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- 4 Personal accountability for effective working relationships
- 8 Resistance to relationship skills
- 13 Survey—Is everyone on board?

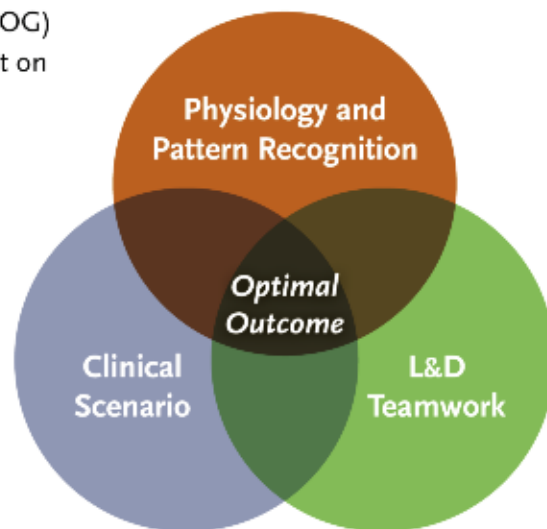
A review of obstetrical lawsuits seen by Medical Protective confirms that inadequate communication is as much a cause of patient injuries as difficulties in the provision of clinical care during labor and delivery.

In response to this conclusion, Medical Protective is pleased to offer an educational resource to help doctors improve perinatal safety. Advanced Practice Strategies (APS) courses address many of the issues involving both mothers and infants in obstetrical cases.

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To learn more about this patient safety resource and to register for this online coursework, visit our website at www.medpro.com, click on Physician Coverage, and then click on the APS button.

About APS. In 1993, APS began working within the Harvard system to support malpractice defense teams by creating visual strategies to educate the lay jury about the complexities of medical care. More recently, they have leveraged this courtroom success and applied the lessons learned there to develop online patient safety education for physicians and nurses. Their goal is to provide effective, engaging patient safety education that empowers caregivers to improve their practices.



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Dear Medical Protective healthcare provider:

Every year the Medical Protective Risk Management Department receives more than 15,000 phone calls from physicians and dentists who are concerned about potential liabilities in their practices.

Many of these doctors believe that problems they are having with their patients arise out of clinical issues. Discussions with risk management consultants tend to reveal that the problems are more often the result of ineffective relationships between doctor and patient or between doctor and staff.

Lack of relationship training can sour not only the doctor-patient relationship but hampers communication among members of the healthcare team. When staff and employees are unwilling or afraid to ask questions, voice concerns, and point out flawed processes, the whole practice is at risk. Lack of receptivity to a team philosophy can foster hostility, frustration, and inefficiency throughout the clinical team. Its effects often extend beyond the individual person who made the error. When staffers are unable to speak about their concerns or to make recommendations, patient injuries may increase – and so might the likelihood of litigation.

In this issue of *Protector*, we examine relationship errors that lead to lawsuits. And we examine ways in which relationship skills can help doctors and those they work with to prevent these high-risk behaviors from occurring.

We welcome the opportunity to hear your own experiences and thoughts on this important subject.

Sincerely,



Kathleen M. Roman
Editor



Protector is published three times a year by Medical Protective as a risk management service to insured physicians and dentists.

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Please share with us topics you would like to see addressed in *Protector*. Send your questions, topic suggestions and comments to:

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Your valuable input helps us to ensure that this risk management publication is useful to its readers. Thank you for your contributions. Contributions from named authors represent solely the view of those authors.

