HOW’S YOUR SOCIAL IQ?

HOW OLD IS “TOO OLD” TO PRACTICE?

SUCCESSFUL PRE-OP CONVERSATIONS

LESSONS LEARNED FROM A WRONG-SITE SURGERY

CLAIM REVIEW: PREECLAMPSIA UNDIAGNOSED AND UNTREATED

FEATURE SECTION: SURGERY
We are very excited to present this edition of *Brink* and its focus on the important issues of surgery and surgical complications.

It is daunting to consider the sheer number of possible complications resulting from surgery, especially for those patients with co-morbidities, all treated by the surgeons we serve. Cardiac, respiratory, neurologic, gastrointestinal and renal systems can all be adversely affected by infection, trauma, ischemic injury, anesthesia and many other factors.

Authors of a large survey published in the *Annals of Surgery* used five grades to classify post-op complications. The range starts at grade one — categorizing the least serious complications and described as "any deviation from normal post-op course" — to grade five, which is the surgical patient's death as a result of complications. Along with systematizing post-op complications in order to address patient safety and risk management, they found striking, significant results about the overall incidence of complications. According to the authors, "One or more complications occurred in 16.4 percent of patients in the cohort."

There are strong correlations between that important survey’s results and our own data and analysis related to surgical risks, which we share in this issue of *Brink*, along with our findings and recommendations. We also provide practical tools you can use in your practices and hospitals to improve surgical patient outcomes.

Our commitment is to you … to providing you with as much assistance as possible so you can perform the important work you do every day. We are humbled by your efforts and skill, and we stand ready to assist you.

Thank you so much for the support and encouragement you provide us, and for the inspiration to do this important work. It is our honor and pleasure to serve you.

All our best,
Bill McDonough, President and CEO, Constellation

---

FEATURE SECTION:

SURGERY

8 OPERATIVE WORDS
Successful pre-op conversations.

13 THE CUTTING EDGE
How do busy surgeons keep up with the latest advances in medicine?

14 BELLY & BONES
Half of MMIC post-surgical claims involve digestive or musculoskeletal procedures. Here’s why.

17 BEYOND 911
An innovative health care model uses paramedics to care for post-op patients.

20 HOW'S YOUR SOCIAL IQ?
Are you a Dr. House or a Dr. McDreamy?

22 WHEN TO SAY WHEN
How old is “too old” to perform surgery?

24 ETC.
Surgery stats and facts.

DEPARTMENTS

2 NEW+NOTABLE
Winter 2016

5 THE DATA MINE
A cut above
Surgical claims are the most common and costly.

6 BOOK REVIEW
The Checklist Manifesto

18 CLAIM REVIEW
From bad to worse
Multiple surgeries and death following laparoscopic cholecystectomy.

25 CLAIM REVIEW
A pregnancy in peril
A woman’s preeclampsia goes undiagnosed and untreated.

28 THE LAST WORD
Will they bring you kolaches?
Lessons learned from a wrong-site surgery.
ARKANSAS TELEMEDICINE LAW TAKES EFFECT

A new Arkansas law requires health plans to cover telemedicine-provided physician services and to reimburse physicians on the same basis as in-person services. The law’s purpose is to encourage the use of telemedicine and to authorize reimbursement and regulation of services provided through telemedicine. There’s a parity provision for health benefit plans; the parity provisions for Medicaid are effective on or after July 1, 2016.

Telemedicine is defined as delivering health care services by real-time two-way electronic audio-visual communications, including assessment, diagnosis, consultation and treatment, while the patient is at one site and the health care professional is at a different site. Under the new law, a patient must be located in a health provider’s office or other health care facility during the visit.

WHAT’S ON YOUR PLAYLIST?

Can music in the surgical suite, as one study claims, actually improve surgery success rates?

According to a report in the British Medical Journal, music (mostly classical) is played between 62 and 72 percent of the time in the operating room. And about 80 percent of operating room team members say that music benefits cooperation between team members, reduces anxiety levels and improves efficiency. Music also increases the surgeons’ ability to focus, according to the research.

It’s not just any music, though — relaxing music and melodies that mimic the resting heart rate are more effective during a procedure, even more than giving a patient certain anti-anxiety medications before anesthesia, according to a 2009 study of 372 patients. Research suggests that this calming, positive effect makes a difference even after a patient leaves the operating room.

TO LEARN MORE:
MEDCITYNEWS.COM/2014/12/GENRE-MUSIC-DOCTOR-LISTENS-SURGERY-AFFECT-OUTCOME/?RF=1#.

SEE DETAILS OF THE LAW AT FTP://WWW.ARKLEG.STATE.AR.US/ACTS/2015/PUBLIC/ACT887.PDF
**MMIC JOINS FORCES WITH ECRI ON HEALTH IT PATIENT SAFETY**

ECRI Institute, a nonprofit organization devoted to improving patient care, was impressed with MMIC’s body of work in the area of health IT and patient safety and extended an invitation to join in ECRI Patient Safety Organization’s Partnership for Health IT Patient Safety.

The Partnership is a multi-stakeholder collaborative, the purpose of which is to make health IT safer through data collection, analysis, identification and dissemination of best practices. Most significant is the Partnership’s role in informing the national strategy about health IT safety priorities.

MMC’s Trish Lugtu, associate director of research, will collaborate in workgroups to design solutions and share practices for advancing the safety of health IT.

**SLEEPY SURGEONS**

A study in the *New England Journal of Medicine* finds that when surgeons lacked sleep due to middle-of-the-night emergencies, patients scheduled for surgery the next day experienced a meaningful complication — or even death — 22.2 percent of the time. However, when those same surgeons performed the same procedures when they hadn’t worked the night before, the rate of complications and deaths was 22.4 percent. So, for these surgeons, waking up and working during the night did not affect their performance the next day. The study claims that “acute sleep deprivation can impair mood, cognitive performance and psychomotor function.” But after analyzing procedures performed on nearly 40,000 patients, they did not find any significant difference in outcomes.

**CELL PHONES IN THE OR**

While cell phones are not generally restricted in the OR, some say it’s time for clear guidelines on their use. Clinicians have cited colleagues who send texts from the surgical suite, hide a phone and check it periodically, or shop online or check Facebook when they think no one is watching. The issues are noise, infection control and distraction from the patient.

In a 2011 incident, a Texas anesthesiologist was accused of sending text messages and emails while monitoring a patient. Her oxygen levels dropped, which the anesthesiologist allegedly didn’t notice for nearly 20 minutes, and the patient died in surgery. Cameras may also discourage disruptive or disrespectful behavior, as in the recent case of a patient in Virginia who inadvertently recorded his surgical team mocking him during a colonoscopy. In the video, doctors insult him and express a desire to physically assault him, deliberately misdiagnose him and instruct an assistant to lie to him.

**SAY CHEESE!**

Can having cameras in the OR help reduce medical errors? Patient safety advocates and legislators think so. In order to pinpoint the exact cause of medical error, proponents want mandatory audio and video recordings of surgical procedures.

In Wisconsin, legislation has been introduced that would require cameras in every operating room, following a woman’s death from getting excessive amounts of anesthetic propofol during surgery. Cameras may also discourage disruptive or disrespectful behavior, as in the recent case of a patient in Virginia who inadvertently recorded his surgical team mocking him during a colonoscopy. In the video, doctors insult him and express a desire to physically assault him, deliberately misdiagnose him and instruct an assistant to lie to him. Recordings offer transparency, truth and accuracy in collecting data for the medical record and testimony, and data, oversight and insight for medical boards and prosecutors.

But opponents, including the hospital lobby in Massachusetts, have led the fight against attempts to require providers to allow recording by a licensed videographer. The current American Medical Association policy encourages filming procedures for educational purposes, but only with explicit patient consent. And in other cases providers, wary of lawsuits, have stifled the movement to record procedures.

**TO LEARN MORE:**


**SLEEPY SURGEONS**

A study in the *New England Journal of Medicine* finds that when surgeons lacked sleep due to middle-of-the-night emergencies, patients scheduled for surgery the next day experienced a meaningful complication — or even death — 22.2 percent of the time. However, when those same surgeons performed the same procedures when they hadn’t worked the night before, the rate of complications and deaths was 22.4 percent. So, for these surgeons, waking up and working during the night did not affect their performance the next day. The study claims that “acute sleep deprivation can impair mood, cognitive performance and psychomotor function.” But after analyzing procedures performed on nearly 40,000 patients, they did not find any significant difference in outcomes.

