ED LEGAL LETTER™

THE ESSENTIAL RESOURCE FOR EMERGENCY MEDICINE MALPRACTICE PREVENTION AND RISK MANAGEMENT

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## INSIDE



***Editor's Note: This is a special issue dedicated to complaint management, specifically, how to target and solve issues before they turn into lawsuits.***

# No Margin, No Mission

*Whether based on strong evidence or not, it is believed that experience of care drives market share and that market drives the bottom line*

*By Kevin Klauer, DO, EJD, Chief Medical Officer, Emergency Medicine Chief Risk Officer, Executive Director, Patient Safety Organization, TeamHealth*

Many clinicians believe the practice of medicine is all about the science and that patient experience of care is an ill-defined, unquantifiable intrusion into the practice of medicine. Thus, this administrative imperative, aimed at non-outcomes-based metrics, is nothing more than marketing noise and a loss of focus on quality of care. Admittedly, the quality and quantity of research is limited regarding patient experience of care, formerly referred to as patient satisfaction. Many who don't believe this is important clinically support its invalidation on this point. However, just because there isn't enough evidence to convince some or even many doesn't mean that the hypotheses aren't true. In other words, we shouldn't wait for clear and convincing evidence before accepting that there is some value in addressing experience of care. Satisfying patients provides some value, albeit variable, perhaps, among providers, geographic regions, and subsets of patient populations. Experience of care costs nothing — at least it shouldn't — and may positively affect clinical outcomes, provider medical malpractice risk profiles, and reduce

> EXPERIENCE OF CARE MAY POSITIVELY AFFECT CLINICAL OUTCOMES AND MEDICAL MALPRACTICE RISK PROFILES WHILE REDUCING ADMINISTRATIVE BURDENS.



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the administrative burden of addressing and dispositioning patient complaints. Valid criticism exists regarding the expansion of experience of care data beyond its intended use for over-broad purposes, with reliance on precision and accuracy of the results generated, which simply cannot always be supported by their methodological design. Although vendors often are the targets of such criticism, considerable responsibility rests with those using the data. Hospital administrators find themselves in a difficult position. Whether founded with credible data or not, it is believed that experience of care drives market share, which drives the bottom line. Although the bottom line sounds too financially oriented for most clinicians, these are the metrics to which hospital administrators perform. Furthermore, it is that very bottom line that funds hospitals, allowing them to serve their communities. This concept is not new: "No margin, no mission."

Experience of care is not perfect, but when it comes to the baby and the bathwater, I'll keep the baby. Clinicians cannot conveniently ignore the importance of margin, while administrators must not be blinded to the limitations of these metrics. Simultanously, administrators also must realize that overreliance on such metrics may destabilize the provider base responsible for carrying out the mission. Are there areas of common thinking and shared goals on which clinicians and administrators can agree? Certainly. Hospital administrators don't just perform to the numbers, they take pride in providing high quality of care, making certain the ship doesn't run a ground. Most clinicians recognize, for a variety of reasons, that happy patients are better than unhappy patients.

From a risk management perspective, the benefits of happy patients, compared to unhappy patients, are compelling. The data isn't perfect, but it never will be. When exploring associations, and in particular cause and effect relationships, between uncontrolled variables (i.e., subjective observations) and claims data, the number of claims and lawsuits compared to the number of exposures (patient encounters) is so much smaller in magnitude that it creates inherent and unresolvable limitations for any study attempting to measure this relationship. However, the outcomes for patients, clinicians, hospitals, and insurers often are so devastating that risk managers accept the limitations in the data to avoid delays in intervention. In other words, medical professionals don't need more or better data to act, and they cannot afford to wait for the day when that data may be available.

