hospital trial simulation are to help increase participants' awareness of the legal system and to improve job performance by highlighting how the legal system scrutinizes a variety of treatment decisions, from documentation to policy implementation, made daily by healthcare professionals. By participating in a medical malpractice trial simulation, participants experience the different factual and legal components necessary for a lawsuit to reach a jury and learn the lessons of a medical malpractice lawsuit without having to endure the stress, cost and uncertainty of an actual lawsuit.

As the cost of healthcare continues to increase, physicians, nurses, and healthcare executives have a growing need to understand the pieces of a medical malpractice lawsuit. Healthcare providers and executives who understand the legal process are in a much better position to evaluate and manage the hundreds of thousands of dollars organizations expend in legal fees and litigation costs when forced to defend the care provided. A trial simulation teaches providers and healthcare executives the importance of quickly learning the facts driving a lawsuit so the healthcare organization can make an informed decision to either defend the care provided or attempt an early settlement.

As healthcare organizations develop competency-based health management education programs, they will increasingly look for ways to integrate various program elements in exercises and activities that develop leadership and competence in

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areas such as analytical thinking, communication skills, impact and influence, and strategic orientation [4].

Ultimately the medical negligence trial simulation allows providers and healthcare executives to learn the black letter law impacting healthcare while also gaining a practical and first hand understanding of how a lawsuit actually develops. Once physicians, nurses, and executives understand the complexities of a lawsuit, they will be in a better position to manage their own personal risk, their organization's risk, and better understand and manage the significant legal expenses involved in being a defendant in a lawsuit.

Simulation Set-Up:

Session 1 Part A- Assignment of Duties- Participants learn the various pieces of the medical malpractice lawsuit puzzle, which prepares them for their role in the culminating mock trial conducted during Session 2. After a brief overview of the medical-legal process, the participants choose or are assigned as advocates for the plaintiff or the defendant, or to serve as a potential member of the jury. Depending on the number of participants, roughly one third of the participants advocate for the plaintiff, one third of the participants advocate for the defendant and the remaining serve as jury members.

The participants who advocate for the plaintiff know from the beginning of the session that they will need to present a given scenario in the light most favorable to the injured patient and also have the burden of proof to convince the jury of the merit behind the patient's lawsuit. The plaintiff team is also responsible for preparing the plaintiff's witnesses for testifying at trial. The plaintiff's witnesses include family members of the plaintiff, and the plaintiff's nursing expert who support the plaintiff's position that the hospital's nursing staff violated the prevailing nursing standard of care. The plaintiff team also has to equally divide the various trial responsibilities of a plaintiff's lawyer.

The participants who advocate for the defendant know from the beginning of the session that they need to present facts in the light most favorable to the defendant. Although the defendants do not have the legal burden of proof, they have the responsibility of providing the jury with a plausible explanation that refutes the plaintiff's negligence claims. The defendant team is responsible for preparing the defense witnesses for testifying at trial. The defense witnesses include the nurses, physicians, and other healthcare providers who cared for the patient, and the defense nursing expert who will testify that the care provided by the hospital employees met the prevailing nursing standard of care. The defense team also has to equally divide the various trial duties of a defense lawyer .

Finally, the jurors, at the beginning of the mock trial, participate in the process of jury selection whereby both the plaintiff and defense teams ask each member of the jury questions to identify juror bias for or against one party of the lawsuit based upon the prospective jurors responses to pre-printed questions designed to elicit areas of juror bias for or against either the plaintiff or defendant. Although the jurors have less pre-trial preparation work than the plaintiff and defense team members, they have more post-trial work. The jurors have to stay after the trial until they reach a verdict or reach an impasse. Additionally, during the post trial debriefing session, jurors have to explain which arguments they found either convincing or unpersuasive after sharing their verdict with the participants.

Session 1 Part B- Preparing for Trial with Pleadings and Depositions

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After assigning each participant to a team, the participants are given a different piece of the trial puzzle to read, digest, and incorporate into their version of the case. Although attorneys working on an actual lawsuit would not necessarily have such a predictable or controlled flow of information, the use of selective pleadings and depositions establish enough information for each side of the lawsuit to feel that they have the material necessary to present a convincing case to the jury.

