MIEC

SPECIAL REPORT

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The physician-patient relationship: an invitation to collaborate

INSIDE

Special Report Claims Alert
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This newsletter shares a patient's personal experiences related to the discovery, diagnosis, and treatment of squamous cell carcinoma. The story demonstrates how easy it is to overlook the importance of positive patient relations in a medical setting and how it can be carelessly undermined. The newsletter also includes tools that you can incorporate into your patient education program to help reduce the possibility of patient injury, increase patient compliance and invite collaboration and compliance.

A Cautionary Tale (and true story)

"Your biopsy results came back and you have a squamous cell carcinoma on your neck with lymph node involvement," said the ENT.

"I have a 'squeamish cell' what?"

"You have a big skin cancer and the cancer may have moved into the lymph nodes in your neck," explained Sam's otolaryngologist, "I want you to see a radiation oncologist."

"Okay," shrugged Sam, a 77-year-old, healthy, educated male who had been seen by his PCP, a dermatologist, and now an ENT for treatment of a large neck lesion. Sam doesn't ask questions, primarily because he has a difficult time understanding what his doctors try to communicate to him. "I'll just do what they tell me to do," is his position. Sam also stops listening once he hears the word "cancer." His history includes prostate cancer with a TURP and brachytherapy, and removal of numerous skin cancers, including another lesion on his neck (different site). Fortunately, Sam then asked his daughter to accompany him to various visits because he knew he needed her to listen on his behalf.

The problem: *The patient doesn't ask questions, is scared, and stops listening after "cancer" is mentioned as part of his diagnosis. The physician doesn't describe the alternatives to treatment.*

A solution: *Anticipate questions the patient may have and answer them. Encourage the patient to ask questions. Reassure him as best you can without giving false hope. Be sure the patient and family members have no further questions before they leave your office. (Remember to document the discussion.)*

So began Sam's treatment, medical care punctuated by a series of miscommunications and clerical errors, an experience that he later compared to a "carnival fun house, minus the fun." Every step of his care included some administrative mishap that complicated Sam's life, as you will see.

Sam was seen in consultation by a radiation oncologist who recommended radiation therapy for six weeks. Post-therapy, the lesion had not decreased in size and looked like an angry volcano oozing pus. Rebiopsy of the tumor was positive for squamous cell carcinoma. The ENT sent Sam for a CT scan with contrast and referred him to a head and neck surgeon.

Sam, together with his wife and daughter, went to the diagnostic imaging center for a CT scan with contrast. Shortly after they arrived, the radiology technologist reviewed Sam's lab results and noted that the

BUN and creatinine levels were out of normal range; therefore, contrast medium was contraindicated. The technologist tried to explain to Sam that she could not inject the dye as planned because it might cause problems for his kidneys. After speaking wth the ENT, the radiology technologist instructed Sam to come back another day for an MRI that could be done without dye; the center's schedule was full that day.

The problem: *The ENT had not seen the lab results which may have prompted him to order a different study or to call to save Sam a trip to the center. The patient had to be rescheduled for another day and left convinced that something was wrong with his kidneys.*

A solution: *Review lab results before they are filed. Contact the patient to discuss any changes in recommended studies or treatment. If you ask a staff member to call, ensure that he/she can clearly explain the reason for the change and your advice.*

Eventually, Sam was referred to a head and neck surgeon at a well-known teaching hospital. After waiting for two and a half hours past the scheduled appointment time and receiving no explanation for the delay, Sam spoke with a nurse practitioner (NP) who was to obtain his medical history. The images, together with the radiologists' reports, had been sent to the consultant in advance of the appointment; however, the NP had not reviewed any of the information before speaking with Sam and was unfamiliar with his basic history. Sam's wife and daughter became quite upset when the NP asked several times, "And why are you here today?"