Unhappy patients are one thing, but those who escalate their concerns to generating a formal complaint are another thing altogether. Intuitively, one can make the leap that many, if not most, patients who report a complaint are, on average, more disgruntled than those who are unsatisfied, but choose not to complain. Additionally, those that take the time to report their concerns are looking for action and may be providing an opportunity for satisfactory resolution. Avoiding a claim, and an associated lawsuit, is critical. Effective complaint management is about risk mitigation, while poor complaint management results in lost opportunity, regret, and, perhaps, 39 months of one's life disappeared (the average number of months to earn a defense verdict at trial).[1]

## Complaints and Professional Liability

Complaints are inevitable, with a frequency of 1.65 to 3.14 per thousand ED visits reported.[2] The correlation between experience of care and complaints is clear, and the concept that complaints correlate with lawsuits has been well published. Although not specific to emergency medicine, Hickson et al reported that unsolicited patient complaints correlated with a more adverse physician risk profile.[3] Stelfox et al compared patient satisfaction, broken into tertiles, to unsolicited complaints and risk management events. Comparing the first tertile (high satisfaction scores) to the third tertile (lowest satisfaction scores) over a three year period, 200 complaints were received in the first tertile and 492 in the third. Additionally, malpractice lawsuit rates were 110% higher.[4] A study published in 2011 identified 375 complaints and 61 risk management episodes from 2,462,617 ED visits. Patient satisfaction scores were not noted to be associated with increased risk management episodes. However, the odds ratio for generating a complaint was 1.84, almost twice as likely, for those in the lowest quartile for patient satisfaction. Those with two or more patient complaints in a quarter were 4.13 times more likely to experience a risk management event.[5]

It is very important to recognize at-risk populations for complaint generation, which may increase risk for professional liability. A common misconception is that indigent patients or those in lower income groups are more likely to complain and file lawsuits. The facts tell a different story. In an analysis of 277,210 ED visits, generating 675 complaints, patients living in higher income ZIP codes were more likely to complain than those from lower income areas.[2] McClellan et al performed a systematic review of the medical and social literature, identifying studies studying the malpractice rates among socioeconomically disadvantaged patients compared to other groups. They also found that lower income patients were less likely to sue.[6] The reasons for this phenomenon are unknown. However, clinicians should be mindful of the potential for unconscious bias, assuming these patients are more likely to complain and file lawsuits, which may affect interpersonal interactions and care delivery.

IT IS IDEAL TO RECOGNIZE A CONCERN IN EVOLUTION PRIOR TO THE GENERATION OF A FORMAL COMPLAINT.

## Complaint Avoidance

Although it may appear to oversimplify the issue, avoiding complaints before they happen should be the primary goal. It is ideal to recognize a concern in evolution prior to the generation of a formal complaint. There are some misconceptions about who complains. Providers tend to view situations from their perspective, noting that their role is to save lives and deliver healthcare in an environment that often is chaotic and largely dictated by factors out of their control. However, like it or not, healthcare is a service industry, and patients have choices. Although the nature of the services provided are vastly different, the operations and basic consumer expectations, whether they are consuming healthcare or a meal at a restaurant, are similar. At a minimum, patients and their families/significant others expect to be treated with respect, receive treatment in a reasonable timeframe, receive high-quality (or at least satisfactory) service in a clean environment, and receive an explanation when the aforementioned won't or didn't occur. Recognizing these basic expectations and empowering ED staff to intervene is necessary for the early resolution of complaints.

Baseline operations should include a streamlined intake process, at least acknowledging the patient has arrived and documenting a medical complaint. Perform each process of care and transition in a reasonable timeframe. All care areas should be clean, and all clinicians, from triage to the cath lab, should be competent and well qualified, treating all patients with respect.

Of course, rarely does a shift go according to plan, but the plan should include trying to satisfy patients. Although medical professionals aren't all alike, the golden rule applies, "Do unto others as you would have them do unto you." It's worth mentioning that clinicians often are judged on how patients observe their interactions with others, and not only their personal interaction with the clinician.

When these imperatives aren't met, that's when communication should begin. Silence does not imply satisfaction. When delays are expected or have occurred, the patient

should be advised. If the bed is not clean, apologize and address it. If someone seemed discourteous, note it and apologize. Most patients will accept the inherent unpredictable nature of an ED visit, but there are limits.