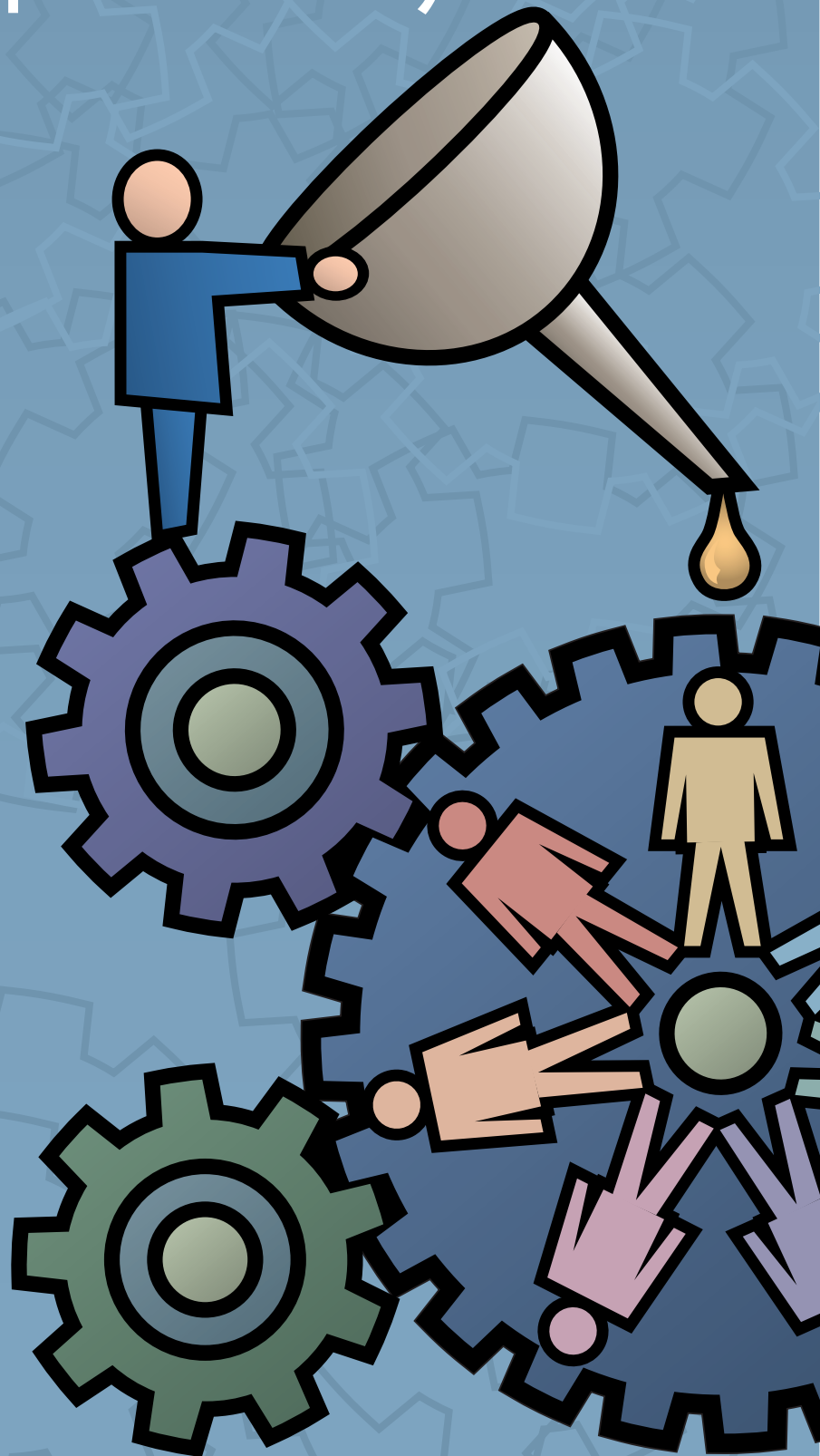
Personal accountability for effective working relationships: A critical component in patient safety

Doctors too often see themselves as the sole purveyors of healthcare. They provide medical care or dental care and sometimes forget that others also share responsibility for what happens to their patients. However, Quality and Performance Improvement research can no longer be ignored. From at least the 1950s, respected experts, beginning with Deming and Duran, have concluded that humans cannot succeed in group activities unless they are willing to work in organized teams.

In recent years, more and more research has generally shown that healthcare has more similarities to manufacturing than differences. And, one of the most consistent messages coming out of quality-focused research is that people cannot work in a vacuum—especially in high risk environments such as healthcare.

For physicians and dentists, personal accountability extends beyond the individual activities of diagnosing and treating patients. Personal accountability requires that physicians and dentists must also see themselves as coaches and mentors and educators. Some doctors reject this school of thought. A Medical Protective insured once said, “I can be a good doctor or I can stand around all day and sing ‘Kumbaya’ with my patients, but I can’t do both.” He missed the point. He was equating good clinical care with technical expertise. He wasn’t holding himself accountable for the human give-and-take that turns a clinical technician into someone who heals patients.

Here’s an example. Recently, a well respected surgeon performed a total knee replacement—on the wrong knee. How did it happen? Two knee replacements were



scheduled for the same morning. At the last minute, the 9:00 a.m. right knee surgery was cancelled because that patient had come down with the flu. The 11:00 a.m. surgery was rescheduled and the “left” knee patient was prepared for surgery. The surgeon was in a hurry. He instructed the nurses that he wanted to start “on time” even though, technically speaking, this patient’s surgery was starting nearly two hours early. His expectations pressured the nurses who were prepping the patient and the nurse anesthetist. As anyone with surgical experience knows, a Time Out should be performed prior to the beginning of any procedure and requires the presence of the entire surgical team—including the surgeon. In this case, the nurses felt compelled to complete a Time Out before the surgeon entered the operating room.

Nonetheless, the surgery was initiated and it wasn’t until they discovered that the patient’s right knee was healthy that the error was noted. When discussing the matter with a Medical Protective risk management consultant, the surgeon attempted to rationalize the error by blaming the nurses for failing to do their jobs correctly. In short, he didn’t see himself as part of a team; he saw himself as someone who had been put upon by an incompetent staff.