The problem: *Scheduling caused a 2 ½ hour delay in the examination. The front desk staff offered no explanation or apology.*

A solution: *Remind front desk staff to apologize for delays. It is helpful to offer patients options: If you are considerably behind in your schedule, ask staff to call your patients to schedule a new appointment or advise them that they can come later than originally scheduled. If patients leave before being examined, consider a call to apologize to them.*

The problem: *Once Sam and his family were brought to an examination room, their first encounter was with a nurse practitioner who had no knowledge of the patient and was unskilled at formulating questions based on the information before her.*

A solution: *If you work with nonphysician clinicians, ensure they are well-trained and manage patients as you would.*

When the surgeon arrived, he apologized for his tardiness, which helped Sam, his wife and his daughter, to relax and enabled them to engage in conversation. The surgeon spent a great deal of time with Sam and discussed numerous options with him and his family, including: a traditional skin graft; a skin flap graft from the trapezius muscle with a neck resection to remove any cancerous lymph nodes; or more conservatively, a skin flap graft only and "watch the nodes via PET scan." No definite decisions were made at the initial visit and Sam was not told how any of them would affect the quality of his life. Sam and his family were not given any written information to supplement the discussion and Sam's recollection of the oral discussion was fragmented. His primary question, "Am I going to die from this?" was followed by, "If he takes the flap from my shoulder, how will he rotate it to my neck?"

The problem: *A complicated procedure was discussed orally; no written information or diagrams were dispensed to explain the complex options.*

A solution: *Supplementing oral communication with written or audio visual information promotes understanding and, in many instances, cooperation. We suggest that physicians use pictures and pamphlets to show patients what an operation will entail. Encourage patients to read the information and ask follow-up. questions. (Remember: Document that you informed the patient.)*

In the days that followed the initial surgical consultation, a three- to four-hour surgery was scheduled for lesion removal with skin flap graft using the temporalis muscle, with no further mention of a neck resection. The scheduling clerk gave Sam's wife oral pre-operative instructions: NPO after midnight; no aspirin, Advil, or ibuprofen; only liquid from midnight to 6:00 a.m.

The problem: *A surgery was scheduled even though the physician, the patient and family had not arrived at a mutually understood decision. When the patient's daughter questioned the scheduling clerk about the surgery (i.e., temporalis v. trapezius muscle? No neck resection? Only 3-4 hour surgery?), the clerk insisted that her information was correct. Up to this point, the patient had not given his informed consent.*

A solution: *We suggest that staff members be taught to entertain the possibility of miscommunication. When there is a discrepancy between the information that a scheduling clerk has and what the patient's family understands, this could prompt the staff member to check with the surgeon and ensure that she is scheduling the correct procedure.*

The problem: *Oral pre-operative instructions appeared to be incomplete.*

A solution: *Staff members who communicate important information to patients should be trained about what to say. Many physicians have developed written protocols to assist staff. In this scenario, written pre-operative instructions could have been sent to the patient in follow-up to the telephone communication.*

A day before the procedure, Sam and his family returned to the teaching hospital for pre-operative lab work, chest X-ray, and discussion with the anesthesiologist. He had not spoken to the surgeon since the initial consultation. After completing numerous forms for the facility, the patient was again greeted by an NP who began her pre-operative review, "Do you have any questions about your surgery?" to which Sam's daughter responded, "Actually, yes, we do. We're unclear where the skin flap will come from. The surgeon told us that it would probably be from the shoulder and the scheduling clerk said that it would be from the temporalis muscle off the right side of Sam's head. Also, is the doctor doing a neck resection, or not?" The NP had the same questions, as there was a contradiction between what the surgeon had dictated in his consultation report about the proposed surgery and the surgery that was scheduled. Sam was sent back to the surgeon's office.

The problem: *There appeared to be misunderstanding between the surgeon and scheduling staff as to what procedure was going to be performed. The clerical error caused Sam and his family to question the staff's competence, which reflected on the physician.*

On the day before surgery, Sam and his family again met with the surgeon for another 30-minute session. While waiting for the doctor, a physician assistant came into the room, did not introduce herself to the patient and his family, and began to give her opinion about Sam's condition and the surgery that should be performed, "We talked about you at the Tumor Board and everyone questioned why a tumor that size wasn't surgically removed before you received radiation therapy. We're going to fix that hole and take out the lymph node. No problem!"