**CELL PHONES IN THE OR**

While cell phones are not generally restricted in the OR, some say it’s time for clear guidelines on their use. Clinicians have cited colleagues who send texts from the surgical suite, hide a phone and check it periodically, or shop online or check Facebook when they think no one is watching. The issues are noise, infection control and distraction from the patient.

In a 2011 incident, a Texas anesthesiologist was accused of sending text messages and emails while monitoring a patient. Her oxygen levels dropped, which the anesthesiologist allegedly didn’t notice for nearly 20 minutes, and the patient died in surgery. Cameras may also discourage disruptive or disrespectful behavior, as in the recent case of a patient in Virginia who inadvertently recorded his surgical team mocking him during a colonoscopy. In the video, doctors insult him and express a desire to physically assault him, deliberately misdiagnose him and instruct an assistant to lie to him. Recordings offer transparency, truth and accuracy in collecting data for the medical record and testimony, and data, oversight and insight for medical boards and prosecutors.

But opponents, including the hospital lobby in Massachusetts, have led the fight against attempts to require providers to allow recording by a licensed videographer. The current American Medical Association policy encourages filming procedures for educational purposes, but only with explicit patient consent. And in other cases providers, wary of lawsuits, have stifled the movement to record procedures.

**TO LEARN MORE:**

UPCOMING WEBINARS ON WEDNESDAYS

To register for a webinar, visit: MMICgroup.com/resources/webinars/upcoming
All webinars are presented from noon–1 p.m. CST and are available on demand at MMICgroup.com after the initial presentation.

FEBRUARY
17
DISSECTING THE DATA:
AN ANALYSIS OF SURGICAL MALPRACTICE CLAIMS
Presenters:
Emily Clegg, JD, MBA, CPHRM, UMIA Senior Risk and Patient Safety Consultant, Trish Lugtu, BS, CPHIMs, CHP, MMIC Associate Director of Research

FEATURED ON-DEMAND WEBINARS

WHEN THINGS GO WRONG: APOLOGY AND COMMUNICATION
Presenters:
Emily Clegg, JD, MBA, CPHRM
and Shelly Davis, BSN, JD

To err is human, and members of the health care team are human, too. When errors happen, your team may feel hesitant to engage in meaningful and open communication with patients and families. This program will discuss the moral and ethical importance of open and timely communication about unanticipated outcomes and adverse events. Participants will hear about strategies, tools and best practices for communicating effectively, preserving relationships and enabling patients and families to begin the healing process.

VIRUSES & MALWARE:
USER AWARENESS AND BEST PRACTICES
Presenter: Paul Remillard

Increase your awareness about viruses and malware and how to practice safe email

Surgical allegations take the lead in both occurrence and loss at MMIC. Through an analytical deep dive of surgical claims, we identified underlying factors and areas for improvement throughout each pre-, intra-, and post-operative phase of surgical treatments.

INCLUDE ALWAYS: AN INNOVATIVE MODEL FOR PATIENT AND FAMILY ENGAGEMENT
Presenter: Lisa Juliar

Patient and family engagement is not just a buzzword; it is critical to the safety and quality of our health system. The Minnesota Hospital Association, along with a patient engagement consultant, have created an innovative approach to help inspire health care providers to listen, engage and include patients in every level of care, at all times. The transition to “include always” should be launched in a systematic, meaningful way. Learn how this approach is creating a foundation that can reach across the continuum of care and is changing the way hospitals include patients and families … always.

JANUARY
20
WHAT YOU DON’T KNOW CAN HURT YOU!
HOW BEHAVIORAL HEALTH CARE INTEGRATION DECREASES RISK
Presenter:
Monica Cooke, BSN, MA, RNC, CPHQ, CPHRM, FASHRM

The American Hospital Association has stated that physical and mental health care are indivisible. The percentage of patients in the continuum that have a primary or co-morbid psychiatric disorder is continuing to rise and presents significant risk and quality care concerns for health care organizations. This session will review the prevalence of behavioral health disorders and discuss how care integration can work to improve the quality of care and patient/staff safety. Concrete strategies will be presented that can assist in the safe management of aggression and self-harm — two of the greatest risks that behavioral patients present. A tool box will be provided to the attendees containing resources that will assist in care integration and risk identification.

VIRUSES & MALWARE:
USER AWARENESS AND BEST PRACTICES
Presenter: Paul Remillard

Increase your awareness about viruses and malware and how to practice safe email...
MIMIC, in partnership with CRICO Strategies, has identified several important thematic drivers in surgical treatment allegations through an analysis of 1,843 professional liability claims and suits (collectively referred to here as “cases”) asserted against MMIC policyholders between 2010–2013.

Surgery at the top

Allegations involving surgical treatment prove to be the most prevalent and costly overall, both for MMIC policyholders and for medical practitioners nationwide.

Responsible services

While orthopedics and general surgery are identified as the most frequently named responsible service in surgical cases at MMIC, allegations exist across many surgical specialties.

A view by systems

Multidimensional views of the data produce even stronger themes within allegations of improper performance. When grouping cases by system, operations on the musculoskeletal and digestive systems comprise over half (53 percent) of cases. While these systems align closely with the top responsible services named, operations on the musculoskeletal and digestive systems are not singular in specialty. The majority of musculoskeletal system cases involve orthopedics, neurosurgery and podiatry, while the majority of digestive system cases involve general surgery, colorectal, bariatric and gynecologic surgery.

Surgical performance and management

When examining cases in detail, two classes of allegations contain 84 percent of the cases: improper performance of surgery (66 percent) and improper management of surgical patients (18 percent). Allegations of improper performance of surgery most often originate in the operating room (OR), and the majority (76 percent) result in medium severity injuries: permanent minor, temporary minor or major injuries. (See page 14 for more on improper management of surgical patients and post-operative risk.)
AN OUNCE OF PREVENTION, A POUND OF CURE

Author Atul Gawande offers a straightforward way to manage increasingly complex care environments.

According to The Checklist Manifesto, the now-classic book by Atul Gawande, MD, MPH, there are currently more than 13,000 categorized diseases, syndromes and types of injuries treatable with more than 6,000 drugs and 4,000 medical and surgical procedures. In the book, Dr. Gawande makes the case that this proliferation has resulted in a more complicated, fragmented and hard-to-manage system of care.

Dr. Gawande, author of the recent bestseller Being Mortal: Medicine and What Matters in the End, is a MacArthur Fellow, general and endocrine surgeon at the Brigham and Women’s Hospital in Boston, staff writer for The New Yorker and associate professor at Harvard Medical School and the Harvard School of Public Health.

The Checklist Manifesto highlights a checklist program developed in 2001 by Peter Pronovost, a critical care specialist at The Johns Hopkins Hospital, who decided to make a difference in patient safety by focusing on one prevalent risk: central line infections. To this end, Pronovost created a standard 5-point checklist for doctors, essentially laying out step-by-step guidelines to avoid infection while putting in the line.

Pronovost began his evaluation of the checklist by asking nurses how often they observed any of the steps being skipped. Their response: At least one step was being skipped by doctors at least a third of the time.

Pronovost then distributed the checklist throughout the hospital, and nurses were authorized to stop doctors if any of the steps were being skipped. One year later, results showed the 10-day rate of line infections went from 11 percent to zero. It was estimated that just by using this simple tool, the hospital prevented 43 infections and eight deaths, and saved $2 million in costs.

Interestingly, the first formal record of a checklist being used for safety was by the U.S. Army Air Corps in 1935, after a fatal but preventable crash of a new Boeing-made bomber with a complicated set of controls. Instead of requiring more training or testing of pilots, the military created a pilot’s checklist to manage the new complexity, an approach that is now standard practice throughout aviation.

But if checklists have been adopted so completely by other safety-focused industries, why hasn’t medicine embraced their use? Gawande points a finger at the prevailing medical culture, including doctors who view medicine as more art than science. He summarizes a common viewpoint: “Charts and checklists, that’s nursing stuff — boring stuff.” To prove his point, he surveyed doctors about a checklist that had been proven to reduce surgical deaths by nearly 50 percent. He found 20 percent of physicians thought the checklist “wasn’t easy to use” and “did not improve safety.” Fair enough. But when those doctors were asked whether they, personally, would want that same surgical checklist to be used by their own surgeon if they were having an operation, 93 percent said “yes.”