Several studies have reported similar findings with respect to the cause of the complaint. Taylor et al reported that 2,419 ED patients reported concerns about 3,418 issues during a 61-month period. Of these, 63.1% were made by someone other than the patient, underscoring the importance of families, significant others, and visitors. Further, 33.4% were related to patient treatment (inadequate diagnosis and inadequate treatment), while 31.6% were related to communication issues (e.g., poor staff attitude and rudeness). Meanwhile, 11.9% were related to delays in treatment.[7] A 12-year study in a university ED noted that waiting time was the most common reason for complaints (46.35%), while interpersonal issues were less common (attitude, 8.67%; communication skills, 3.35%).[8] A Turkish complaint database collected 218,186 complaints from 2005 through 2011, with 48.9% of complaints reported in the final year. Not benefiting from services was the most common complaint (35.4%). Not receiving treatment in a respectable manner and in comfortable conditions followed (17.8%), with not receiving timely information the next most common (13.5%).[9]

Although the order of frequency of complaint types vary, the themes remain relatively constant, emphasizing the importance of efficient operations, high quality care, professionalism (attitude), and effective communication.

## Resolution

There are two critical times when complaints can be resolved: prior to ED departure and when a formal complaint has been filed. Of course, the former is preferred. As noted above, there are proactive strategies for avoiding common sources of complaints and real-time identification when complaints occur. However, many EDs receive complaints after the patient's departure.

SINCE ONE OF THE GOALS OF COMPLAINT MANAGEMENT IS RISK MITIGATION, ONE MUST BE MINDFUL THAT ALL WRITTEN AND VERBAL COMMUNICATIONS ARE DISCOVERABLE.

Such complaints must be handled carefully, with sensitivity and consistency. Since one of the goals of complaint management is risk mitigation, one must be mindful that all written and verbal communications are discoverable. Choose words and carry out actions carefully. It is critical to know if a state passed an "apology law," making either expressions of sympathy and/or an admission of fault inadmissible in court.

There should be a standard mechanism for distribution of complaints to the responsible party. The nursing director should address nursing complaints, the medical director should address physician complaints, and accounting should handle billing complaints. It is likely that some complaints may include several components. Thus, multiple individuals may be necessary to evaluate and resolve the complaint. There are several key principles involved with successful complaint resolution:

1. Be prompt in responding, usually by phone and follow up in writing.
2. Acknowledge the concern.
3. Gather the necessary facts before determining the validity of the complaint or the outcome.
4. If the point of contact reports he or she has retained legal counsel, discontinue the communication and notify risk management (i.e., hospital and group).
5. Patient complaints are not always based on a legitimate foundation. However, always address their concerns respectfully.
6. Although complaints most often are resolved with compromise and negotiation, the complaint manager should not feel compelled to offer restitution of any kind when not warranted.
7. Document and keep records of all written and verbal communications with patients or their designee(s).
8. Service recovery may be used. However, exercise caution to make certain that what has been offered is compliant with regulatory requirements. For instance, "OIG has advised that Medicare or Medicaid providers must limit service recovery gifts to a retail value of no more than $10 individually, and no more than $50 in the aggregate per patient. The gift may not consist of cash or a cash equivalent." Additionally, routine forgiveness of co-pays may constitute fraud under state and federal

statutes. Waiver of co-pays may be acceptable with some private insurers under certain circumstances outlined in the provider's agreement. Waiver of Medicare co-pays or deductibles may be acceptable for specific reasons such as financial hardship. When this happens routinely or without appropriate justification, this has been viewed as a fraudulent misrepresentation of physician charges. For example, if physicians receive 80% of the allowable amount under Medicare, the patient is responsible for $20 of a $100 bill, and Medicare is responsible for $80. However, if the co-pay is waived, that reduces the total to $80, and 80% of $80 is now $64, and billing the full $80 may be deemed fraudulent. If one waives fees for one payer (the patient), it may be safest to waive the entire bill. Waiving the co-pay while still billing the insurance carrier, particularly for service recovery, can be problematic.