The problem: *The PA's criticism of the radiation oncolocogist's care undermined Sam's confidence in his healthcare providers and increased his anxiety. The PA also minimized the surgical risks.*

A solution: *Discourage your staff and nonphysician clinicians from making disparaging remarks about the care provided by other practitioners. Also, an implied guarantee of an outcome could be a set-up for the surgeon if the outcome is less than desired.*

When the surgeon arrived, he and Sam discussed what muscle might be used for the skin flap; that the operation would include a neck resection; and the risk and benefits of the various aspects of the surgery.

The problem: *The patient and his family found out one day before surgery that instead of the anticipated 3-4 hour surgery, it would be a 7-8 hour procedure. The change in length of the surgery "confirmed" for the patient and his family that the wrong procedure was initially scheduled, whether or not this was true. This clerical error continued to erode the patient and his family's confidence in the physician and his staff.*

Lab work, chest X-ray and anesthesia consultation were accomplished on the pre-op day. Surgery was scheduled for the next day at 1:00 p.m. Sam was given written instructions to be NPO after midnight, have only liquid between midnight and 6:00 a.m., and not to take any anti-inflammatories such as aspirin, Tylenol, Aleve, or **Naprosyn**.

The problem: *The patient was instructed not to take anti-inflammatories, including Naprosyn. The scheduling clerk five days prior had not mentioned Naprosyn, a drug the patient took daily; the patient didn't learn of this important prohibition until the pre-op day.*

A solution: *Implement policies to ensure that patients receive appropriate, complete, and timely pre-op instructions in writing.*

The morning of the procedure, the surgeon again met with Sam and his family, as did the anesthesiologist, to review the operation and discuss what to expect. As promised, the procedure lasted seven hours, after which the surgeon spoke with Sam's wife and daughter to explain his surgical findings.

"Sam should be out of recovery within the hour," the doctor said as he disappeared through a set of double doors. Sam's family was invited to call the Recovery Department on the hospital's "white phone," which they did, only to be advised that Sam would be out "soon." Three hours later, Sam was wheeled to his hospital bed.

The problem: *The family was unable to obtain reliable information about the patient's progress.*

A solution: *Acknowledge that recovery time varies from patient to patient, it is helpful for staff to come to the waiting area and advise the patient's family of his/her progress.*

Sam spent four mostly-uneventful days in the hospital. A small group of residents visited him one morning during rounds. Without warning or explanation, one physician ripped the bandage off Sam's neck to show his colleagues the wound. No apology was forthcoming for the inflicted pain or the resident's rude behavior.

The problem: *The resident was disrespectful to the patient and needlessly inflicted pain.*

A solution: *A dignified approach would include the resident introducing himself to the patient, explaining that he would like to show his colleagues the surgical wound, and gently removing the bandages. Patients feel vulnerable when hospitalized. It is important for physicians and their staff to protect their patients' dignity and to treat them with kindness.*

On the fourth post-op day, Sam was discharged. A resident dictated the discharge summary in which he described a portion of the wound as necrotic. A nurse reviewed with Sam written discharge instructions that included wound care and a follow-up visit with the ENT; she did not mention wound necrosis. When Sam called his ENT to set up a follow-up appointment, he was denied an appointment and told to contact the surgeon, "We never see surgical patients unless they are first seen by the surgeon," he was told. After Sam's daughter placed a few phone calls to the surgeon's office, it became clear that the surgeon intended that the ENT manage Sam's wound, paying particular attention to the necrotic area noted by the resident in the discharge summary. The otolaryngologist agreed, examined Sam's neck, and assessed that there was no necrosis, only dried blood.