With that statistic alone, Gawande makes a compelling case for team-wide adherence to a system of checklists as one proven method for reducing risk and improving patient safety in an ever-more complex system.
DESPITE ADVANCED SURGICAL TECHNIQUES AND TECHNOLOGIES, PROCEDURES AS Routine AS A TONSILLECTOMY CAN STILL GO WRONG. ACCORDING TO MMIC CLAIMS DATA, SURGERY RANKS HIGHEST OF ALL MEDICAL SPECIALTIES FOR FREQUENCY AND SEVERITY OF INJURIES TO PATIENTS. IN THIS ISSUE OF *BRINK*, WE EXPLORE WHY THIS IS THE CASE, AND WE SUGGEST WAYS TO REDUCE RISKS RELATED TO SURGERY.
Perhaps one of life’s scariest moments is talking with one’s surgeon about an upcoming surgical procedure. It’s a conversation that can be filled with fear, anxiety and confusion, all of which might lead to a strained doctor-patient relationship, says Laurie Drill-Mellum, MD, MPH, MMIC’s chief medical officer and vice president of patient safety solutions.

“People might be able to understand with their rational mind that a surgery is intended to help a negative health situation reach a positive resolution,” Dr. Drill-Mellum says. However, hearing the specifics of what’s going to happen can trigger worries about unpredictability and a loss of control, which are the most commonly cited causes of stress in surgical patients.

Dr. Drill-Mellum suggests that physicians acknowledge those worries when speaking with patients during pre-operative conversations, and try to achieve open, constructive, empathetic communication. “There may be a history of loss, mistrust or fear that needs to be expressed, and we need to be open to that,” she says.

Successful pre-op conversations involve setting expectations, educating patients and maintaining an open dialogue.

**Educational support**
One important element of pre-operative conversations is providing the patient with helpful, accurate information, delivered in a way that is accessible and understandable.

Mark Odland, MD, chief of the department of surgery at Hennepin County Medical Center, has been through countless pre-operative conversations in his more than 30 years of practicing medicine, and he is convinced that the current process could be greatly improved with educational technologies that help surgeons create a more personal patient experience.

For Dr. Odland, the ideal pre-operative conversation involves a surgeon and a patient sitting side-by-side and reviewing information on a tablet that has been customized for the patient’s specific procedure and situation. “Before the surgeon comes in the room, the patient could have the opportunity to review a short video, or to learn more about how their specific comorbidities could affect outcome and recovery,” he says. “Printouts could match the presentation, and they could be visually appealing, easy to understand and tailored for each individual patient.”

*by Julie Kendrick*
That might be what happens in the future, but Dr. Odland acknowledges that there is much progress to be made before such highly personalized pre-operative information will be available to the majority of patients. “Right now, the materials we have are too wordy, and are written for a generic audience,” he says.

Informed consent: beyond the form
“I receive a number of questions about informed consent, and it often seems as though physicians and clinicians are focused on making sure their consent form is ‘right,’” says Emily Clegg, MMIC’s senior risk and patient safety consultant. “But I believe an emphasis on ‘correctness’ of the form is missing the basic point. The form is only a tangible record of an in-depth conversation that takes place between a physician and a patient. The conversation is the opportunity for relationship-building and confidence-building, which are important components of the pre-operative process.”

Clegg cites three essential elements to any successful pre-operative consultation: (1) the conversation itself, (2) the completed form and (3) medical record notes made on the day of the conversation. “Those notes might include comments on what was discussed, questions that were asked by the patient or family members, and concerns that were expressed,” Clegg says.

In addition, it is important to keep the conversation going until the patient fully grasps important information about the impending procedure. “I know I’ve done my job when I’ve given patients an adequate explanation of the surgery, and I receive feedback to indicate they’re capable of understanding what I’ve said,” Dr. Odland says.

Dr. Odland’s pre-operative consultations always include a discussion of the benefits and risks of the procedure, what to expect after the procedure (time in hospital, returning to normal activity, etc.) and the most frequent complications specific to that operation. “I can’t talk about every possible complication, because whole textbooks are written on them,” he says. “But I do focus on ones that are high-risk or could lead to chronic problems.”

Avoiding the three Rs: Rushed, Routine and Rote
Taking enough time to reach thorough patient understanding requires patience from the physician, perhaps aided by a deep breath and an adjusted mindset. In a worst case scenario, informed consent can be compromised if the physician feels rushed and adheres strictly to a routine outline for the pre-operative conversation.

“If you’re wondering if your providers are truly obtaining good informed consent, the answer is often ‘no,’” says Shelly M. Davis,
SAFETY CHECK
How one internist helps ensure patients are prepared for surgery.

There’s only one kind of “routine” surgery, and that’s the kind that isn’t performed on you. That’s what I tell patients during the five to 10 pre-operative consultations I conduct every week. These patients come to me because they’re scheduled for procedures ranging from conscious sedation for an upper endoscopy, to a knee or hip replacement, to major cardio-thoracic surgery. And they look to me to treat their upcoming procedure as anything but routine.

I work in the trenches of internal medicine, and I am committed to providing each patient with my full attention and concern as I review their medical status and help them prepare for operations. It’s important for me to make sure I understand what is being asked of me.

As a consulting physician, it’s not possible for me to “clear” someone for surgery. Instead, my role is to certify each patient’s risk level as low, medium or high, and to help clarify any outstanding issues or concerns they might have. Every surgical procedure carries inherent risks, but I can let a surgeon know that their patient is in satisfactory condition to proceed as planned.

The standard process for my practice’s pre-operative assessment involves completing a pre-surgical template we’ve created. This template includes most of the information requested by surgeons, as well as other areas we’ve learned to include based on our role as medical consultants. Part of any good consultation is a discussion with the patient of their prior experiences with anesthesia, or their family’s history with surgeries, both of which our checklist addresses.

Understanding meds
One of the most important aspects of consultation is a complete review of current medications and supplements. I sometimes see patients who are taking as many as 20 different medications, but taking the time to ensure a clear understanding of the pre-operative pharmaceutical landscape is utterly essential for patient safety.

Patients need to understand what medications they should stop taking prior to surgery, and when to stop taking them. They also need to understand which medications must still be taken. For example, I might advise a patient to discontinue their fish oil supplements one week before surgery, as they may contribute to excess bleeding, but to continue taking their high blood pressure medication even on the morning of the surgery, with a small sip of water.

Ensuring good outcomes
The old practice of pre-op phone calls with surgeons is certainly not as common as it used to be. Still, when in doubt, I pick up the phone and talk to the surgeon or anesthesiologist directly about any red flags I see, if possible while the patient is right there in my office. I believe that the completed pre-op chart is important, but it is only a reference tool that is best backed up by a one-on-one conversation when indicated.

TARA MCMICHAEL, MD
Lakeview Clinic
Waconia, Minn.

MMIC’s senior claim consultant. “Every provider has a pat speech relating to procedures, but they often don’t individualize that dialogue for individual patients. The reality is that providers think they spend more time on informed consent than they actually do.”

Davis believes that small changes in the approach to obtaining informed consent can make a huge difference in patient understanding and peace of mind. Her first suggestions — easy to suggest and harder to do — is simply to slow down.

“Calmly walking into a room, greeting the patient by name, sitting down and looking a patient in the eye gives the message you have time to spend with the patient,” Davis says. “Ideally, when discussing informed consent, it is a give-and-take conversation customized for the individual patient. This conversation should be face-to-face, which is one of those seemingly small gestures that can make a big difference in strengthening our human connection.”
Informed refusal
While reasons in favor of consenting to surgery may seem clear to the surgeon, all patients have lives that are much more than the sum of their symptoms or diseases. Sometimes what seems to the surgeon to be an “obvious” need for a specific procedure is met with a patient declining to proceed with the surgery. This is called informed refusal.

“I can be talking to someone about the benefits of a procedure and how it could positively impact their health, but all they’re thinking about while I’m speaking is how they’re never going to be able to get a dog sitter when they’re in the hospital,” Dr. Odland says. “That’s the sort of thing that’s under the surface, but which can definitely lead to informed refusal, and physicians need to understand that.”

