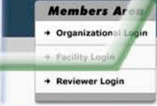

THE SULLIVAN GROUP

TSG NEWSLETTER

SAVING LIVES - REDUCING RISK

From The Editor

I have to admit that I had some healthy skepticism regarding the Disclosure & Apology movement until I hosted a panel on the subject at the 2012 ACEP Scientific Assembly (SA). The bottom line before that time was that I basically did not know enough! Like so many other physicians, I felt that apologizing to a patient was simply a ticket to litigation and no way was I going there. After researching Disclosure & Apology and working with an incredible panel for the SA presentation, I was a convert. The literature is now very convincing regarding the effectiveness of early reporting, intervention, transparency, reduction in lawsuits, and lives changed by a more human and reasonable experience.

As a result, The Sullivan Group has partnered with a leader in this field, Mr. Doug Wojcieszak, the founder of Sorry Works! We are working with Doug to help get his message out there; we now offer two new online Disclosure & Apology courses for front-line clinicians and managers. Doug is a man on a mission; he has a burning passion to make the world a better place through the disclosure process following the death of his brother from medical error followed by an incredible series of miscommunications and mismanagement with Doug's family. I hope you have an interest in this incredibly important subject and can avail yourself and your organization of Doug's teaching, services and online education.

The Sullivan Group's (TSG) mission is to reduce risk and

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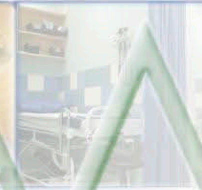
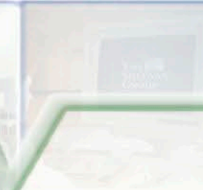
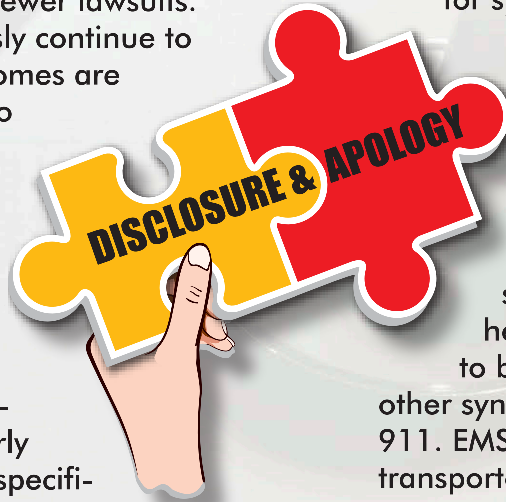



medical errors resulting in improved patient safety and, as a result, fewer lawsuits. However, errors obviously continue to occur and adverse outcomes are sometimes inevitable. So Doug fills in a key piece of the puzzle that TSG had not previously addressed; with his Disclosure & Apology education, it is a wonderful fit and a great relationship. I welcome you to our quarterly newsletter with a focus specifically on Disclosure & Apology.



The case reviewed in this newsletter actually came to me from my friend Michael about a recent medical experience. One day Michael stopped by our home; he was visibly shaken and asked if he could speak to me about a medical event that involved his father. He and his family were completely baffled as to how to handle the situation. This is an incredible story. I asked Doug if he would provide some teaching moments at key points along this narrative. They are highlighted in the ***"D.W. Teaching Moment"*** references. ■

The Medical Event

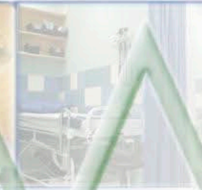
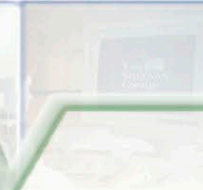
Mr. Cross is 75 years old and in remarkably good health. Prior to the events that are the subject of this issue, his only significant past medical history was a series of syncopal episodes attributed to vasovagal incidents. His prior cardiac and neurologic workups for syncope were negative.

About four months ago at approximately 8:00 pm on a Friday evening, Mr. Cross had a syncopal episode. He fell to the floor and slowly began to regain consciousness. His wife noted a small bruise and cut on his forehead. His return to normal seemed to be taking a little longer than his other syncopal episodes, so his wife called 911. EMS arrived within 15 minutes and transported Mr. Cross to the closest hospital.

When EMS arrived, Mr. Cross was awake and alert. On the 40-minute trip to the hospital in this farming community, the paramedic communicated to the emergency department (ED) that the patient had a syncopal episode, fell and hit his head. The initial blood pressure taken by the paramedic was 88/60.