The problem: *Because the surgeon's office was a considerable distance from the patient's home, he thought the ENT could treat the small necrotic area on the patient's wound. However, neither the surgeon nor his nonphysician clinicians contacted the ENT to discuss the wound or to ask that the doctor manage it.*

A solution: *Communicate with other treating physicians to ensure continuity of care and decrease confusion for office staff and patients.*

This true story is offered as an example of a process that was laden with miscommunication and patient-perceived carelessness in fourteen administrative mishaps for one patient, who fortunately had an excellent surgical outcome. What happens when a patient experiences a negative result preceded by a frustrating process that leaves the patient and his/her family concerned about physician competence, convinced that "no one cares," and less than satisfied by the overall process? Many patients then seek a second opinion — from an attorney! We know that MIEC policyholders work diligently to educate their patients about medical conditions, proposed surgical interventions, and ongoing care and treatment. However, doctor-patient conversations are only some of many in which patients participate, that they must interpret, or that affect them.

Patients often have concerns they may not know how to verbalize. Instead of asking their doctors the relevant questions, patients surf the Internet, talk to family and friends, watch television, and read news articles and magazines. Failure to undergo recommended diagnostic tests, self-medicating, and failure to return in follow-up as advised may indicate lack of understanding rather than conscious non-compliance. False stops and starts, misinformation, and obvious lack of communication between professionals, all serve to undermine patient confidence and cause confusion.

Another solution: Communication tools to help your patients

The Loss Prevention staff, together with MIEC's Loss Prevention Committee Chair, have developed the attached communication tools that we believe will enhance patient comprehension about their medical care and the overall process, while strengthening the physician-patient relationship. We suggest that healthcare providers encourage their patients to ask questions. Office staff also should be receptive to questions, and prepared to provide appropriate information and guidance within the parameters of their skills and training. Doctors who help their patients navigate the sometimes rough waters of medical care also help themselves. See **Figures 1** and **2** for patient checklists.

We thank Gene Cleaver, MD, Loss Prevention Committee Chairperson, for his contribution, review, and advice for this edition of *Special Report Claims Alert.*

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Working Together: Surgery and More

(A brochure for referring physicians to give patients)

It takes your doctors ***and you*** to take good care of you.

As you know, I've recently recommended that you see a surgeon to discuss the possibility of an operation. This is a big decision for you and, as a patient, you need to take some responsibility for your medical management. This pamphlet includes some specific information that will help you work with your surgeon (and other physicians involved in your care) if you must have surgery. The process of making a decision to have an operation, scheduling the procedure, spending time in the hospital or surgicenter, and then recovering may feel like a lot, especially if this is the first time you've had the experience.

Here are some things that you can do to help yourself and your doctors if surgery is recommended as part of your care and treatment:

- ☐ **Ask the surgeon questions:** What will you do? How will the operation help me? What will my recovery be like? What types of things could go wrong? What could happen if I don't have the surgery? Make sure that your questions have been answered before you agree to the surgery.

- ☐ **Before surgery,** ask your surgeon for a pamphlet or written handout that explains the procedure or the medical condition requiring surgery and how the information applies to you personally. Written information will help you understand what the surgeon is suggesting for your care. It may also prompt you to ask additional questions.

- ☐ **Before surgery, ask for a written check list of things you need to do (or shouldn't do) before surgery.** Getting ready for surgery takes some preparation. To make sure you're ready to undergo an operation, the surgeon may ask you to get some lab work done, to get a chest X-ray, and to have an electrocardiogram (a test for your heart). Other instructions on the check list may include: not to eat or drink anything a certain number of hours before your scheduled operation; to stop taking certain medicines before surgery; to pre-register at the hospital; what time to arrive at the hospital on the day of your operation. If you have questions about the instructions, ask them.

- ☐ **Ask your surgeon how your surgical site will be marked if there is a "right vs. left" side choice.** Surgical societies strongly recommend that operative sites be indelibly marked to avoid possible injury. Some write "not this one" on the opposite side.