This is the kind of case that never should have happened in the first place. The surgeon was at fault for failing to follow his hospital’s Time Out protocol and for not allowing his team members to do their jobs in an effective manner. The nurses and anesthetist were also at fault for allowing themselves to be manipulated into a situation in which a patient was placed at risk. Anyone could have said, “Doctor, we need to review this case before we get started.” Regardless of his response, the other members of the surgical team should have insisted on getting it right.

The hospital may also have been in the wrong if it consistently allowed its medical staff to ignore policies and procedures that had been designed to protect patient safety and ensure consistency in the way that medical care is provided.

The above example is useful because it shows how three levels of care failed to prevent a completely preventable injury. This wasn’t clinical negligence. It was caused by one individual refusing to see himself as part of a team and acting in a manner that can only be classified as bullying.

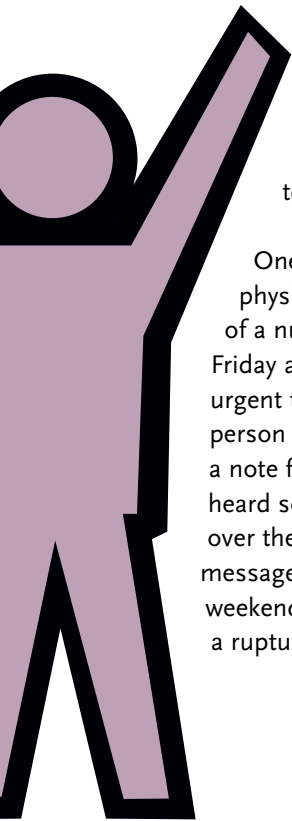
From a risk management perspective, doctors need to remind themselves that the “irritating” person who insists on reconfirming an order, or who wants to review a treatment plan, may be the doctor’s best ally. It is such individuals who may prevent a catastrophic outcome and a malpractice lawsuit that names the doctor—rather than other members of the staff—as the cause of a patient’s injury.

While much of the media focuses on lack of effective communication in hospitals, these same teamwork flaws also occur in medical and dental offices all the time.

In another case, a dentist called a risk management consultant to report that he was in a dispute with a patient who wanted him to pay for several thousands of dollars of additional dental work. During the course of the discussion, he was asked if the patient had signed an informed consent document that specified the exact nature of the original treatment plan. “Well, I thought there was a signed consent, but my stupid ‘girl’ didn’t get one.” This statement provides an opportunity for significant risk management analysis.

Obviously he was blaming his assistant for a duty that is, in many states, both legally and ethically solely his own. So, if he doesn’t personally obtain informed consent from his patients, he is delegating his obligation to someone who may be compelled to act outside the scope of her training—exposing himself to possible disciplinary action.

His comment also shows a possible lack of good business process in his office. Setting aside the question as to whether or not a staff member should be obtaining consent, how did it occur that she didn’t follow a formal process for documenting the patient’s consent? What kind of training and oversight does this doctor invest in his staff? Why didn’t he check the patient’s record before commencing any treatment? He assumed but did not confirm that everything was in order.



And finally, the dentist's disrespect for a fellow healthcare professional (for this is how he should see his staff) and the dismissive referral to her "stupidity" shows a lack of accountability for his own actions and for his obligation to be the leader of his team. The team can't follow if the leader won't lead.

One final case example occurred in a family physician's office—but it could have occurred in any of a number of medical specialty practices. On a Friday afternoon a radiologist called to report an urgent test result for one of the doctors' patients. The person taking the call, a new receptionist, merely left a note for the doctor who'd ordered the test. She'd heard someone mention that he might be in the office over the weekend and assumed that he'd get the message. The doctor did not come into the office that weekend and the patient died on Sunday afternoon of a ruptured aneurysm.

Everyone who works in healthcare must acknowledge the duty to prevent injury to others. Whether the individual is a highly-trained physician or dentist—or an inexperienced receptionist—the nature of the job requires adequate training to ensure that any member of the team will take action when he or she sees anything that may pose a risk to patients. It's imperative that staff education and oversight of new employees prevent them from being "turned loose" until it is clear that they have made a sufficient commitment to the trust they have earned and until they have mastered the skills necessary for their duties.

Conclusion.

Regardless of an individual's status or seniority, anyone associated with a medical or dental practice must be willing to stop the process in order to confirm the appropriate next steps in patient care. No one should be exempted from this obligation. Training is essential to success. Those who cannot or will not accept the importance of this policy may not be suited for work in a healthcare environment. ■

Medical Protective's Risk Management Self Assessment

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Assessing risk is the first step to *reducing* risk in your practice. Medical Protective wants to help you determine what steps you could take to reduce your risk by offering all insureds a FREE online risk assessment.