The hospital ED staff called a trauma alert before the patient's arrival. On arrival the nurse took a full set of vital signs:

BP	Pulse	Resp
92/60	96	20
afebrile		

THE SULLIVAN GROUP

NEW e-Learning Courses

Emergency Medicine

- Documentation Guidelines: Requirements for Reimbursement Emergencies
- Pediatric Seconds-to-Minutes Emergencies, Part 2

Patient Safety & Risk Management

- Handoffs, Transitions & Discharges: Key Moments in Patient Care *(updated with videos added)*
- Information Security Tips for Healthcare Professionals
- Workplace Violence in the Healthcare Setting

Click on the course name to see the course description.

Client Support

The Client Services staff is available for one-on-one support calls Monday-Friday 8:00 am – 5:00 pm CST

Phone: **630.268.1188**
Toll free: **855.RSQ.INFO** (777-4636)
E-mail: clientservices@thesullivangroup.com

IT e-mail support is available **24/7**
E-mail: support@thesullivangroup.com

Mr. Cross was awake and alert and in no distress. He was resting comfortably on the stretcher and talking to the nurses when the trauma team arrived.

At the direction of the trauma team, the nurse drew blood for a *trauma profile*. Prior to speaking with the patient or his family, the trauma physician sedated and intubated Mr. Cross and set up for the insertion of a central line, intending on using the internal jugular (IJ) on the right side. He began the procedure and hit the right carotid artery, which bled profusely before the bleeding was controlled. The physician then switched to the left IJ, which he successfully cannulated; he then ordered a bolus of 20cc/kg of normal saline.

There is a series of vital sign measurements that were automatically obtained and recorded in the electronic medical record. Twenty minutes after arrival and before the fluid infusion, Mr. Cross had a blood pressure of 130/84 and a pulse of 80. After his

initial non-hypotensive BP, his vitals stayed stable and within normal limits throughout his hospital stay. There was not a single hypotensive blood pressure.

While all of this was happening, Mrs. Cross was in the waiting room constantly asking to see the treating physician in order to provide her husband's medical history. She was told to sit and wait until Mr. Cross was stabilized.

A portable chest X-ray film was reviewed by the trauma surgeon a few minutes after the saline infusion began. Following the insertion of the left IJ, Mr. Cross developed a pneumohemothorax on the left (a complication related to the central line insertion). Therefore, the surgeon inserted a left-sided chest tube, which drained approximately 300 cc's of blood.

With the workup done and the vitals stable, the surgeon contacted the nearby university hospital because this small community hospital did not have an ICU and this patient was intubated, had a chest tube and a central line, and required intensive care.

Mrs. Cross was told that a medical helicopter had been dispatched and she should drive the hour to that hospital and go to the ICU.

Mr. Cross remained in the ICU for 10 days as the left chest continued to drain blood through the chest tube. After that stopped, he was discharged from the ICU; he was discharged from the hospital 5 days later.

Family Concerns

Concern #1: Following discharge, Mr. Cross and the family were extremely angry over the medical management, apparent mistakes, and the failure to communicate. They felt strongly that something was wrong. They contacted three attorneys who would not take the case, as there was no lasting injury

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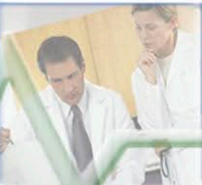
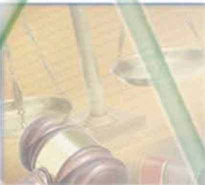
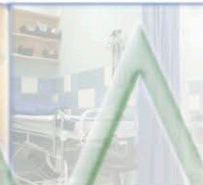
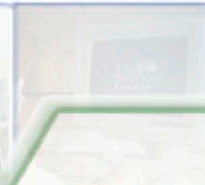
"This was a particularly valuable activity and reminded/reinforced very basic, but crucial interpersonal skills. I was also intrigued by the evidence correlating patient satisfaction with malpractice activity."

Patrick Snowman
Hilton Head Medical Center
PatientSET #1: Introduction for All Healthcare Providers





and thus no significant damages. They had contacted the initial hospital, but were told there was no basis or interest in having any discussion about the case.

D.W. Teaching Moment: *The hospital had a great opportunity here to get involved early, reach out and be proactive. This was an opportunity missed. The hospital should have* ***run to the problem****.*

Concern #2: The bill for services was over $75,000. Insurance and Medicare paid for around $65,000. The family was in no position to pay the remaining $10,000. They had hoped that communication with the attorneys or the hospital would result in assistance with the $10,000.

Concern #3: This family lives in a small community. They truly believe that an increased awareness of these problems could help other families and patients in the future.

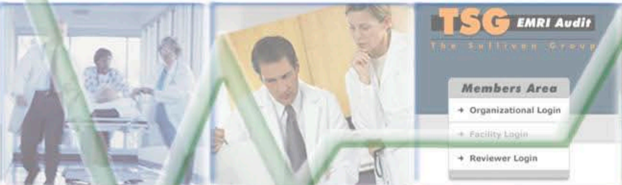
The family then asked for my help.