From anger to curiosity
When encountering an informed refusal, it is important for surgeons to turn off judgment and turn on inquisitiveness, Dr. Drill-Mellum says. “A physician wouldn’t recommend a course of treatment unless it seemed like the best option,” she says. “When the patient declines, the response can be frustration or anger.”

Instead of reacting in an offended, “doctor knows best” manner, Dr. Drill-Mellum suggests that refusal should always be seen as a valid choice, never a waste of time. “It can be helpful to ask, ‘What about what I’ve just explained is making you hesitate, and what are your concerns?’” she says.

Dr. Drill-Mellum notes that the answer to this question can often be surprising. “Many times it has to do with economic concerns, family obligations, lack of transportation or the needs of a pet,” she says. “It’s usually not about their confidence in you or your recommendation.”

Handling “against medical advice”
Being respectful of a patient’s reasons for refusing a procedure does not preclude a physician from issuing an “against medical advice” (AMA) notice. This might occur when a patient leaves the hospital early or declines follow-up treatment.

“It can feel challenging when your patient refuses treatment that’s medically indicated and statistically safe,” Dr. Drill-Mellum says. “You can try to get to the bottom of their motivation while still being respectful. But if they insist, then it’s important still to leave the door open. You might say, ‘I understand your need to attend to something else right now, so I’m going to ask you to sign this AMA form, which outlines your risk of death and disability. But please know that if you come back, I will welcome you. I think we need to take care of this now, and I want what’s best for you, because we’re in this partnership together.’”

The ultimate key to success in pre-operative consultations, Dr. Drill-Mellum says, is active empathy, though she admits this sounds simple in theory and is much more challenging in actual practice.

“Put yourself in the other person’s shoes,” she says. “How would you feel if this procedure were about to be done to you? Think about that, then act accordingly.”

JULIE KENDRICK
Freelance medical and science journalist in Minneapolis, Minn.

Ask the critical questions
This pre-operative Medical Evaluation Checklist was adapted from an article in the journal Anaesthesia:

- Do you experience chest pain or breathlessness walking up two flights of stairs?
- Do you have asthma? Bronchitis?
- Do you have diabetes, and do you treat it with injectable insulin or tablets?
- Do you suffer from epilepsy or seizures?
- Have you had a heart attack? Irregular heartbeat? Angina? Heart failure?
- Do you have kidney disease, thyroid disease or liver disease?
- Do you have problems with pain, stiffness or arthritis in your neck/jaw?
- Have you had a stroke?
- Have you or a family member ever had problems following anaesthesia?

References
It looks like a science fiction movie. A huge robot, with two articulating arms, hovers over a patient in an operating room. Through 8 millimeter incisions in the patient’s abdomen, the robot’s forceps and dissecting instruments perform the delicate procedure needed to correct this patient’s acid reflux condition.

But it isn’t the robot conducting the surgery — it’s the human sitting at a console 15 feet away with his grasp on the master controls. His hand, wrist and finger movements are translated by the system into precise, real-time motions as he views the surgery in high-definition 3D images.

The surgeon is Daniel Dunn, MD, with Surgical Specialists of Minnesota. This nine-surgeon practice initially intended to use the robotic system primarily for esophagectomies, since its instrumentation and 3D views are a great improvement over the flat images and less sophisticated instruments used in laparoscopic surgery. But the partners quickly realized that conducting esophagectomies at their typical rate of only about three per month would not provide enough experience for the surgeons or the operating team, experience vital to the success of the operation. So they decided to use the robotic system for all esophageal surgeries.

Getting everyone up to speed
Each surgeon at Surgical Specialists of Minnesota learned how to perform robotic-assisted surgery by working in tandem with a partner who was already experienced with the technology.

“Many surgeons won’t take the time to do that,” Dr. Dunn explains. “It’s extra time out of their practice for training and proctoring. But we did our first 25 reflux procedures together, making it less likely that there would be mistakes or complications.”

This conscious choice to elevate everyone’s skills came naturally to a practice always seeking new and better ways of taking care of its patients, Dr. Dunn says.

Culture is key
A culture that values innovation makes it easier to keep up-to-date. “You want to be surrounded by people who are making improvements and trying out new things,” Dr. Dunn says. “Those are the people you want to add to your practice. And you have to have the desire to keep up, to be curious about new ideas and willing to track new technologies and ask, ‘What problems are you running into? Do you know anyone using it?’”

Dr. Dunn admits it takes time — even cutting into his evenings after work — to learn about innovations. But a supportive professional infrastructure and family can make all the difference. “I have the encouragement of my group and the hospital,” he says, adding wryly, “and my wife lets me do it.”

Keep on keeping up
How can a busy surgeon stay current? Dr. Dunn offers these suggestions:

- Have confidence in yourself that you can learn new things.
- Also have confidence in data citing low risk to patients.
- Be willing to sacrifice the time it takes to be proctored by someone.
- Don’t waste time going to national meetings to learn about new technology or pharmaceuticals. “Call around locally and get the opinion of respected peers,” Dunn says.
- Prioritize the advances that make sense to you. “When you think about how they affect patient care,” Dunn says, “it should be easy to see their advantages.”
Half of MPL cases alleging improper management of surgical patients involve post-op issues of digestive or musculoskeletal system procedures.

**DIGESTIVE SYSTEM PROCEDURES**

**WHERE THE RISKS ARE:**

**IN THE HOSPITAL**

**KEY PLAYERS:**

**SURGEON AND CARE TEAM**

MMIC N=10 CASES, ASSERTED 2010-2013, ALLEGING IMPROPER MANAGEMENT OF SURGICAL PATIENTS INVOLVING A DIGESTIVE SYSTEM PROCEDURE

Digestive procedure patients are more likely to experience post-op complications while still in the hospital.

55% of cases involve post-op complications while in the PACU, patient room or ICU.

After undergoing a hemicolectomy, a patient experienced signs and symptoms of a possible bowel perforation, but the cause was thought to be an ileus. Communication gaps between the surgeon, radiologist and nurse delayed diagnosis, and the patient died. The cause of death: peritonitis due to anastomotic leak.

**INJURY SEVERITY**

- **HIGH**
- **MEDIUM**
- **LOW**

**INJURY SEVERITY**: **HIGH**: Death, Permanent Grave, Permanent Major or Permanent Significant; **MEDIUM**: Permanent Minor, Temporary Major or Temporary Minor; **LOW**: Temporary Insignificant, Emotional Only or Legal Issue Only

Death occurred in more than half of the digestive system procedure cases alleging improper management of a surgical patient. Top injuries preceding these deaths were infection due to perforation or anastomotic leak, and bleeding from a laceration.

**MOST POST-OP COMPLICATIONS OF DIGESTIVE SYSTEM PROCEDURES OCCUR DURING POST-ACUTE CARE.**

**Top major injuries**

<table>
<thead>
<tr>
<th>Top major injuries</th>
<th>% of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death</td>
<td>53%</td>
</tr>
<tr>
<td>Abscess</td>
<td>11%</td>
</tr>
<tr>
<td>Dehiscence</td>
<td>11%</td>
</tr>
</tbody>
</table>

**POST-OP RISKS: KEY CHALLENGES FOLLOWING DIGESTIVE SYSTEM PROCEDURES**

- Most cases stem from undetected injuries that occur during surgery, e.g., perforation and laceration
- Recognition of and response to post-op complications by the care team
- Injury severity level: high
INJURY SEVERITY

Top procedures with post-op risk

<table>
<thead>
<tr>
<th>Procedure</th>
<th>% of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total joint replacement/revision (hip, knee)</td>
<td>12%</td>
</tr>
<tr>
<td>Spinal fusion</td>
<td>12%</td>
</tr>
<tr>
<td>Arthroscopy (knee, ankle, shoulder)</td>
<td>4%</td>
</tr>
</tbody>
</table>

INJURY SEVERITY*: HIGH: Death, Permanent Grave, Permanent Major or Permanent Significant; MEDIUM: Permanent Minor, Temporary Major or Temporary Minor; LOW: Temporary Insignificant, Emotional Only or Legal Issue Only

MUSCULOSKELETAL SURGERY

WHERE THE RISKS ARE:
IN YOUR OFFICE AND AFTER THE PATIENT LEAVES

KEY PLAYERS:
SURGEON, ADVANCED PRACTICE PROVIDERS, PATIENTS AND CAREGIVERS

MMIC N=34 CASES, ASSERTED 2010-2013, ALLEGING IMPROPER MANAGEMENT OF SURGICAL PATIENTS INVOLVING A MUSCULOSKELETAL SYSTEM PROCEDURE.