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2. Type in your policy number.
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Upon completion of the assessment you can be entered into a drawing for a \$15 gas card.

Your results will be kept anonymous and separate from the drawing entry. Deadline to be entered in the raffle is June 15, 2009.

Risk Management List of “Excuses” for Lack of Personal Accountability

Following is a list of excuses that have appeared in depositions of many Medical Protective malpractice lawsuits over the years. When they occur in conversation in a medical or dental office, they are danger signs.

“It isn’t my job.”

In healthcare, patient safety is everyone’s job. Anyone who can’t be convinced of this is right—it shouldn’t be their job any longer.

“I didn’t ask her to confirm the dose because she gets angry when I do.”

Organizational policies should require willing cooperation with requests designed to ensure patient safety. Individuals who refuse to comply with these policies are a threat to patient safety and to the reputation of the staff and organization. Anyone who has a leadership role is also a teacher. That includes the process of education, oversight for correct implementation of learned skills, reinforcement of the need to use those skills appropriately, and interventions that may include reminders and disciplinary action, if necessary.

- *This information can be used as the basis for a team-building exercise. It can also be constructive during review of existing human resources policies and procedures. It may help re-train or re-educate those who are resistant to change.*

“It was one of those days when we were all in a big hurry.”

Being in a hurry is not an excuse for errors. In fact, quality training experts advise that the best response to being rushed is to purposefully slow down. This may include an entire group’s decision to catch their collective breath, review the situation, and reconfirm their proposed actions. Individuals or groups who are consistently pressured by lack of time or shortage of staff may face significant quality of care liability since a number of expert organizations have reported that errors increase proportionately as resources and time dwindle.

“This will teach him a lesson.”

Hidden agendas, refusal to cooperate, antagonism, and the desire for revenge are signs of serious problems in any organization, from the smallest dental practice to the largest surgicenter. Doctors who understand the importance of leadership try to reinforce a culture of cooperation and openness. It is unrealistic to attempt to build an organization in which differences of opinion will never occur or disputes are preventable. Rather, occasional debates may actually improve the quality of the organization. What is important is to provide methods that individuals can use to work through disagreements and to invest in solutions that are respectful to all—and beneficial to the quality of care.

“You do it your way and I’ll do it my way.”

Rather than focusing on the right to maintain one’s individuality, members of any healthcare team should actively and continuously seek best practices that improve consistency and accuracy of process while ensuring the safety of staff—as well as of patients. A practice is much more likely to be exposed to liability when some members of the team—and this may include doctors—resist opportunities to reduce variation and to provide commonality in the way that various processes are enacted.

“I don’t like her.”

Medical and dental offices aren’t sororities. Cliques and social ostracism are both immature and unprofessional. Human resources policies and procedures should require courtesy and cooperation. Members of the healthcare team don’t have to be best friends but they do have to be able to work together to effect positive outcomes on behalf of their patients. Disciplinary consequences should follow when efforts to reeducate employees about the importance of team support have failed.

Resistance to relationship skills: Why is this so difficult?

Medical Protective doesn't dictate the standard of care for medicine or dentistry. But because of its national presence, the company is in a unique position to comment on factors that trigger malpractice litigation.

When those factors are clinical in nature, we warn doctors about them and pass along recommendations and advice from respected clinical leaders and from risk management experts. The feedback on these initiatives is usually very positive.

Things become complicated, however, when litigation results from the inability or refusal of members of the healthcare team to work together. Patient injuries that occur because of team dysfunction may sometimes include clinical negligence but can just as easily be caused by ineffective communication alone.

Physicians and dentists, rigorously trained in hard science, sometimes become uncomfortable when confronted with data that shows that doctors who don't work well with others are more likely to be sued—even when their clinical skills may be sound. In fact, defense attorneys who serve as guest faculty at Medical Protective risk management seminars, often point out that doctors who cannot maintain effective working relationships with other members of the medical or dental team may inadvertently sabotage acceptable clinical care.

This discomfort level is often accompanied by resistance to an increasingly validated theory that good healthcare is the result of good teamwork. One expert whose work is contributing to this knowledge is Pat Ebright, RN, DNS, Assistant Professor of Nursing and Clinical Nurse Specialist for Indiana University Purdue University School of Nursing in Indianapolis, IN.¹

In her research, Dr. Ebright has come across numerous examples of cross-wired communication between members of various healthcare teams. She thinks that there are several reasons why this is such a high risk area for patient safety.

Speaking doesn't necessarily equate with communication. Many healthcare professionals today have received little or no formal training in communication skills. They often don't understand the different roles of leaders. For example, a fire chief at the scene of a fire models an authoritarian leadership style in which one person gives orders and subordinates obey. While questions or information may be routed to the chief, his primary duty is to ensure that every aspect of the plan of attack is carried out. The surgeon may follow a similar leadership role while directing the efforts of a surgical team.