- ☐ **Bring a family member or friend with you** when you are having a decision-making discussion with the surgeon, and on the day of your surgery. You may be nervous or anxious about the procedure. A relative or friend can help you get answers to questions, help you understand what happens next, and help you remember the important details of what you discussed.

Figure 1

☐ **Know which doctor is in charge of your care.** If you have more than one physician, make sure you know who each doctor is, for what part of your care each is responsible, and which doctor is in charge of your care. This may change at different times in your treatment. If you are going to be admitted to the hospital, ask if a hospitalist (a doctor who treats patients primarily in the hospital) will be managing your care during your admission. Ask if you don't know or understand.

☐ **After your surgery, if you have questions, don't be afraid to ask.** You have a right to have your questions answered. It's a good idea to write them down before you see your doctor. If you have trouble remembering medical details, keep a notebook with you and jot down the answers, or ask the physician for written information.

☐ **Get clear, written aftercare instructions when you are discharged.** When you leave the hospital or surgicenter, be sure that a reliable clinician (doctor or nurse) explains your medicines, tells you when you should have your next appointment with the surgeon, educates you about your physical limitations (if you have any), and advises you what other therapies you should have to maximize your recovery. Ask for instructions in writing. Once again, it may also be helpful to ask a relative or friend to be with you when the doctor or nurse gives you this information.

Other helpful **things to consider**:

☐ **If you don't hear from your surgeon about your surgical results, call his or her office!** During your operation, the surgeon may remove some tissue (e.g., breast biopsy) and ask a pathologist examine it. The surgeon needs to let you know what the pathologist found. If no one informs you of the test results in a reasonable time, call the doctor's office and ask. Do not assume that "no news is good news!" You have a right to have your questions about your health care answered.

☐ **Decide who can speak for you if you are unable to speak for yourself.** Do you have an Advance Healthcare Directive on file with our office or the hospital? An Advance Healthcare Directive is a paper that outlines what you want or don't want to happen to you in case of unforeseen complications and designates a family member or friend to make medical decisions for you if you're unable. If you have definite wishes about a Do Not Resuscitate order, do you have one on file? Each state has laws about these things. Think about what you want for yourself, and if you wish, ask me, your surgeon, or the hospital staff to tell you how to obtain the information and the forms to fill out. These directives, made while you are in good health, help your family avoid unnecessary disputes about your health care decisions if you are unable to make them yourself.

☐ **Expect to be billed by a number of providers or services.** Anytime you undergo surgery, there are expenses involved. You are likely to receive bills from: the surgeon, assistant surgeon, anesthesiologist, pathology (lab), radiology (X-rays), and hospital or surgicenter facility. You may want to know that these charges are covered by your health insurance plan. If the plan does not cover the expenses 100%, you can ask the plan representative how much it will pay.

☐ **Please tell your physician(s) if you have questions** about your care, suggestions to improve the delivery of health care in hospital or surgicenter, or complaints about any aspect of your treatment. Your involvement and input help your medical care team give you the best care possible.

Figure 1, cont'd

Working Together: Medicines and More

(A brochure for physicians to give patients)

It takes both of us—***you and me***— to take care of you.

You've probably read that you, as a patient, need to take some responsibility for your medical management. This pamphlet includes some specific information that will help us work together for your benefit. I am your physician, and my staff and I do our best to provide you with the best medical care, but we are not perfect. Like you, in spite of our best efforts, sometimes we get too hurried, become impatient, forget something, or fail to realize that you don't understand what we've said. Because every health care decision—including doing nothing—has risk, and because human beings make mistakes, we all need to think carefully about what we do and pay attention to details. We need your help to make your health care the best it can be.

Here is a list of things that you can do to help me and my staff take good care of you when I prescribe medicine as part of your treatment:

☐ **Ask, if you have questions.** I will prescribe your medicine carefully, tell you what to expect, tell you how you should take it, tell you about the important side effects, and write the prescription so that you and the pharmacist can read it. I want you to understand your medicines.