During the first session, each participant receives a copy of the complaint and session time is spent describing how its factual and legal components mirror the essential components of any lawsuit. Each participant also receives the defendant's answer to the complaint and the instructor follows the same process of explaining the legal and practical tactics to follow when responding to a lawsuit brought against a healthcare organization.

Depositions are tools that both plaintiff and defense lawyers use to prepare their case for trial. They are a pretrial discovery mechanism in which one party's attorney asks oral questions of the other party or of a witness for the other party (6). Depositions are sworn testimony conducted before trial of treating witnesses, such as Nurse Sally, factual witnesses, such as family members, or expert witnesses. Depositions allow each side to refine their case theory based upon the sworn testimony of the various players in the lawsuit.

Next, the participants receive each deposition, which gives new facts for each side to weave into their case theory and also serves as a guideline for what each witness would say at trial because depositions are sworn testimony. Therefore, when asked the same questions, truthful witnesses should have the same testimony at trial as the testimony they had provided in their deposition. The development of the mock trial facts through depositions provide the opportunity to educate participants about the purpose of depositions and how to effectively give a deposition, because as healthcare providers or administrators they or their employees will likely have to give a deposition at some point in their career.

Simulation Activities: Session 2 Part A: The Medical Negligence Trial Simulation

After the completion of Session 1, 2-4 weeks are given for the participants to prepare for their role in the simulated trial. The first part of session 2 begins with the mock trial. The instructor serves as the judge for the mock trial and rules on issues of law, overrules or sustains objections made by the attorneys, and instructs the jurors regarding their roles and responsibilities. After both the plaintiff and defendant legal teams conclude their questioning of the prospective jurors, each side requests that the biased jurors be removed from the jury panel. The judge grants or denies their requests if the requesting team sufficiently establishes that the juror in question could not be impartial. However, the jurors who are struck do not know they were removed from the jury until the lawyers rest their case and the jury begins deliberations. By not disclosing which jurors are struck until after the trial, all jurors remain attentive during the trial.

The plaintiff team begins the mock trial with an opening statement that introduces their version of the case facts and law for the jury. The plaintiff team selects one person from their team who has the responsibility of delivering the opening statement. Next, the defense team follows the same process. After both sides present their opening statements, the plaintiffs begin presenting their

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case-in-chief since they have the burden of proving that the alleged damages occurred because the hospital employees failed to meet the prevailing standard of care that would have been provided by other hospitals under the same or similar circumstances.

After the plaintiff completes the direct examination of a witness, then a member of the defense team has the opportunity to ask the witness any other questions necessary to present the jury with a complete picture of the witnesses' testimony during a process known as cross-examination. The process of the plaintiff team calling witnesses necessary for their case-in-chief, followed by a member of the defense team conducting a cross examination of the same witness, continues until the plaintiff rests its case.

Once the plaintiff rests its case, the defense has an opportunity to conduct a direct examination of the defense witnesses. The defense team follows the same procedure as the plaintiff team and one member of the defense team serves as the defense lawyer responsible for conducting the direct examination of the defense nursing expert whose testifying role is played by another member of the defense team. After the defense lawyer completes the direct examination, a lawyer from the plaintiff's team has the opportunity to cross examine the defense witness to make sure that the jury has a complete picture of the witnesses' testimony. During the cross examination of witnesses, both plaintiff and defense lawyers effectively use the witnesses' prior deposition testimony to impeach those witnesses who changed their sworn testimony from deposition to trial.

Simulation Activities: Session 2 Part B: Jury Verdict

After deliberations, the jury reaches a verdict. The jury's decision allows participants to see how legal principles learned in Session 1 practically play out in the trial. Comparative fault and patient responsibility as well as adequate medical record documentation are important concepts that healthcare providers and executives can see first hand how the jury uses such evidence to reach a verdict for or against the hospital. Advocates for both sides also learn the delicate balance of asking a jury to consider assigning fault for a patient's injuries to the patient even when the hospital may have some responsibility. If the issue of comparative fault is not handled appropriately, the jury may become angered and assign more financial responsibility to the hospital.

Of the simulated mock trials conducted at the University of Florida and Shands, participants typically describe the experience as one of the best continuing education learning activities they have had. If you would like more information regarding the simulated lawsuit experiential learning activity, you may contact me at 273-7006.

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