## Conclusion

Poor patient experience of care leads to complaints, and patient complaints often are the gateway to medical malpractice. However, using a proactive approach to avoid common sources of complaints and developing a robust, structured mechanism to address them, either real-time or following the patient's departure, will substantially reduce professional liability exposure for the clinicians, hospital, and other stakeholders involved. ■

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# Don't View Patient Complaints As Annoyances

*Unsolicited complaints are 'nuggets of gold' and valuable risk reduction tools for EDs*

Few patients who are dissatisfied with their ED visit come forward and say so. "We find that because of the intimidating nature of a fast-paced emergency room and other things, many people will not speak up in the moment," says **Gerald B. Hickson**, MD, senior vice president of quality, safety, and risk prevention at Vanderbilt University School of Medicine.

This means that when someone complains, "we are looking at the tip of the iceberg," Hickson says.

Without training, many emergency physicians (EPs) respond defensively to complaints, pointing the finger at the patient or family.

"If we spend our time blaming patients or discounting their stories, we miss the opportunity to learn what those patients are collectively telling us," Hickson explains.

Valuable information can be gleaned when a patient complains about an ED visit.

"We should not be afraid or angry about receiving complaints. They may represent nuggets of gold," Hickson says, noting that patients and families "are uniquely positioned to tell us about our dysfunctional systems and sometimes our nonprofessional colleagues."[1]

Patient complaints are routinely shared with EPs in a nonjudgmental way.[2]

"We do this not to embarrass or humiliate, but promote reflection to learn and fix," Hickson says. It's not easy for EPs to listen to someone saying they've done a poor job

without becoming defensive. "To be able to master that skill is really the hallmark of a professional," Hickson adds. Here, he offers some complaint management strategies for the ED setting:

**• Address dissatisfaction right when it's occurring.**

"This increases the chance that we get the right diagnosis and outcome," Hickson says. "And when individuals do have adverse outcomes, it reduces the risk of unnecessary litigation."

If a patient or family is clearly agitated because of a long wait, for instance, an ED nurse should acknowledge this, apologize for the delay, and promise to get them back as soon as possible.

"That's not perfect, but it's better than letting patients think they have been forgotten," Hickson says. "Dialing down unnecessary inflammation is important."

**• Encourage patients and families to speak up if the ED does not meet or exceed their expectations.**

"There are patients who are vocal, and those who walk away silently but are just as angry," Hickson says. The goal is to identify as many dissatisfied patients as possible — even those who are silent on the subject.

"This begins by standardized training for all professionals and unit leaders on the best techniques in service recovery — the practice of making right what patients and family believe may be wrong," Hickson says.[3]

The ED posts signs encouraging patients to report concerns. "But most important is addressing our natural tendency to be defensive," Hickson says.

Sometimes a patient's demands are truly unreasonable, but it's still worthwhile to hear him or her out.

"It's about being a professional and trying to view a situation from someone else's perspective," Hickson explains.

**• Implement a system to handle complaints outside the ED when appropriate.**

One patient complained that the EP stated that her primary care physician should have ordered the tests, but just wanted to pass it off to the ED. Another reported, "We were just here last night, and we told them Mom was not ready to go home!"

At Vanderbilt University Medical Center, the ED wouldn't handle either of these complaints. Instead, complaints are referred to the hospital's Office of Patient Relations if they:

1. remain unresolved at the point of service;
2. are repeat concerns;
3. involve several departments or healthcare professionals;
4. involve physicians;
5. involve quality of care issues;
6. allege malpractice or involve an adverse event;
7. involve threats to call the media or regulatory bodies;
8. involve a patient request to terminate a provider relationship;
9. allege abuse or boundary issues;
10. concern issues of privacy or confidentiality;
11. involve injury on the premises.

If a complaint touches on one of these areas, the hospital's patient relations specialist reaches out to the individual and conducts formal service recovery.

"We get about 6,000 patient and family stories a year. Of those, about 12% originate in our emergency medicine units," Hickson says. "We've learned how to conduct service recovery and then convert those stories into data."

Most ED complaints involve care and treatment, but some are about failed communication, such as the ED discharging a patient with no explanation to family caregivers. A smaller group of complaints are about perceived disrespect, such as the EP seeming too busy to take care of a patient. One patient complained that the EP "was very abrasive and condescending"; another said the EP made her feel unimportant.