Injuries often manifest after a patient leaves the provider’s care. Infection continues to be a significant factor in musculoskeletal surgery cases.

A patient who received a total knee replacement complained of numbness and was told that the symptoms would resolve. After ongoing complaints, a thorough workup revealed an arterial occlusion, which resulted in damage to the peroneal nerve.

Following a late diagnosis of infection after a total knee replacement, a patient sought follow-up care with a new surgeon due to frustration spawned by communication issues with the original surgeon.

A LARGE PROPORTION OF MUSCULOSKELETAL CASES ORIGINATE IN THE OFFICE SETTING. Often, patients with complaints are not fully examined, and post-op complications are not recognized.

OF MUSCULOSKELETAL POST-OP CASES INVOLVE POOR COMMUNICATION WITH THE PATIENT AND/OR CAREGIVER.

POST-OP RISKS: KEY CHALLENGES FOLLOWING MUSCULOSKELETAL SYSTEM PROCEDURES

- Expectation setting and post-op communication with patients
- Recognizing and responding to complications in the office setting
- Injury severity level: medium

* Derived from the National Association of Insurance Commissioners (NAIC) Severity scale
Develop triggers for evaluating and addressing worrisome clinical and/or patient experience scenarios and create trigger cards for easy reference.

Educate your patients and their families on key signs and symptoms of post-operative complications and invite them to speak up with any concerns.

Seek opportunities to hone your communication skills, focusing on “difficult conversations” with patients, especially in situations of dissatisfaction and/or noncompliance.

---

**SHARPENING CLINICAL JUDGMENT**

- MMIC Preventing Diagnostic Errors resources
  MMICgroup.com/resources/preventing-diagnostic-errors
- AAOS Communication Skills Mentoring Program (CSMP)
  www.aaos.org/education/csmtp/index.cfm

**IMPROVING COMMUNICATION WITH PATIENTS AND FAMILIES**

- Center for Shared Decision Making
  med.dartmouth-hitchcock.org/csdm_toolkits.html
- Shared Decision Making National Resource Center
  shareddecisions.mayo Clinic.org
- Informed Medical Decisions Foundation
  www.informedmedicaldecisions.org
  www.biomedcentral.com/1471-2474/16/14
- Empathetics – Scientifically based empathy education that teaches health care professionals how to detect and manage the emotional states of patients and how to respond with empathy and compassion, even in difficult interactions.
  empathetics.com

**IMPROVING COMMUNICATION AMONG THE HEALTH CARE TEAM**

- TeamSTEPPS – An evidence-based teamwork system
  www.teamsteppersportal.org
- Safer Healthcare sample – SBAR communication tools
  www.saferhealthcare.com/default/assets/File/sbarsamples.pdf
- AORN Patient Hand-Off Tool Kit
  www.aorn.org/toolkits/patienthandoff
- CRICO Triggers for Resident-to-Attending Physician Communication
  www.rmfstrategies.com/Clinician-Resources/Article/2009/Triggers-for-Resident-to-Attending-Communication

---

An emergency medical technician (EMT) pulls up to a residence in a rural Minnesota county. But instead of driving an ambulance with a blaring siren, he quietly parks his own SUV. And instead of a heavy paramedic’s uniform, he wears slacks and a dark shirt with a shoulder patch.

The EMT steps up to the door and rings the bell, arriving without drama. Because instead of responding to an emergency, he is there to check on a patient recovering from recent surgery.

The EMT is a community paramedic (CP), specially trained to provide primary care to patients in communities underserved by hospitals and clinics.

Minnesota’s Community Paramedic Program began in 2007 as an effort to save costs by reducing the number of non-acute emergency room visits, and to improve access to primary care for patients in rural settings.

To become a CP, highly skilled paramedics with at least two years of full-time experience must complete an accredited program at one of several colleges in the state, and they must be certified by the Minnesota Emergency Medical Services (EMS) Regulatory Board. CPs serve under the orders and supervision of a licensed physician, usually the medical director of the EMS organization. The original innovator of community paramedicine, Minnesota now has 100 trained CPs, 60 of whom have achieved certification.

Paramedics dedicate 12 hours a week to CP work, making house calls for up to 16 patients a day, even as they continue to serve as emergency responders. And if an emergency arises while they’re visiting a patient? They drop everything and respond.

Typically, CPs are dispatched to primary care patients at the request of a county public health service, or a health promoter or caseworker in a hospital’s outpatient ward. In Minnesota, Medicaid and Medicare cover the kinds of care provided by CPs.

In addition to drawing labs, caring for trach-tube stomas and educating patients on proper nutrition and medication use, CPs provide other valuable services to post-op patients. According to Mike Wilcox, MD, medical director for the community paramedicine program at Hennepin Technical College and an early proponent of this health care model, post-surgical follow-up falls into four basic areas:

- **Orthopedics**, including patients who have had hip or knee replacements, ortho procedures or surgery for fractures
- **Gastric bypass patients**, at risk of complications such as electrolyte balance, abnormal blood sugar levels, renal disturbances and respiratory problems
- **Cardiac patients**, who benefit from medication reconciliation, nutritional counseling and weight monitoring
- **Wound care**, including diabetics with skin breakdown and circulation issues

“Our community paramedicine program provides excellent bang for the buck,” says Dr. Wilcox, “and great quality of care for the patient.”

---

**BEYOND 911**

An innovative health care model uses paramedics to care for post-op patients.

---

An emergency medical technician (EMT) pulls up to a residence in a rural Minnesota county. But instead of driving an ambulance with a blaring siren, he quietly parks his own SUV. And instead of a heavy paramedic’s uniform, he wears slacks and a dark shirt with a shoulder patch.

The EMT steps up to the door and rings the bell, arriving without drama. Because instead of responding to an emergency, he is there to check on a patient recovering from recent surgery.

The EMT is a community paramedic (CP), specially trained to provide primary care to patients in communities underserved by hospitals and clinics.

Minnesota’s Community Paramedic Program began in 2007 as an effort to save costs by reducing the number of non-acute emergency room visits, and to improve access to primary care for patients in rural settings.

To become a CP, highly skilled paramedics with at least two years of full-time experience must complete an accredited program at one of several colleges in the state, and they must be certified by the Minnesota Emergency Medical Services (EMS) Regulatory Board. CPs serve under the orders and supervision of a licensed physician, usually the medical director of the EMS organization. The original innovator of community paramedicine, Minnesota now has 100 trained CPs, 60 of whom have achieved certification.

Paramedics dedicate 12 hours a week to CP work, making house calls for up to 16 patients a day, even as they continue to serve as emergency responders. And if an emergency arises while they’re visiting a patient? They drop everything and respond.

Typically, CPs are dispatched to primary care patients at the request of a county public health service, or a health promoter or caseworker in a hospital’s outpatient ward. In Minnesota, Medicaid and Medicare cover the kinds of care provided by CPs.

In addition to drawing labs, caring for trach-tube stomas and educating patients on proper nutrition and medication use, CPs provide other valuable services to post-op patients. According to Mike Wilcox, MD, medical director for the community paramedicine program at Hennepin Technical College and an early proponent of this health care model, post-surgical follow-up falls into four basic areas:

- **Orthopedics**, including patients who have had hip or knee replacements, ortho procedures or surgery for fractures
- **Gastric bypass patients**, at risk of complications such as electrolyte balance, abnormal blood sugar levels, renal disturbances and respiratory problems
- **Cardiac patients**, who benefit from medication reconciliation, nutritional counseling and weight monitoring
- **Wound care**, including diabetics with skin breakdown and circulation issues

“Our community paramedicine program provides excellent bang for the buck,” says Dr. Wilcox, “and great quality of care for the patient.”
A 68-year-old woman complaining of mid-epigastric pain radiating to her back was referred to a surgeon who ordered a right upper quadrant ultrasound that showed multiple calcified mobile gallstones. The surgeon recommended laparoscopic cholecystectomy. After obtaining the patient’s informed consent, the surgeon performed a cholecystectomy via a traditional four-port laparoscopic approach. In his report dictated five days post-operatively, he noted the gall bladder had chronic inflammatory changes. Further, he noted that he carefully dissected adhesions between the fundus, body and omentum and that the patient had tolerated the surgery with no apparent complications. Because the patient was complaining of severe post-operative pain, the surgeon admitted her to the short stay observation unit of the surgery center.

