

Reduce malpractice claims with proven patient satisfaction tools and techniques

Dear Reader,

I hope you enjoy the following excerpt from the HealthLeaders Media book, ***The Satisfied Patient, Second Edition: A Guide to Preventing Malpractice Claims by Providing Excellent Customer Service.***

These days, physicians cannot be careful enough. Medical malpractice insurance premiums are through the roof. Pay for performance and other measures that tie reimbursement to quality have turned an even brighter spotlight on the need to ensure patient satisfaction.

You must do everything you can to reduce your liability risk and prevent potential lawsuits. This means making sure that patients leave your facility feeling good about their experience.

The advice is simple: Treat patients with care and stay out of the courtroom.

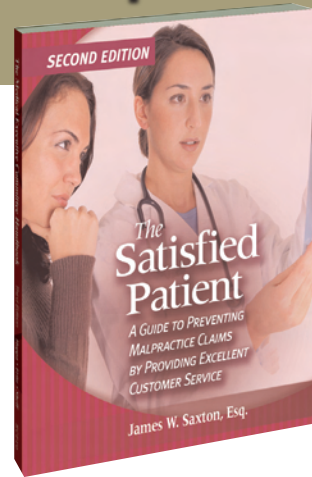
The Satisfied Patient, Second Edition is a resource that every modern physician needs. Written by an experienced healthcare attorney, this fully updated book illustrates how focusing on patient satisfaction can better your organization, reduce the potential of professional liability claim, and significantly affect the outcome of that claim if initiated. Choose one of the following ways to order your copy today!

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When an Adverse Event Occurs, How Do You Tell the Patient?

Part of event management necessarily involves the question, “What am I going to tell the patient?” The first inclination is to refrain from telling the patient exactly what occurred. Nationally, however, momentum is gaining to fully disclose adverse events to patients. Doing so is tied to ethical considerations—the patient’s right to know what is occurring with his or her own body—as well as quality and patient safety initiatives. Transparency is taking hold nationwide, and disclosing an adverse event is part of that. Some states require it. In 2001, The Joint Commission on Accreditation of Healthcare Organizations began requiring hospitals to disclose to patients all unexpected outcomes of care.

The value of saying you’re sorry

Doug Wojcieszak, national leader and spokesperson for the Sorry Works! Coalition (www.sorryworks.net), travels the country explain-

ing to physicians, risk managers, and other leaders how saying “I’m sorry” can help the patient and help you. Wojcieszak’s personal story follows:

In 1998, my brother Jim went to an emergency room in Cincinnati at 2 a.m. with heart-attack symptoms—chest, shoulder, neck, and

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stomach pains. Jim was big, burly guy, the kind of guy who was asked to play football in high school, and he shouldered pain very well. For him to show up in an emergency room at 2 a.m. with no prodding meant he was in excruciating pain. The attending physician told my brother that at age 39 he was too young to be having a heart attack and that he must be suffering from indigestion or stomach flu and sent him home with two antacid pills. The physician never drew blood or performed an EKG to confirm his diagnosis—he just assumed because of my brother's age and physical appearance that nothing was amiss.

How I wish he had been right. He was discharged with instructions to take Tums. Jim's condition worsened, and he returned to the hospital the next day. My folks had to drive Jim to the hospital because the oxygen levels in his blood were dropping and he was passing in and out of consciousness. This time blood was drawn, and, sure enough, the enzyme was present in the blood showing the heart was in distress. Jim was admitted to the ICU, where

a serious second error occurred. The computer monitor over his bed read "Ray Wojcieszak." Who's Ray? That's my Dad. This was a critical fact because Dad had a stress test performed in the same hospital a few months before my brother's death, and even though Dad was in his 60s at the time the cardiologist said he had the heart of a 30-year old man. No blockage. Low cholesterol. Excellent cardiac health.

So, there was my Dad arguing with the attending physician about who was who and having to produce driver's licenses to prove he was indeed Ray and the man in the bed was Jim. The staff changed the name on the computer monitor to read "Jim Wojcieszak," but we believe they were still probably looking at Dad's charts, showing no blockage, low cholesterol, excellent cardiac health. For three days the doctors and nurses plugged Jim full of antibiotics, thinking he had a bacterial infection of his heart.

The autopsy afterward showed he had two to three heart attacks while under the care of the hospital. Jim

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was admitted on a Monday and died on a Thursday, at 39 years of age.

The last afternoon Jim was alive he was in great pain and spitting up blood when a nurse rushed into his room and excitedly announced, "We're finally going to do something for this young man! We're going to take action!" My parents were shocked and thought to themselves, "What do you mean you're going to finally do something? What have you people been doing for the last three days?"

The staff wheeled Jim down to a different room and ran a probe up his leg "just to see if they had missed something." What they found were three major arteries blocked, 95% or better. Worse, Jim crashed on the table during the test, his ear lobes and finger tips turning blue as he was prepped him for emergency open-heart surgery. However, the hospital didn't have a surgeon on site that day—the only surgeon available was stuck in downtown rush hour traffic. Precious time was lost.

After a significant delay they were

able to get Jim in surgery and on the heart/lung machine, but they could never get him off the machine. The back of his heart was blown out. He died on the operating table.

The surgeon, who had not been involved in Jim's care prior to the surgery, walked out of the operating room and told my father the following:

"If these jerks at this hospital had done their job and got your son to me three days ago when they should have, I could have saved him—no problem. We do bypass surgeries all time, and your son would be on his way to recovery, but he is dead. I'm sorry."

That was the last bit of honesty and candor we received from the hospital.