The key is employing someone who engages dissatisfied patients and families.

"Offer an apology, if appropriate, and attempt to address the needs of the patient," Hickson advises. ■

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# Give Unhappy Patients Chance to Air Concerns

*This could help the hospital avoid a lawsuit*

After an emergency physician (EP) determined the preliminary X-rays of a patient with an injured wrist were negative, the EP sent the patient home with a splint, instructions to follow up if pain and/or swelling persisted, and pain medication. Later, a radiologist also interpreted the X-rays as negative.

The patient returned to the ED several days later because of continued pain. A repeat X-ray revealed a navicular fracture, and the patient was referred to the orthopedic clinic.

Several months later, the patient filed a claim against the EP alleging delay in diagnosis and treatment of his wrist fracture, resulting in nonunion that required bone grafting surgery.

"The patient complained during both visits to the ED that the EP was unconcerned, rude, minimized his pain, and was not worried about the wrist injury," says **Kathleen Shostek**, RN, ARM, CPHRM, vice president in the healthcare risk management and patient safety division of Sedgwick, a Memphis-based third party administrator for professional liability claims.

Shostek says the second ED visit was a "lost opportunity" for the EP to intervene, listen to the patient's concerns, and offer an apology. The EP also could have taken the time to explain to the patient that navicular fractures are not always observed on an initial X-ray.

"This may have prevented the patient from filing his claim," Shostek says, noting malpractice suits rarely are filed solely because the EP was uncaring, rude, or rushed.

"But when the patient experiences an error or delay that results in an injury or some sort of harm and had a poor personal encounter with the EP, that can tip the scale in favor of filing a liability claim," Shostek adds.

## Learn Concerns Within 72 Hours

If a bad outcome occurs due to a clear breach of standard of care in the ED, a successful malpractice lawsuit is fairly likely.

IF A BAD OUTCOME OCCURS DUE TO A CLEAR BREACH OF STANDARD OF CARE IN THE ED, A SUCCESSFUL MALPRACTICE LAWSUIT IS FAIRLY LIKELY.

"Typically, you can't prevent or mitigate an actual lawsuit in those situations. They're going to sue regardless," says **Terrence W. Brown**, MD, JD, FACEP, chairman of the ED at Banner Estrella Medical Center and counsel to Emergency Professional Services, both in Phoenix.

Other malpractice lawsuits, however, are less likely.

Banner Estrella's ED admits 15-20% of the 90,000 patients seen in the ED annually.

"Out of that large number that go home, there's going to be patients that feel they didn't get the right care or a mistake was made," Brown says.

Waiting until the patient formally complains to hospital administrators is a poor approach. By then, too much time has passed.

"That gives the patient and family time to stew and get more upset," Brown explains. "What seems to help is if someone can identify an issue soon after the ED discharge."

A follow-up call, made within 72 hours, gives patients a chance to vent before they end up calling an attorney.

"Not having the chance to voice concerns seems to be the biggest thing that drives the threat to sue," Brown says.

Very rarely does an EP find out that a mistake was actually made. More often, simple misunderstandings on the part of the patient are corrected. For example, patients don't always realize that it sometimes takes time for a diagnosis to become clear. It's also important to note that not all discharged ED patients are called.

"It's just not practical for EPs to be chasing down everyone that they've seen. So we try to target it to specific groups," Brown notes.

This includes patients with vague presentations who were discharged with the same diagnosis with which they presented.

"They may say, 'I came in with chest pain and was diagnosed with chest pain. What's going on?' Or a family member says, 'They didn't do anything for you,'" Brown says. Some patients are happy just to be going home after hours in the ED but later become distressed at the unclear diagnosis.

The phone call does two things: It conveys that the EP cares how the patient is doing, and gives the opportunity for the patient to share concerns.

"We tell them, 'We really do mean it that we want you to come back if you feel something was missed,'" Brown says.