Later that evening, the nurses contacted the hospitalist on duty and reported that the patient was rating her pain as 10 out of 10, was guarding her abdomen and that her BPs were considerably lower than the immediate post-operative readings. The hospitalist ordered Dilaudid for pain.

Both the surgeon and the hospitalist examined the patient early the next morning. The surgeon ordered an enema and suppository for suspected constipation. The hospitalist ordered an IV fluid bolus to treat the hypotension.

During the day, the patient used increasing amounts of oral pain medication but reported her pain was better controlled. Her BPs continued to fluctuate and slowly drop. At midnight, the patient’s nurse contacted the hospitalist on duty because of decreased urine output. At 0400, the hospitalist paged the surgeon because the patient’s BP was 70/47 and she had no urine output for two hours.

The surgeon took the patient back to the operating room and performed an exploratory laparotomy with gastropexy and small bowel resection with anastomosis. Unfortunately the patient did not do well after this surgery and had to be returned to surgery the next day with a diagnosis of intra-abdominal sepsis with necrotizing fasciitis.

FROM BAD TO WORSE
A patient requires multiple surgeries and dies following complications of laparoscopic cholecystectomy.
Over the next 12 days, the patient had three more surgeries. She developed septic shock, respiratory failure, acute renal failure, bilateral deep vein thrombosis, disseminated intravascular coagulation and subsequent heparin-induced thrombocytopenia and eventually died.

The family filed a malpractice claim against the surgery center, the surgeon and the hospitalist alleging improper performance of laparoscopic cholecystectomy and improper management of post-operative complications.

Disposition of case
The case was settled against the surgeon, the hospitalist and the surgery center.

Patient safety and risk management perspective
The experts who reviewed this case were critical of the surgeon for attributing the patient’s post-operative symptoms to constipation and not including sepsis in his differential diagnosis. They opined that symptoms of significant post-operative pain and hypotension needed evaluation and should be presumed to be caused by operative complications until proven otherwise. The experts criticized the surgeon for not having a heightened awareness of post-operative complications given that he was using a new surgical technique. They were also critical of the nursing team for failing to notify the hospitalist sooner given that the patient had increasing pain and dropping BPs.

Surgical claims
Surgical claims — primarily surgical performance and post-operative management allegations — are the most prevalent case type for MMIC. Sixty-six percent of surgical allegations are related to surgical performance and generally involve medium severity injuries. While post-operative management allegations account for only 18 percent of cases, their outcomes are often more severe, with 53 percent of cases involving patient death.

Clinical analysis of these surgical cases reveals that they frequently involve digestive system and musculoskeletal procedures and are driven by:

- Pre-operative decision-making and communication challenges
- Intra-operative technique and complications
- Post-operative judgment and communication failures

Patient safety and risk management strategies should be implemented for the entire peri-operative period. The goal of safe peri-operative care is to provide better conditions for patients before, during and after surgery.

PATIENT SAFETY AND RISK MANAGEMENT TIPS

- Develop a standardized pre-operative risk assessment system for patients with previous surgical histories and/or co-morbidities (e.g., previous abdominal surgery, diabetes, anticoagulant therapy) including visits with specialists for each co-morbidity to ensure readiness for surgery
- Ensure full consideration of all available clinical information, including medical-surgical history, previous complications and input from specialists when determining surgical approach
- Improve and maintain technical skills and practice risk awareness for nerve and adjacent structure injuries (e.g., SAGES Safe Cholecystectomy Program)
- Develop communication trigger tools for surgeon notification to evaluate worrisome clinical and/or patient experience situations
- Implement a patient-centered, shared decision-making model for obtaining informed consent that includes a discussion of expectations and goals
- Facilitate regular case conferences to maintain broad perspective on surgical treatment decisions
- Educate patients and families on key signs and symptoms of post-operative complications and encourage them to speak up with any concerns
- Seek opportunities to develop empathetic communication skills, focusing on “difficult conversations” with patients and families (e.g., Empathetics and AAOS Communication Skills Mentoring Program)

Resources
AAOS Online Education
www.aaos.org/education

AAOS Communication Skills Mentoring Program
www.aaos.org/education/csmp/index.cfm

CRICO Triggers for Resident-to-Attending Communication
www.mfh.harvard.edu/ Clinician-Resources/ Article/2009/Triggers-for-Resident-to-Attending-Communication

Empathetics
empathetics.com

SAGES Safe Cholecystectomy Program
www.sages.org/safe-cholecystectomy-program

Safety in Surgery: The role of shared decision-making
www.pssjournal.com/content/9/1/24

LORI ATKINSON, RN, BSN, CPHRM, CPPS
Manager, Research, Development & Education, MMIC
Lori.Atkinson@MMICgroup.com

But sometimes these strong character traits can have a darker side: Surgeons can be perceived as aloof, abrasive, egocentric, abrupt, even heartless.

For decades, a caring physician’s personality was known as “good bedside manner.” But now we know that the importance of demeanor isn’t limited to a patient’s bedside — it’s also critical to achieving positive relationships with families and coworkers, and important for good quality of care.

The ability to understand others and successfully communicate with them is sometimes called “social intelligence.” A surgeon’s social IQ is key to the patient experience. Yet some physicians don’t fully recognize how others perceive them.
Getting serious about social IQ

For a rough idea of your social IQ, take this quiz and see how you score.

**Physician, score thyself**

For a rough idea of your social IQ, take this quiz and see how you score.

<table>
<thead>
<tr>
<th>SCORING: 1 = NEVER 2 = SOMETIMES 3 = OFTEN 4 = ALMOST ALWAYS 5 = ALWAYS</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. With patients, I ask them something personal to make them feel at ease (e.g., “What kind of work do you do?”)</td>
<td></td>
</tr>
<tr>
<td>2. I generally use my patient’s name at the beginning, middle and end of each visit.</td>
<td></td>
</tr>
<tr>
<td>3. When I’m running late to the office, I alert my staff to the situation and ask them to apologize for me to any waiting patients.</td>
<td></td>
</tr>
<tr>
<td>4. I regularly look for opportunities every day to tell staff and/or colleagues, “Work well done.”</td>
<td></td>
</tr>
<tr>
<td>5. When I am wrong or mistaken, I look for opportunities to admit it (so that I can role model admitting mistakes to others).</td>
<td></td>
</tr>
<tr>
<td>6. I regularly address staff by name.</td>
<td></td>
</tr>
<tr>
<td>7. I show patience — and hide my frustration — when I have to teach someone the same thing twice (or more).</td>
<td></td>
</tr>
<tr>
<td>8. I know my triggers when I’m under stress, and I know how to manage my reaction so I can stay calm and constructive.</td>
<td></td>
</tr>
<tr>
<td>9. When disagreeing with colleagues, I balance being direct with being diplomatic.</td>
<td></td>
</tr>
<tr>
<td>10. I work hard to be approachable and open to suggestions from staff at all levels.</td>
<td></td>
</tr>
<tr>
<td>11. I communicate a clear and comprehensive care plan to my team and patient, and I always check to make sure they understand.</td>
<td></td>
</tr>
<tr>
<td>12. I avoid sarcasm when answering questions from colleagues and staff.</td>
<td></td>
</tr>
<tr>
<td>13. I assign tasks and state my needs in the form of requests, not commands.</td>
<td></td>
</tr>
<tr>
<td>14. When walking through the halls, I try to say “Hi” to patients and families.</td>
<td></td>
</tr>
<tr>
<td>15. I begin my consults with open-ended questions, such as, “How can I help you today?” And I end with “Do you have any other questions or concerns?”</td>
<td></td>
</tr>
<tr>
<td>16. I listen to my patients for at least the first minute of every consultation, without interrupting.</td>
<td></td>
</tr>
<tr>
<td>17. If the patient seems (or says he or she is) confused by what I am saying, I apologize before restating.</td>
<td></td>
</tr>
<tr>
<td>18. I wait for my patient to nod or say “Uh huh” before continuing to the next thought.</td>
<td></td>
</tr>
<tr>
<td>19. When I am running late, I go to the waiting area and tell patients something like, “I apologize for running late, but I will see each of you. Thank you for your patience.”</td>
<td></td>
</tr>
<tr>
<td>20. I encourage staff (clinical and non-clinical) to ask questions so that they have all the information they need.</td>
<td></td>
</tr>
</tbody>
</table>

**SCORING:**

75 – 100: Excellent — You’ve got great social IQ! You’re respected and liked by patients, families and coworkers alike. If you were a fictional doc in a popular TV series, you’d be Dr. Derek “McDreamy” Shepherd.