My Case Analysis

The family shared the medical records with me. On my review it appeared that Mr. Cross had a vasovagal episode, and other than the initial EMS blood pressure, there was not a single hypotensive reading. Although there is always concern after a syncopal episode in an elderly person, particularly if there is an actual injury (abrasion to the forehead), the knee-jerk trauma team response was incredibly over the top and probably a medical error.

Although some workup was indicated, the patient was awake, alert and conversive, with normal vital signs on arrival; having some discussion with the patient and his wife was clearly indicated. However, before having any conversation with Mr. Cross or his wife and with no apparent need for immediate intervention, Mr. Cross was intubated without an indication; additionally, he had a right IJ attempt without an indication, a mistakenly cannulated right carotid artery, a left IJ cannulation without an indication, and a resulting left-sided hemopneumothorax.

In my opinion, this was substandard care that resulted in medical errors, morbidity,



and an extended hospitalization. There is no question that it left Mr. Cross emotionally scarred. He has pretty much made his life about this incident, and there are better things to do when you are a healthy 75-year-old.

My Recommendation

With my awareness of the Disclosure & Apology movement and what appeared to be obvious mistakes made at the initial facility, I strongly urged the family to set up a meeting with hospital administration. The hospital granted the meeting.

At meeting #1, the hospital Chief Medical Officer attended with the hospital attorney. The attorney had instructed the CMO to listen but not speak. The family told their story, the lawyer took notes, and the meeting was over.

D.W. Teaching Moment: *When the Cross family got this meeting, the hospital attorney demonstrated he/she does not understand Disclosure by giving the CMO bad advice in telling him not to speak. There should have been empathy, a promise to review the situation - including a review of the family's concerns - and concrete follow-up steps going forward. That should have been the beginning of recovering the relationship.*

Online Disclosure & Apology Training

Empathy Without Admitting Fault

The Sullivan Group and Sorry Works! formed a partnership to develop online disclosure and apology training courses for healthcare organizations.

The first course, titled **Just-In-Time/Introductory,** is a 12-minute video that provides 10 key tips to understand how to empathize and stay connected post-event without prematurely admitting fault. Included with the 10 tips are two brief scenarios that show disclosure meetings. This 12-minute video will help all staff understand the basics of disclosure, and it can be a refresher for any staff member who needs a quick review before meeting with an upset patient or family. This short course should be required training for existing clinicians in your organization as well as a part of your onboarding process for new hires and new practices.

The second course, titled **Disclosure and Apology Fundamentals**, provides an in-depth overview of disclosure, including how to get connected with patients and families pre-event and how to stay connected with them post-event with empathy and great customer service. Sample scripts for post-event discussions, lists of "dos and don'ts," and case scenarios are provided in the course. Also, videos are embedded throughout the text covering disclosure role-play scenarios and commentary. It's a very comprehensive disclosure training course!

If you are interested in learning more about Online Disclosure & Apology Training, please contact: Brant Roth at broth@thesullivangroup.com

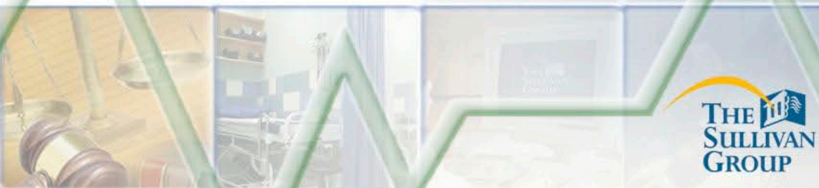
Following that meeting and unknown to the family, the hospital sent the case out for review. They called the family to let them know that the reviewer considered all care appropriate and within the standard of care, and they had no intention of continuing the conversation.

D.W. Teaching Moment: *Instead of calling the family, the hospital should have invited them in for a meeting to discuss the review.*

The family asked that I meet with them so that they could better understand the issues. I agreed to meet; I reviewed the medical issues with them and what I thought were important points to make with the hospital administration. I explained to the family that I felt the treatment had been far too aggressive, resulting in injuries to Mr. Cross. I thought it was completely appropriate to ask the hospital to discuss the issues and perhaps wave the balance of the billing. I familiarized them with the Disclosure & Apology movement and told them that hospital administrations are increasingly getting on board with early disclosure and problem resolution.

The family requested and was granted a second meeting. At meeting #2, Mr. Cross arrived fairly level-headed with all my good recommendations in mind, but just after the beginning of the meeting, he became visibly angry, pulled out a tape recorder, and turned it on. He indicated that all would be recorded, and that if he and his family were not satisfied with the results of this meeting, they would be contacting an attorney. The rest of the family cringed as the hospital ended the meeting immediately.