This prevents the scenario of a patient in the early stages of an evolving illness, such as appendicitis, going to another ED days later and receiving a diagnosis there. In that scenario, patients are likely to blame the first ED for not delivering the correct diagnosis. A follow-up call encouraging patients to come back can prevent this.

"It's more likely that they will come back to your ED, and that they didn't have to go somewhere else to get the correct care, in their mind," Brown says.

The vast majority of patients don't have any concerns at all about their ED care.

"Almost all of them are just grateful for the call," Brown says.

In about one out of 20 calls, the patient expresses an unresolved concern. Usually, this involves a minor question that's easily answered.

"It's rare that something turns up," Brown notes. "But if you multiply those by all the patients who come in, it does catch a pretty decent number of patients who are sort of simmering and wondering what to do next."

For example, one patient asked if the EP wanted to end a previous antibiotic course before beginning a newly prescribed one.

"This prevents those month-later complaints where a patient will say, 'My primary care physician says I never should have been taking that medication in the first place,'" Brown explains.

If the patient is extremely upset or angry, the EP involves the medical director or ED chair.

"Most of the time, if you can address it within three days of the visit, the patient doesn't have time to research online for an attorney or talk to their family who thinks they should call an attorney," Brown says.

IF THERE TRULY IS A CONCERN THAT THE STANDARD OF CARE WASN'T MET, OR A PATIENT MENTIONS HE'S BEEN IN TOUCH WITH AN ATTORNEY, THE EP INVOLVES THE HOSPITAL'S RISK MANAGEMENT DEPARTMENT AND ITS MALPRACTICE CARRIER.

If there truly is a concern that the standard of care wasn't met, or a patient mentions they've been in touch with an attorney, the EP involves the hospital's risk management department and its malpractice insurance carrier.

"It's best to have them on board to guide you through the next step," Brown recommends. "You don't want to inadvertently acknowledge a breach in the standard of care, and now you're a witness."

## Address Concerns in ED

Several years ago, Banner Estrella Medical Center's ED piloted a program to identify patient concerns before patients left the ED, reducing the number of formal complaints by 87%.[1]

A designated individual asked every ED patient about to be discharged if they had any unresolved concerns. If the patient said yes, the EP went back to the patient and resolved the concern.

Some patients admitted they weren't comfortable going home, or had noticed an abnormal finding in their lab work that the EP hadn't mentioned.

"After the EP tells them, 'We're going to send you home,' we gave them 10 minutes to think about it," Brown recalls. "It gave us a second chance to correct misconceptions."

It worked very well for a designated person to visit every patient about to be discharged, instead of a clinician doing so, since not many had concerns. Of 5,969 ED patients surveyed over a one-year period, 348 expressed a concern about their care. The real-time survey allowed EPs to visit only the small number of patients with concerns.

However, the project was time-intensive and costly, so the hospital discontinued it.

"But it really did reduce a lot of those angry encounters a few days later," Brown adds. "Ideally, you want to catch them before they leave. If you can do that somehow, you are saving tons of time."

One patient was confused as to why the EP prescribed a certain antibiotic even though the patient

presented with a penicillin allergy. This gave the EP the chance to explain that the antibiotic was in a different class of medication. If the EP hadn't explained this at the point of discharge, the patient might have decided not to take the medication, risking a poor outcome.

Another approach would be for ED nurses to take on this role, and ask if patients have any concerns before discharging them.

"But that takes a lot of culture change. It's just not how we do things in the ER," Brown says. "Once we know the patient is stable to be discharged, we are looking for the next crashing patient." ■

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# Is ED Patient Unhappy With ED Care?

*Or is an unexpected bill the real problem?*

As chair of the ED at Mount Carmel St. Ann's Hospital in Westerville, OH, **Michael B. Weinstock**, MD, manages all patient complaints involving ED care. He has noticed a recent uptick in complaints whereby a patient who receives a large bill calls to complain about the ED visit.

"It typically happens months later, which is a clue that billing has factored into their decision to submit a complaint," says Weinstock, who also is an adjunct professor at The Ohio State University's department of emergency medicine.

Frequently, the care was acceptable to the patient at the time of the ED visit.

"The patient didn't complain until they received their bill," Weinstock explains. "We are seeing that more and more."