☐ **Tell me what else you take. It's important.** I know that other physicians may be treating you for various medical conditions and prescribing medicine for you. Every time you come to my office, bring your medicines with you in a bag, or bring a list of medicines you take. Make sure to write down the name of the drug, the dose, and the instructions.

Tell me if you're taking over-the-counter (nonprescription) medicines, herbal remedies, vitamins, or nutritional supplements. These are also "medicines." You are taking them to cause a change in your body, and they may affect how your body reacts to the medicines I prescribe. If you are on a special diet, or if you use drugs "recreationally," please tell me about that, too. I need to know every medicine that you are taking so that I can make sure that the combination is not a problem.

☐ **Tell me if you've ever had a side effect or allergic reaction** to anything you have ever taken before you accept a prescription from me. **Important**: If I prescribe a medicine to which you know you are allergic, tell me! Don't hesitate to remind me of your allergies so we can make sure you get safe medicines to help you.

☐ **Tell me promptly if you develop new side effects** to any medicine, over-the-counter drug, supplement or herb.

☐ **When you pick up your prescriptions, ask any questions you may have right then.** The pharmacist might fill your prescription with a generic drug (i.e., Some health care plans have a special "formulary" for medicines. In order for the insurance plan to pay for the prescription, the pharmacist uses a medicine from the formulary—same drug, different name, less expensive—to fill the prescription.) The first time the medicine is filled, the pharmacist should give you written information about it and point out anything special about the instructions. If you have questions, ask.

Figure 2

I am counting on you to read the information page when you get home, and to keep it for reference in

case you develop problems with the medicine in the future. If there is a difference between what I told you and what the pharmacist tells you, please call my office. Leave a detailed message with my staff, which they will give to me when I am not with patients. One of us will call you back to make certain you have the correct instructions to take your medicine safely.

☐ **Use a measuring spoon or measuring device for liquid medicine** (you can find one at your pharmacy) instead of a kitchen spoon.

☐ **Let me know how your medicine is working.** Medicines should work in the time frame you and I discussed with no more than the expected side effects. If the medicine doesn't help you or you experience extreme side effects, call my office. Don't worry about bothering me or my staff, and don't wait until your next visit.

If the medicine worked, make sure to tell me about it at your next scheduled appointment. If you do not have an appointment scheduled, call the office to let me know that the medicine did the job (except if it was for a brief illness like a cold, when we expect you will recover promptly). It is important for me to know, and document in the chart, your response to medicine.

☐ **When you refill your prescription, carefully check what you are getting.** If you changed the pharmacy (or HMO) where you get medicines since you first received your prescription, the pills may look different when you get a refill. First, look carefully at the label and what you are given. Make sure that the medicine name, dose, instructions and amount are the same as your original prescription, unless we have discussed a change in advance. **If you have any question about the refill**, ask the pharmacist.

Other helpful **things to consider**:

☐ **If you don't hear from my office about your test results, call us!** If I sent you for a special test (or X-ray, or lab work), do not assume that "no news is good news!" If no one informs you of the test results in a reasonable time, call the office and ask for the results. My assistant or I will get you the information you want. You have a right to have your questions about your health care answered.

☐ **Decide who can speak for you if you are unable to speak for yourself.** Do you have an Advance Healthcare Directive on file with our office or the hospital? An Advance Healthcare Directive is a paper that outlines what you want or don't want to happen to you in case of unforeseen complications and designates a family member or friend to make medical decisions for you if you're unable. If you have definite wishes about a Do Not Resuscitate order, do you have one on file? Each state has laws about these things. Think about what you want for yourself, and if you wish, ask me, your surgeon, or the hospital staff to tell you how to obtain the information and the forms to fill out. These directives, made while you are in good health, help your family avoid unnecessary disputes about your health care decisions if you are unable to make them yourself.

☐ **Please tell me if you have questions** about your care, suggestions to improve the delivery of health care in my office, or complaints about any aspect of your treatment in my office. My staff and I appreciate being part of your health care team.

Figure 2, cont'd