After the funeral and all the relatives and friends went home, my parents went back to the hospital seeking answers, especially my father, the PhD engineer. My parents had significant questions: What happened? Why did it happen? Can the processes be improved so it

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never happens again? But the door was unceremoniously slammed in their face. Phone calls were not returned. Even the surgeon who was so honest the night Jim died told my parents, "Look, our legal counsel has instructed me not speak with you any further. You will have to leave."

Here was my father, who made a living asking countless questions so that airplane engines and nuclear-powered naval vessels would be safe, and he was not so politely told to butt out of his own son's death. It was maddening.

This "deny and defend," circle-the-wagons routine made my parents extremely angry. It made litigation, which should have the last recourse, the only option available to us. It made money, which should have been the third or fourth concern, the only issue worth fighting over. So, we sued.

After a year and a half of litigation in Cincinnati, the judge literally turned to the hospital, doctors, and their attorneys and proclaimed they

were wasting the court's time, malpractice was clear, and they should settle with our family.

After money exchanged hands and my parents signed off on further liability, only the attorneys apologized, but they never admitted fault. Furthermore, they never took ownership of the mistake, nor did they tell us how the hospital and doctors were going to improve their processes so the same mistakes would never be repeated.

Despite the fact our family received money—what tort reformers consider the holy grail of medical malpractice—we still have not found peace almost a decade after Jim's death. We are still angry the doctors never sought us out and apologized. Furthermore, we believe the errors that killed Jim are injuring and killing other patients today.

That's my personal story, my personal tragedy, the personal element that led to the development of Sorry Works!

— Doug Wojcieszak

When an Adverse Event Occurs, How Do You Tell the Patient?

Recall our discussion in previous chapters about what causes claims. As mentioned, miscommunications and service lapses, including a failure to disclose or to take responsibility for one's actions, can become the “plus.” Although any situation may not be solved simply with an “I’m sorry,” if the doctors and hospitals are more open and communicative, explain what went wrong, say they are sorry, and explain what they are doing to ensure the same circumstances would not occur to future patients, lawsuits can be prevented.

Remember as well, that we often see suits filed that are a combination of maloccurrences (adverse events) coupled with a miscommunication or service lapses. Let’s be clear: Saying “I’m sorry” and taking responsibility for the unfortunate event should be reserved for very specific circumstances in which due diligence supports such a conclusion. However, dealing with all adverse events calls for empathy and good communication.

You can see the importance of disclosing an adverse event in the right way. It is important to remember that how you communicate will have consequences as well. You need to be careful not to express an apology in a way that admits liability. You need to take the perspective, as mentioned previously, of being in the shoes of the patient. Following are some tips for disclosing an adverse event.

Who should disclose?

The doctor bears the main responsibility in disclosure of an adverse event. The doctor should already have in place good communication with the patient (remember the relationship bank!). Sometimes, for various reasons (e.g., the doctor is away, the doctor is not a good communicator), another individual will need to provide the disclosure. Therefore, always have a backup who is trained

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to properly disclose. Do not let the absence of the doctor allow silence to be your response to an adverse event. If you do, patients will often think there has been a cover-up, which will send them to a lawyer for answers.

Also consider having risk management personnel in attendance during the disclosure or some other witness. When multiple providers are involved, coordinate disclosure and send a unified message. Do so in collaboration with risk management. This drives home the importance of event management (see Chapter Ten: Managing Adverse Events).

What should be disclosed?

Information should be limited to what is actually known—the facts. *Never* speculate. You may not know immediately why an adverse event occurred. Take the time to investigate appropriately, but do not let this keep you from discussing the event with the patient. Acknowledge the unexpected event and let the patient know an investigation is taking place and that you will provide him or her with additional information when it is available (and do so!).

Always focus on the patient's safety and his or her understanding of how the treatment will continue. This ensures patient involvement. It means disclosing the consequences of the error to the patient's continued care and management. Answer any questions related to this—and refrain from placing blame.

Also take this opportunity to apologize. Do so without taking on liability or again placing blame, but rather by expressing empathy such as, “I am truly sorry about your Mom. We all feel terrible about the complication. Let me review what we are now doing for her . . .”

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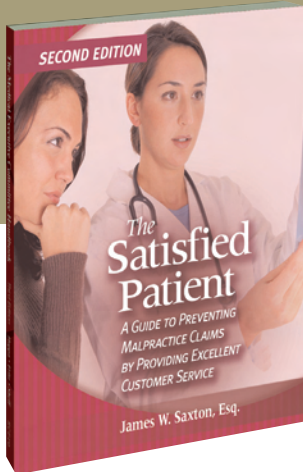
Provide the patient with contact information—whom they should contact about the incident in the future so that any questions that arise can be answered. Following this framework will work to allow you to explain what you know to the patient, express empathy, and show that action is taking place. This is what patients want to know.

Procedural considerations

The disclosure conversation should take place as soon as possible after the event. Allow the patient to have another individual present during the conversation. As noted, you should have another individual from your organization present during the conversation, as well.

Document the disclosure and any subsequent conversations. Include the date, time, and place of disclosure; who was in attendance; what was discussed; the assistance that was offered; and the questions asked by the patient/family. This is vital evidence.

Most important, use this adverse event as an opportunity for quality assurance and improvement. Learn from it. Not only do you have an opportunity, both ethically and legally, to provide information to a patient to reduce professional liability risk in this instance, but you have an opportunity to prevent future, similar occurrences. Take advantage of the opportunity in a no-blame, no-shame way. You can see how disclosure done the right way by the right people can have more positive implications than negative ones.



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