One reason is that many ED patients face higher deductibles or co-pays.

"Patients are more likely to complain about the bill if there was a misdiagnosis or delayed diagnosis," Weinstock notes.

Weinstock is aware of at least one situation in which an ED bill likely triggered a malpractice lawsuit. The patient stopped breathing and died after receiving a dose of pain medication in an ED.

> IN SOME CASES, THE PATIENT OR FAMILY ARE INVITED TO COME TO THE ED TO DISCUSS CARE OPENLY SO THAT ALL THEIR QUESTIONS CAN BE ADDRESSED.

"It was questionable as to whether this is what caused the patient's demise," Weinstock says, noting that the patient's family sued after receiving a bill from the ED, which included a charge for the dose of pain medication.

"Receiving a bill for medication that they thought might have killed their loved one certainly could have been the tipping point," Weinstock offers.

In some cases, a family member is the one who calls the ED to complain after the patient receives a large bill. Sometimes he or she is unaware of what actually transpired during the ED visit.

"I tell them what actually happened in the ED, which sometimes differs from the version they were told by the patient," Weinstock says.

Rarely will Weinstock agree to have the entire ED bill written off.

"If something got missed and the patient had to return, I may call and ask that that portion of the bill be forgiven," he says.

However, in almost every case, he simply states that he is unable to address the financial aspects of the ED visit.

"I tell them, 'I am not a billing or insurance expert. I am calling to discuss the medical care you received,'" Weinstock says.

## Answer Questions

Weinstock encourages ED providers to inform risk managers if they're aware of a patient's or family's dissatisfaction with ED care. In some cases, the patient or family is invited to the ED to discuss care openly so that all their questions can be addressed.

"We've had cases with bad outcomes that couldn't have been prevented, but the family had all kinds of questions," Weinstock says. "Why not address those with the family in a collegial way, before there is any threat of litigation?"

Typically, one would carry this out with a phone call, but sometimes a sit-down meeting occurs with the provider, risk management, nursing, and administration.

In Weinstock's experience, there is no downside to such meetings. Patients appreciate ED providers making themselves available.

"They don't look at it from the perspective of, 'You're trying to cover up malpractice,'" Weinstock explains. "We have done this several times, and it's worked great each time."

ED providers occasionally acknowledge that some things could have been done better. It may turn out that the patient or family decides to sue anyway.

"But giving them an explanation is not going to make it more likely for them to sue," Weinstock warns. ■

### SOURCE


- **Michael B. Weinstock**, MD, Adjunct Professor, Department of Emergency Medicine, The Ohio State University College of Medicine/Chairman, Mt. Carmel St. Ann's Emergency Department, Columbus, OH. Phone: (614) 507-6111. Email: mweinstock@ihainc.org.


# Follow-up Text or Email Might Prevent Malpractice Suit

At Edward-Elmhurst (IL) Health, all discharged ED patients routinely receive a follow-up the following day to answer a simple question: Are they better, the same, or worse?

Malpractice risks have decreased with this simple practice, according to ED Chair **Tom Scaletta**, MD, FAAEM.

"Very few EDs are doing it in a structured manner," he says.

Some EDs conduct follow-up calls, but only for patients that they already are concerned about, such as complex cases in which the ED suspects an evolving disease process.

"While that's a great practice, what you really want to uncover is cases that went in a direction that you weren't anticipating," Scaletta recommends.

Scaletta was part of a team that developed EffectiveResponse (offered by Standard Register Healthcare), which reaches ED patients by email or text message to assess next-day well-being.

"We find all sorts of patients that need to be encouraged to return when they are getting worse," he says. "We also untangle any follow-up obstacles they may encounter."

> SOME DEPARTMENTS CONDUCT FOLLOW-UP CALLS, BUT ONLY FOR PATIENTS THEY ALREADY ARE CONCERNED ABOUT.

With the automated system, he says, "you often will find problems you had no idea were going to be a problem. Some patients have a downward trajectory that was completely unanticipated."

Sometimes pneumonia or asthma progresses more rapidly than expected.