However, once the fire is over, the fire chief may engage in collegial consultation with other members of his team and he may use education, instruction, mentoring, and consensus-gathering techniques to get buy-in and compliance among his team members. In this scenario, the fire chief, acting as a teacher, takes a more collaborative leadership role.

In the same way, the surgeon will want to use a different approach if a rookie nurse asks him to confirm or explain a medication order. In this leadership model, the surgeon has the opportunity to build a more effective working relationship with a fellow healthcare professional by educating the nurse about the particular drug or dosage.

Most doctors have been influenced by teachers they studied under or with whom they have worked. As teachers and mentors, physicians and dentists have great sway over their students. While most medical and dental schools offer some level of communication training, Dr. Ebright believes that doctors are more likely to follow the examples of their teachers. "Communication skills include not only the ability to give directions, but also to engage in difficult conversations in a way that supports the quality of care," Ebright says. "That means not just the ability to work with the patient and the patient's family. It also means interacting in a positive way with anyone who is also involved in the patient's care." This approach

1. Dr. Ebright's research has focused on workload complexity in healthcare environments and how it impacts the quality of care. In addition to her doctorate in nursing, Ebright has also completed fellowships in Patient Safety Leadership, sponsored by the national Patient Safety Foundation and in Informatics with the Roudebush Veterans Administration in Indianapolis.



Patricia Ebright DNS

needs to be implemented in medical and dental offices as well as in hospitals. “We need to teach these skills throughout the curriculum, not just in a one-semester course. And, we should expect that students will learn them and use them,” Ebright says.

Access to resources is important. “It’s also important that every member of the healthcare team be able to access the necessary materials, supplies, and resources whenever they need them.” Ebright says. Trying to find missing equipment or medicines or supplies can harm patients. This challenge includes staffing shortages, as well. Overwork is a physical and emotional stress that may trigger the human fight or flight elements of the brain. “Some organizations may give lip service to teamwork but that doesn’t help if everyone is exhausted and bickering.”

“Sometimes we invest in the ‘magical’ solutions because they’re big and expensive and they get lots of attention,” Ebright says. “New technology may not be the solution—or it may be only part of the solution. An administrator may tell you that they don’t have the

“Communication means not just the ability to work with the patient and the patient’s family. It also means interacting in a positive way with anyone who is also involved in the patient’s care. ... We need to teach these skills throughout the [medical, dental, nursing curricula], not just in a one-semester course. And, we should expect that students will learn them and use them.”

budget to invest in relationship skills training. But that same person may turn around and spend a fortune on a new piece of equipment or software without batting an eye. Without the team’s ability to work together, that new technology may make things even worse—especially if [the group] hasn’t done a risk assessment to find out how that equipment will change the way they interact with each other or with patients.”

Dysfunctional communication has financial implications too. The Joint Commission warns that disruptive behavior has a negative effect on patient safety and suggests that healthcare leaders formalize steps to hold every member of a healthcare team accountable for learning and modeling behaviors that are consistent with a code of conduct.² It has also been suggested that employee turnover is considerably higher in medical or dental organizations where disruptive behavior or lack of collegiality are tolerated.³

Increasingly, hospitals and large healthcare organizations are changing their medical bylaws and human resources policies and procedures to hold every employee accountable for the success of patient care. For example, the University of Michigan Health System has published an on-line *Patient Safety Toolkit*. In it, the authors point out the complexity of healthcare and the need for “many hands” in order to achieve good outcomes for patients.

The toolkit, which is available to all who comply with its copyright statement, would make an

excellent resource for physicians or dentists who are trying to develop policies and procedures for their own practices. It can be accessed at www.med.umich.edu/patientsafetytoolkit/.

Unacceptable behavior includes environments in which lax processes aren’t addressed

and there are no consequences for disruptive behavior, rudeness, or agendas that, even inadvertently, undermine the organization’s mission statement. Investment in teamwork may be the best money a medical or dental practice can spend. There is hard data to show that excellence cannot occur in an organization that perceives its people as a ‘problem.’⁴

2. Powers, K. Rude Language, Hostile Behavior Threaten Safety, Quality. Joint Commission Alert: Stop Bad Behavior among Health Care Professionals. July 09, 2008.

3. Nurse and Employee Perspectives on American Health Care: Check-Up Report 2007. Press Ganey.

4. Hansen L. The Architecture of Safety Excellence. Professional Safety Management. 2000;45:26-29.

Few medical or dental offices can afford to lose well-trained and team-oriented staff. Yet numerous studies have shown that disruptive behavior and unresponsive administrators, are among the top five reasons why employees leave healthcare groups.⁵ Aside from the increased potential for error when a practice is understaffed, morale suffers when good people leave. And, it should be remembered that—especially in tough economic times—excellent employees will be the ones most likely to be able to find new jobs.