D.W. Teaching Moment: *The hospital blew it in the second meeting. Although not advisable, Mr. Cross had every right to get angry and every right to tape the conversation. That should have been met head-on by the hospital with empathy and transparency: "Mr. Cross, you have every right to be angry, and if you want to tape this meeting that is fine ... we will use our own tape recorder as well so we have a copy too. Now, let's talk about your concerns..." If it turns out that Mr. Cross has problems down the road*



because of this bad care or there any other factors that might attract a plaintiff's attorney, the fact that the hospital cancelled this meeting will be GREAT evidence for the plaintiff. This is an excellent scenario for disclosure training and role-playing.

There has been no further communication between the family and hospital, and there has been no resolution.

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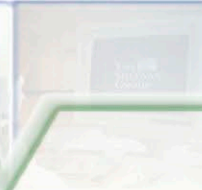
XL Group's Bermuda Insurance Operations Partner with The Sullivan Group to Provide Clinical Risk and Loss Prevention Services to Healthcare Clients

On February, 11, 2014, XL Group's Bermuda Insurance Operations announced a new partnership with The Sullivan Group ("TSG"), one of the premier providers of clinical risk and loss prevention services to hospitals, physicians and nurses throughout the US.

Through this new partnership, XL Group's Bermuda Insurance Operations, XL Insurance (Bermuda) Ltd ("XLIB"), seek to align their portfolio of healthcare clients and prospective clients with TSG's mission of improving patient safety by reducing medical errors and lowering the frequency of malpractice claims.

Wesly Guiteau, Senior Vice President and Healthcare Practice Leader at XLIB, said: "We are pleased to have reached this agreement with TSG to provide our clients with first-class complementary risk management and online education services. For more than 27 years, XLIB has provided leading insurance solutions to this industry. This new partnership demonstrates XLIB's continuing commitment to our clients and it is part of a multi-prong effort to realign our platform with our clients' growing need for insurance products, including risk management support."

Read more... http://bit.ly/1jW4d0W



Discussion and Teaching Points

Doug Wojcieszak Discussion

A hospital might be tempted to say to this case, "Yeah, so what? The old guy is alive and our review showed the care was good. So who cares what the Cross family thinks? Let's move on, next case...." Bad idea. First, at a minimum, the Cross family will likely trash this hospital every chance they get. The bad PR the Cross family and their friends generate will likely dwarf the $10K the family was seeking in waived medical bills.

Second, hospitals are supposed to be in the business of caring, and the Cross family is suffering mentally; they have a lot of anger that can only be dispersed with transparency and apology. Third, as this case showed, this hospital does not understand disclosure, and today they screwed up with the low-value Cross case. What happens, though, when they have a high-value case?

As is the case with many other hospitals, there is a great need with this hospital for development of a Disclosure & Apology program, which includes alignment with defense counsel (including possibly hiring new defense counsel and processes to encourage proactive behavior post-event).

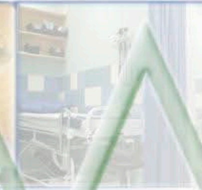
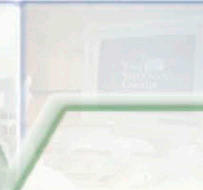
Editor's Comments

There was a medical error; this family deserved an apology, transparency, and some financial consideration. That did not happen. Fortunately, there was no lasting injury or disability nor was there loss of a loved one; but there are certainly some emotional scars. The hospital could have done much more for both itself and the family.

In the best of all worlds, the hospital would have looked more critically at these circumstances, learned from them, and instituted a system solution to avoid similar errors in the future. Considerations may have included:

- Determining when a trauma alert should be initiated; all trauma alerts are not created equal.
- Communicating with a patient (when appropriate) before initiating invasive

"There was a medical error; this family deserved an apology, transparency, and some financial consideration".

and potentially harmful procedures.

- Communicating with immediate family about medical history as time allows; let them be part of the discussion.
- Enabling physicians to express empathy without necessarily admitting medical error.
- Enabling physicians to apologize and in some cases discuss a medical error.

Finally, I must say I was more than a little disappointed that my efforts did not help this family. So Doug had a comment for me:

"Also, one of the things I often tell families (unfortunately) is they may not get justice, answers, compensation, etc., and the family has to find ways to direct their grief and anger. Sure, this situation is not over for the Cross family, but they can't continually stew in negative juices either. The Cross family said to you they don't want this situation to happen to another family (in their community or elsewhere). Well, I would be happy to share their story via Sorry Works! The Cross family story could help countless hospitals and healthcare professionals across the country." ■

Thanks Doug!

As always, all thoughtful comments and questions are more than welcome!

E-mail us at:
info@thesullivangroup.com

Thank You

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