50 – 74: Above Average — You’re on the right track. You connect with those around you, but perhaps not consistently enough. Think about improving your social IQ through a program such as PULSE 360°.

25 – 49: Needs Improvement — Your social skills need some work. If you were a fictional doc in a popular TV series, you might be the brilliant but abrasive Dr. Gregory House. With a higher social IQ, you would be a more effective physician. Consider prioritizing improvements to the “soft side” of your practice.

0 – 24: Cause for Alarm — Ouch! Are you sure your score is really that low? Try taking the quiz again. If your score is still abysmal, your social IQ needs emergency treatment.

FOR MORE INFORMATION ON HOW PULSE 360° CAN HELP MAXIMIZE PATIENT SAFETY AND SATISFACTION BY FOSTERING MORE EFFECTIVE INTERPERSONAL AND COMMUNICATION SKILLS, CONTACT YOUR PATIENT SAFETY CONSULTANT.

**References**


**Resources**

PULSE 360° Survey System: www.pulseprogram.com
WHEN TO SAY WHEN

Like every other baby boomer, many surgeons are aging. How old is “too old” to perform surgery?

In 1959 the Federal Aviation Agency established a rule mandating that airline pilots retire when they reach 60 years of age. Though there was no scientific basis for the decision when it was made, the regulation remains (although the limit has since been raised to 65).

Like airline pilots, surgeons routinely make life-or-death decisions for others. But with age taking a toll on physical and cognitive abilities, late-career surgeons are at a potentially higher risk of misdiagnosing illnesses and conditions, making a careless move during surgery or failing to make a decision quickly enough for a patient on the operating table.

A recent survey calculated that 241,641 physicians in the United States are now age 65 and older. That’s four times more than in 1975. Of these, between 10,000–15,000 are actively practicing surgeons (though it’s not clear how many are actually performing surgeries).¹

In June 2015, the American Medical Association’s (AMA’s) House of Delegates approved a 21-page report from its Council on Medical Education (CME), a report that cited 72 peer-reviewed papers enumerating the many ways that advancing age diminishes a physician’s abilities. As the report notes, all physicians must meet state licensing requirements to practice medicine, and some hospitals and medical systems have initiated age-based screening. But there is no national standard regarding age, nor are physicians uniformly required to test for competency or quality of performance in their area of practice.

In response to the report, the House of Delegates voted to develop competency guidelines to help ensure that aging physicians are able to safely treat patients.² But until those guidelines are in place, an important question remains: How significant is the risk to patients from doctors who should not still be performing surgery?

Health care’s safety net

Perhaps not as significant as one might think, according to Walter Flynn of W. J. Flynn and Associates, LLC, a Minnesota-based human resources consultancy. “Health care has an effective safety net,” Flynn explains. “Hospitals manage this issue by peer review and quality reviews, where every surgery is evaluated per outcome. There are hundreds of situations in which a physician has been identified as having issues by virtue of evaluation.”

Flynn adds that, most often, it’s not a big malpractice claim that brings such issues to light, but rather well-designed quality review processes and meticulous oversight of operating events.

Flynn also points out that surgeons are never in the operating suite alone. “There will be an anesthesiologist or nurse anesthetist and one or two nurses, maybe also another surgeon or physician’s assistant.” If these other health care professionals observe deficiencies in a surgeon’s performance, those issues can come to light and be addressed through the hospital’s or ambulatory surgical center’s processes for quality review.

When there’s a problem

The case for restricting a surgeon’s practice must be made with rock-solid data. “You want to be sure that there really is an issue,” Flynn says. “Hospitals and other environments do look at trends. If there’s a very significant event, they would act immediately. But they are also very aware of small events indicating a pattern. Those who sit in judgment would have much more fortitude — legal and otherwise — if they have good data absolutely documenting an issue that needs to be dealt with.”

Not surprisingly, telling a physician that he or she is no longer competent to perform surgery is “incredibly confrontational,” Flynn says. “People stop talking. It turns ugly. People sue, leave and go elsewhere, or agree to disagree, or they get involved in grievance processes.”

What’s a doctor to do?

Surgeons who feel unfairly disciplined by a hospital or health system do have recourse. “There’s a fair amount of due process,” Flynn explains. “They can appear before a panel or board to say why they disagree with the findings. Due process takes time, and surgeons may still be able to operate until the review is complete.”

Whether surgeons are forced to hang up their scalpel — or whether they voluntarily adjust their practice in growing recognition of their limitations — doesn’t necessarily signal the end of a career. “I’ve known many surgeons who have curtailed their practice so they’re doing simple procedures or diagnostics,” Flynn says. “There are alternatives, such as teaching. I know spine surgeons who no longer perform surgery but rather do only diagnoses and care planning. They can do other things and practice successfully.”

Prevention is the best medicine

Contractual agreements can help ensure that a clinic’s or hospital’s physicians are fit to safely care for patients. “If you’re a part of a five-partner group and one of the partners is having issues, it has tremendous implications
for the practice," Flynn notes. That's why many partner practices are adding protections to their agreements, informing physicians when they sign on that they could be subject to competency assessments. “These agreements can withstand legal scrutiny because partners are informed before the fact.”

Similarly, hospitals can make competency assessments conditional in their employee contracts or other relationship documents, requiring physicians to agree to them in order to obtain the position. “It's not unlike a pre-employment drug screening,” Flynn says.

If you see something, say something

What should coworkers and colleagues do if they notice diminishing abilities in a surgeon? The answer: Find out how to file a report. Most clinics and hospitals have a formal process for reporting incidents and concerns, usually anonymously, which often leads to a review and evaluation.

But sometimes, Flynn says, issues can be handled informally and discreetly. He recounts the story of a radiologist who noticed that a colleague was consistently misreading diagnostic images, so he approached him privately and shared his concerns. As it turned out, the other radiologist just needed a new pair of eyeglasses.

References
EVERY 14 SECONDS

How often surgeons interrupt their patients during pre-surgery consultations.²

$317k

Average annual compensation for general surgeons.³

Ten years

The average length of education before a surgeon is able to find employment in the U.S.⁴

51.4 million

Total inpatient surgery procedures performed in the U.S. in 2010.⁵

A PREGNANCY IN PERIL

An OB patient has symptoms of preeclampsia that go unrecognized and untreated until she suffers a seizure. Her baby dies following emergent delivery.

Facts of the case
A 24-year-old gravida 1 woman with a BMI >40 and history of one pack per day tobacco use called her obstetrician’s (OB) office at 25 weeks gestation with complaints of nausea, vomiting and headache. The nursing staff advised her to go to the local hospital emergency department (ED) for evaluation. The on-call OB evaluated her and noted normal blood work, 1+ urine protein, reassuring fetal heart rate (FHR) and blood pressure (BP) of 142/87. He prescribed Zofran and IV fluids, and discharged her home with instructions to rest and be examined at her next regularly scheduled OB visit.

The next day the patient called to report that she had not been able to tolerate anything by mouth, and had epigastric pain and a headache. She was instructed to report to the ED where the on-call OB admitted her for overnight observation with a diagnosis of gastritis and possible dehydration, as well as elevated BPs in the 130–160/70–100 range.

Early the next morning, the on-call OB examined the patient and noted that she was feeling better. He documented that her urinalysis showed 2+ protein and BPs in the 130–160/70–100 range. The OB ordered Zofran and a 24-hour urine test, and discharged her home with instructions to follow up in the office the next afternoon for an assessment and results of the 24-hour urine test.