From a purely financial perspective, high employee turnover is a significant drag on a medical or dental practice's stability. According to one study, the loss of an employee can be conservatively estimated at 150 percent of that employee's annual compensation.⁶ For administrators and supervisors, that amount can rise as high as 250 percent of annual compensation.⁷ And that doesn't take into account the "trend risk" that occurs when one or two highly-respected employees leave and others decide to follow. A resource for calculating the losses associated with turnover in the healthcare field can be found at WorkForce One.⁸ In an example, the worksheet calculates the loss to an organization in the Denver/Boulder area when a registered nurse leaves a practice. The calculator predicts a loss of \$32,226.

Ignoring employees' concerns may have deeper financial implications. Recently, Stanford Hospital & Clinics of Palo Alto, CA announced that it had saved more than \$14 million in one year, merely by asking its employees where they could save money without downgrading patient care. Administrators reported that the savings was only one benefit of the initiative. Claiming to have changed their culture, the organization anticipates significant future savings—as well as other benefits for improved patient safety that will be proposed—because employees believe that their leadership will respond to their ideas and suggestions.⁹

Conclusion. Healthcare has become increasingly complex. Regardless of the practitioner or of the treatment, success relies on the efforts of a team. Physicians and dentists need to take into account the contributions of other members of their respective teams. Just as they seek to improve their clinical skills, doctors must also improve their ability to work effectively with colleagues, subordinates, and other parties who may be only peripherally involved in their patients' care. Failure to take this important skill into account is detrimental to patient safety, to the effectiveness of the healthcare team, and to the risk management abilities of medical and dental practitioners. ■

5. Op cit. Press Ganey.

6. Bliss, W.G. Cost of Employee turnover. The Advisor. www.isquare.com/turnover.cfm.

7. Ibid.

8. Keep Employees, Inc. 2000-2004. www.keepemployees.com/healthcare3.htm.

9. How to Save \$14 Million? Stanford Hospital & Clinics Asks and Its Employees Speak Up. www.stanfordhospital.com/newsEvents/newsReleases/2008/employeesSpeakUp. June 10, 2008.

Healthcare cannot be

Regardless of clinical skills, no physician or dentist can safely care for patients without the support and contributions of clinical, administrative, and clerical team members.

Opportunities for dysfunctional team communication are just as prevalent in medical and dental offices as they are in hospitals. With the increase of outpatient services, ambulatory care facilities (including dental practices) will be subjected to greater scrutiny. Communication breakdowns should be identified, tracked, and analyzed with an eye toward culture change and patient safety. Regulatory bodies require hospitals to monitor communication problems and to develop policies and procedures that address them. Medical and dental offices face the same challenges and liabilities.

Here are some examples culled from Medical Protective closed claims. Note that all of these lawsuits were triggered by behaviors that took place in medical or dental offices—not in hospitals.



successful in a vacuum

Case A—Ethical and legal duties.

A pediatrician treated a child who exhibited clinical and behavioral signs of physical abuse. Questions asked of the child's mother heightened suspicion that the child was in danger. The nurse, who also happened to be the pediatrician's wife, wanted to call protective services. For reasons that may have had to do with the child's family's social standing, the pediatrician decided to delay. He also ordered his wife not to call the authorities. Her compliance with this instruction placed her in violation of her own ethical and legal duties. Two weeks later the child was admitted to the hospital where he died of third degree burns. Shortly thereafter the police arrested the mother. Both healthcare providers were sued by the child's estate. Both were disciplined by their respective professional boards. The lawsuit was settled out of court.

Case B—Violation of clinical standards.

A dentist undertook a lengthy procedure on an obese diabetic patient. Three hours into the procedure the patient began to have trouble breathing. Unable to stabilize the patient, the dentist had his staff call EMS. The dental assistant confessed to the dentist that she had "forgotten" to take the patient's blood pressure before the procedure and again during a rest period midway through. The dentist told his employee to "fix it" and that he didn't want to "hear any more about it." The assistant entered false readings into the patient's record. The following day the patient died of a heart attack. The remorseful assistant called the dental association and reported what she had done. The dentist was sued. The dental board suspended his license. The local prosecutor attempted to bring criminal charges against the dentist but this was overruled on a technicality. A professional liability lawsuit filed by the patient's husband was settled out of court.

Case C—Personal agenda trumps patient safety.

A patient called his physician's office during the day and reported that he had pain in his belly. He was seen in the doctor's office that afternoon and was referred to the office of a surgeon who ordered a CT. Later in the day, the surgeon's office received a report that the patient had a stone blocking his ureter. The surgeon's staff assumed that the patient would be instructed to go to the hospital.

The surgeon, who had plans for the evening, instructed his staff not to call the patient or to pass the test result along to the patient's PCP until morning. By the next morning the patient was critically ill. He was admitted to the hospital but lost both hands and feet as a result of sepsis. The PCP and surgeon were both sued.

Case D—Consistency is critical.

A multispecialty medical clinic hired a new administrator. She sought to update policies and procedures. The founding doctor, nearing retirement, refused to use a written informed consent stating that he'd never needed one before because his patients "trust" him and the idea of signing a consent form would "scare them." He belittled the practice administrator during a staff meeting and became so argumentative that the other doctors backed down—even though they supported the administrator's recommendations. Less than a year later, the senior doctor and the corporation were sued by a patient who denied that he had ever been warned of the possible complications associated with his treatment. The defense could not verify that consent had ever been obtained. Practice morale plummeted and several physicians broke away to form a new competitor group. The treating physician insisted on a jury trial—and lost. The original group's insurance premiums were increased and continued coverage was contingent on the group's completion of risk management education.

Case E—Standard of care crosses professional boundaries.

The patient, who had cancer, needed extensive oral surgery. The dentist left a message for the patient's oncologist asking for a return call so that they could discuss the patient's treatment plan. The physician did not return the call. On the morning of the scheduled appointment, the dentist once again called the physician's office. He was transferred to a nurse who said that it was the oncologist's policy not to return calls unless he wanted to suggest a different treatment. "You're good to go," the nurse said. The dentist completed the treatment—which was successful; however, three months later the patient was diagnosed with osteonecrosis of the jaw and eventually had to have part of her jaw removed—resulting in scarring, paralysis, and pain. Both doctors were sued.

Note: Thank you to Medical Protective Senior Clinical Management Consultants Gail Harris and Ted Passineau, for submitting some of the cases used in this article.

Your communication process with your patients includes informed consent



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- The leading informed consent and patient education application
- Employed in over 175 hospitals and in thousands of physician practices in all 50 states
- Reduces risk
- Saves time
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- Enhances safety
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- Lowers costs

“Medicine, just like any other service industry, is all about expectations. In my practice, the Informed Consent document is a dialogue starter and discussion outline between the patient (and family) and me. These printed pieces of paper help to spell out what the patient can expect – explain their condition, what will happen in the procedure, the treatment options, and the consequences. Because physicians give this information early (not thirty minutes before the procedure), patients can take this information home with them, review it, share it with family, digest it, and understand what choices they are making. Unfavorable outcomes and complications are received much better by patients and their families who know what to expect when there has been detailed and well-documented communication beforehand.”

James Gottesman, M.D., practicing urologist, Seattle, WA, founder of Dialog Medical and a Medical Protective Insured for 14 years

Dialog Medical's iMedConsent™ application enhances the education, discussion and documentation associated with the informed consent process. The iMedConsent™ application produces procedure-specific consent forms for all relevant treatments and procedures performed in a given medical specialty. The iMedConsent™ application also includes patient education documents and an extensive image gallery. Trusted by more than 15,000 physicians and in over 175 hospitals, this novel solution is integral to efforts to manage risk, standardize communication, comply with regulatory requirements, lower costs, and better document informed consent encounters.

Medical Protective has teamed up with Dialog Medical. **Medical Protective insureds receive a special 30% discount on the iMedConsent™ PE application.** To learn more about this application please contact Dialog Medical at 1-800-482-7963 or visit us at www.medpro.com, click on Physician Coverage, and click on the Dialog Medical section.

Is everyone on board? Are you sure?

Regardless of the type of medical or dental environment, doctors know that people can be more effective if they see themselves as part of a team. In many busy offices, however, the demands of time and money often take precedence over the tangible and intangible resources that staff members need in order to do their jobs.

One of these resources should be a cultural mindset that any member of the team can, and should, question any activity that does not seem to be effective or that is unclear. In numerous studies about team effectiveness in healthcare,

respondents state that their concerns are sometimes ignored or abruptly dismissed. When asked about the effectiveness of team communication in their offices, physicians and dentists may be the last to know when things aren't going well.

In order to help develop a clearer picture of staffers' perceptions about their ability to give feedback or ask for guidance, the following quiz may serve to identify some opportunities for improvement. The quiz should be administered with complete anonymity and in the spirit of improved team effectiveness and patient safety.