The next afternoon, she was examined by her regular OB. He had his staff contact the hospital lab, who reported that the 24-hour urine total protein level was 231. The OB documented that he was concerned about the patient’s symptoms suggesting impending preeclampsia, noting that her BP was 190/107 and 164/84 while on her left side, her urine dipstick showed 4+ protein, she had a trace of edema and her weight had increased by 4 kilograms since her last visit. He sent her home on bed rest with instructions to start another 24-hour urine test and return to the office in three days, which was a Monday.
The next morning, the patient was found by her mother on the floor of her home unconscious and having seizures. She was taken by ambulance to the ED. While in the ED, she continued to have seizures. When the OB arrived in the ED, he accessed her medical record and discovered that the 24-hour urine total protein level was actually 2,980. The patient was taken to the operating room where an emergent cesarean section was performed and a male infant was delivered. The baby required aggressive resuscitation and was transported via air ambulance to a tertiary children’s hospital. The baby subsequently developed pulmonary hemorrhage and other complications and died on day 16 of his life.

The woman had a stormy post-operative recovery. She developed acute respiratory distress syndrome, spent several days in the ICU on a ventilator and continued to have difficulties with hypertension. She filed a malpractice claim against the OB physician group alleging failure to diagnose and timely treat severe pregnancy-induced hypertension/preeclampsia that resulted in the death of her infant son.

Disposition of the case
The case was settled against the obstetrician group.

Patient safety and risk management perspective
The experts who reviewed this case were critical of the on-call OB for not recognizing and treating the patient’s symptoms of severe pregnancy-induced hypertension/preeclampsia.

Maternal morbidity and mortality
The most common preventable conditions resulting in severe maternal morbidity or mortality are severe hypertension, obstetric hemorrhage and venous thromboembolism.\(^1\) The National Partnership for Maternal Safety, an initiative formed to help health care organizations enhance maternal/fetal safety, has launched several maternal patient safety bundles. According to the Institute for Healthcare Improvement (IHI), bundles are a group of evidence-based interventions related to a condition or care process that, when executed together, result in better outcomes than when implemented individually. IHI has found that reliable design reduces unintended variation and perinatal harm.\(^2\)

Currently, three core maternal patient safety bundles have been developed:

- Obstetric Hemorrhage
- Severe Hypertension in Pregnancy
- Venous Thromboembolism Prevention in Pregnancy

Additionally, three supplemental bundles have been recommended:

- Maternal Early Warning Criteria
- Facility Review of Severe Maternal Morbidity and Mortality
- Staff and Family Support

The goal of the initiative is to have the three core maternal patient safety bundles implemented in every U.S. birthing facility over the next several years. Other evidence-based maternal patient safety bundles are being developed.

MMIC AND UMIA POLICYHOLDERS CAN ACCESS RESOURCES AND TOOLKITS FOR MATERNAL PATIENT SAFETY BUNDLES AND OTHER MATERNAL PATIENT SAFETY RESOURCES AT MMICGROUP.COM > LOGIN > RISK MANAGEMENT > BUNDLED SOLUTIONS > OB RISK SOLUTIONS. UMIA.COM > MEMBERS EDUCATION > LOG IN > PATIENT SAFETY RESOURCES > BUNDLED SOLUTIONS > OB RISK SOLUTIONS

ARKANSAS MUTUAL POLICYHOLDERS, PLEASE CONTACT YOUR RISK AND PATIENT SAFETY CONSULTANT.
PATIENT SAFETY AND RISK MANAGEMENT TIPS

- Employ a critical test result policy and procedure that requires verbal communication of critical test results to a provider, and a read-back process to confirm effective communication

- Use Maternal Early Warning Criteria to promptly recognize and respond to abnormal symptoms requiring escalation of care

- Establish a structured communication process with tools for communication within the health care team (e.g., SBAR — Situation, Background, Assessment, Recommendation)

- Implement Maternal Patient Safety bundles to standardize care processes and reduce variation

- Educate team members and physicians on bundle components and processes

- Provide for unit-based drills and simulation training for maternal/fetal emergencies

- Implement a process for timely triage and evaluation of pregnant women in the ED

- Collect and analyze data on bundle implementation and maternal/fetal outcomes for performance improvement

- Conduct multidisciplinary review of adverse events involving mothers and babies for performance improvement

References
2. Institute for Healthcare Improvement Evidence-Based Care Bundles, available at www.ihi.org/topics/bundles/Pages/default.aspx.

Resources

ACOG District II – Severe Hypertension www.acog.org/About-ACOG/ACOG-Districts/District-II/SMI-Severe-Hypertension

Council on Patient Safety in Women’s Health Care – Severe Hypertension Bundle www.safehealthcareforeverywoman.org/secure/ (free download with registration)


CMQCC Preeclampsia Toolkit www.cmqcc.org/resources-tool-kits/toolkits/preeclampsia-toolkit (free download with registration)


LORI ATKINSON, RN, BSN, CPHRM, CPPS
Manager, Research, Development & Education, MMIC
Lori.Atkinson@MMICgroup.com
One of my longtime mentors, a now-retired orthopedic surgeon who enjoys telling tales of his clinical practice, recently shared with me his most memorable surgical error, how he handled it and how the patient and family responded.

The error involved a wrong-site surgery. The surgeon had performed an early morning surgery, after which he had gone to the orthopedic floor to conduct morning rounds. During that time, his next patient, who was to undergo arthroscopic surgery for a meniscal tear, was prepped for surgery. Unfortunately, after the patient was sedated, the wrong leg was prepped and draped. The surgeon returned to the OR, approached the prepped surgery site, made an incision and inserted the arthroscope, only to be surprised by a normal-appearing meniscus. Finding normal knee anatomy, he removed the scope, sewed up the incision and dressed the wound. It wasn’t until the teenaged patient awoke and exclaimed with shock that the wrong knee had been operated on that the surgeon realized his error.

This event, which occurred more than 30 years ago, left an indelible memory on this physician. The feelings of shock, disbelief, embarrassment, shame and concern for his reputation are still fresh, decades after a long and successful career in medicine.

We physicians expect better of ourselves, and when we don’t perform to our own expectations, we are very self-critical. Our obsessive-compulsive tendencies, which contribute to our success as physicians, can also handicap us when we have to face the fact that we are human and make errors.

So, what happened after the surgeon was made aware of his error? He apologized to the patient, then went to the patient’s parents and apologized. He explained what had happened. He told them what outcomes to expect from the wrong-site surgery, chiefly an unnecessary scar. And he offered to do surgery on the correct side as soon as the patient was ready.

The patient and her family, despite advice from an attorney relative that the case could be an easy malpractice lawsuit, chose to return to the physician for the second surgery. All went well. That Christmas, the family delivered a box of kolaches, a Czech treat, to the surgeon’s office, thanking him for helping their daughter.

I believe the physician’s approach to the situation — acknowledging his error, apologizing for it, and communicating straightforwardly and transparently with the patient and her family — surely helped to keep an unfortunate adverse event from becoming something more damaging to everyone.

This kind of open and direct approach to adverse events is gaining traction in health care, and it’s increasingly bolstered by research. We at MMIC, UMIA and Arkansas Mutual support this approach and encourage you to explore the many resources we make available to help you have better conversations when things go wrong. Simply log in to the risk management and patient safety portal at MMIC or UMIA and click our “Apology and Communication” bundled solution. Arkansas Mutual policyholders, please contact your risk and patient safety consultant.

Of course, there is no guarantee that a family or patient will reward a physician’s open communication with kolaches. But we know that avoiding patients and their families when adverse outcomes occur can make service recovery difficult, if not impossible.

By asking what we’d want for ourselves or our loved ones when something goes wrong, and acting accordingly, we may well end up with better results than we expected.

Laurie C. Drill-Mellum, MD, MPH
Chief Medical Officer
MMIC, UMIA and Arkansas Mutual
Laurie.Drill-Mellum@MMICgroup.com

KOLACHES?
Lessons learned from a wrong-site surgery.
FEATURE SECTION: Violence in the workplace

- Violence in a health care setting: what to know, what to do
- Managing bad patient behavior
- Creating a safer workplace

ALSO:

- Medical liability insurance: what it is and why you need it
- The top 5 things you should be doing this year to achieve Meaningful Use
Despite advanced surgical techniques and technologies, procedures as routine as a tonsillectomy can still go wrong. According to MMIC claims data, surgery ranks highest of all medical specialties for frequency and severity of injuries to patients. In this issue of *Brink*, we explore why this is the case, and we suggest ways to reduce risks related to surgery.