	USUALLY	OCCASIONALLY	SELDOM	NEVER
1. Leadership of our practice invests in education and training that enables all of us to improve our relationship-building skills.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Our practice fosters a learning environment in which new skills are expected to be mastered and used for the benefit of our patients and our team.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Our leaders serve as good role models for courtesy and professionalism in the way we address misunderstandings and differences of opinion.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. In our practice, it is assumed that any of us can (and should) speak up if any aspect of patient care or service is in question.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I am confident that my supervisor and practice leadership support anyone who reports a concern or problem. Our team uses these reports to help us improve our clinical quality, our customer satisfaction, and our own morale.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I feel comfortable that I can share my concerns or questions in any situation that involves a superior or leader and that the response would be courteous and productive—regardless of whether or not my ideas are implemented.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Our leadership is willing to experiment with new ideas—and no one is “punished” if they fail.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I feel confident that my peers or subordinates would tell me if they thought I was making a mistake.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Safety initiatives occur as a result of a team effort and address technological as well as human work factors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Our education budget always includes opportunities for team members to enhance their communication skills (e.g., dispute resolution, service recovery, team building, leadership training, etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Regardless of anyone's status or seniority in our practice, we consistently try to help each other strive for a professional working environment where we can still ask questions, challenge, even disagree—but in a way that is respectful to all, for the sake of our patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

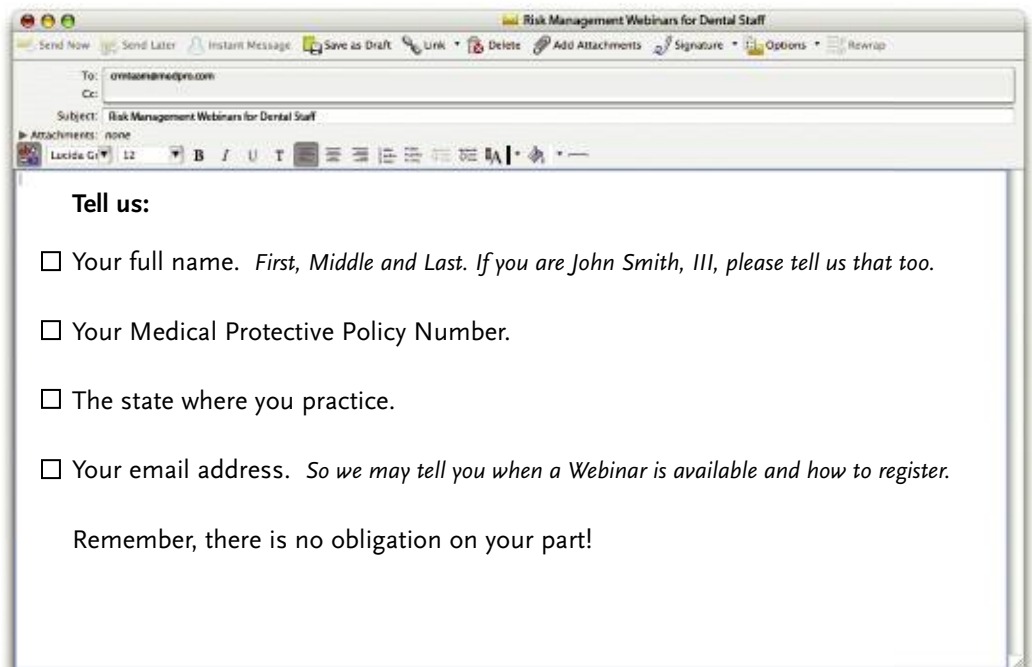
Once you have tallied the results of the survey, you may identify areas of excellence, as well as areas that you would like to improve. Feel free to contact your Medical Protective risk management consultant for ideas on how you and your team can tackle these concerns.

Dentists: Tell us what you think! Vote here for free risk management webinars for dental staff.

Your employees are either your best assets—or your worst liabilities. Dentists who know the importance of teamwork provide their staffs with opportunities to learn and grow professionally. Here is a chance for your staff to increase their knowledge about important risk issues like patient safety, documentation, dispute resolution, professional communication, etc.

Medical Protective webinars are free. They run for one hour, generally around lunchtime. They require an Internet hookup and a telephone line. Each program includes a printable PowerPoint presentation and doctors and their staffs are encouraged to use these presentations as the basis for further discussion and action once the program is over. Faculty for these programs is typically a member of the Medical Protective risk management team. Every program includes a live question and answer session so participants can ask questions.

If dentists tell us that they are interested in these programs, then Medical Protective will offer its first dental staff webinar this year. If you think this is an opportunity that would help you and your staff, use the checklist above to give us your “vote.” **By the way, voting for webinars does not obligate you or register you for any program.** We just want to know if there is sufficient interest and if so, we'll get to work!



Tell us:

- Your full name. *First, Middle and Last. If you are John Smith, III, please tell us that too.*
- Your Medical Protective Policy Number.
- The state where you practice.
- Your email address. *So we may tell you when a Webinar is available and how to register.*

Remember, there is no obligation on your part!

*To vote for Risk Management Webinars for Dental Staff
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