"That is what a comprehensive system does. It finds those needles in a haystack," Scaletta says.

The rate of patients reporting "worse" is 2%. Of those, only 5% are instructed to return to the ED after a phone assessment.

"Thus, one in 1,000 discharges are instructed to come back because of this system," Scaletta says. "The doc thought discharging [the patient] was safe, but [he or she] took an unexpected turn for the worse."

This amounts to one or two patients a month for the health system's three EDs.

"By the time you whittle those down to the ones where you can say, 'I think we saved a life here,' it will only happen a couple of times a year," Scaletta says.

For instance, a patient may leave an ED with a diagnosis of indigestion, but during the follow-up call, reports shortness of breath and pain in the left arm. "If the patient was misdiagnosed, you can reel them in and find out you missed a myocar-

dial infarction," Scaletta cautions.

In one case, a patient presented to an ED with low back strain. At the time, the patient exhibited normal vital signs and was discharged with pain medication. During the phone assessment, the patient reported a fever.

"Now, we are looking at a whole different differential that includes back pain and fever," Scaletta says.

The patient came back to the ED, and received a diagnosis of epidural abscess, which can result in paraplegia and requires urgent surgery.

"During that snapshot in time when they are in the ER, it could be early in the process. Over 24 or 36 hours, things can evolve," Scaletta says.

## Prevent Baseless Suits

It could be that at the time of the ED visit, it wasn't possible to diagnose the patient's condition, and the EP met the standard of care. Still, confused patients may call an attorney claiming they were misdiagnosed, triggering needless litigation.

"Even if you can defend it, you just don't want those to happen," Scaletta says.

If the patient worsens, he or she might go to another ED, where physicians will correctly diagnose the condition. Providers at the second ED may blame the first ED for not diagnosing it.

"You don't want that patient to end up going to another hospital, and they throw us under the bus," Scaletta warns.

If the patient reports problems with follow-up care, case managers handle it. The patient might be told by a physician's office that they can't get in for weeks, when the EP wanted follow-up within 48 hours.

"The case manager can intervene on behalf of the patient," Scaletta says.

About 10 EDs are using the system currently, including the three EDs in Edward-Elmhurst's system.

"People in risk management see this is going to prevent a couple of major problems every year," Scaletta predicts.

Some EDs hire a callback nurse to contact all discharged patients — a costly approach.

"With a 50,000 volume, you might need two FTE nurses," Scaletta says, estimating the cost of salaries and benefits, plus administrative overhead of hiring, training, space, and equipment, to be about $200,000. "If you trade that for an automated system, it's about a quarter of the cost."

With an automated system, nurses only end up calling the patient about 4% of the time. This prevents unnecessary follow-up, such as a patient with whiplash who reports worsening pain, which is expected.

If a patient is checked the next day and indicates he or she is getting better, this is legally protective for EPs if a bad outcome ultimately occurs, according to Scaletta.

"Another chunk of lawsuits have a major complaint that's based on an unrealistic expectation or misperception about how things are done," Scaletta says, explaining that if patients indicate they're dissatisfied for any reason, it gives the ED a chance to address the concern. "If there is any kind of complaint about the staff or facility, that is where the administrative team jumps in and intervenes."

This team assures patients that their concerns are under serious consideration.

"If the patient feels like they were heard, they're less likely to grab onto a lawsuit and not let go," Scaletta says. "Even if it's not justified in the end, it still costs money to defend." ■

### SOURCE


- **Tom Scaletta**, MD, FAAEM, Chair, Emergency Department, Edward Hospital, Naperville, IL. Phone: (630) 527-5025. Email: tscaletta@edward.org.


## CME/CE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify legal issues related to emergency medicine practice;
2. Explain how the legal issues related to emergency medicine practice affect nurses, physicians, legal counsel, management, and patients; and
3. Integrate practical solutions to reduce risk into daily practice.

## COMING IN FUTURE MONTHS

- Common allegations in successful missed ectopic pregnancy cases
- Warning signs that defendant EP's interests conflict with the hospital's interests
- How attorneys prove EP delivered negligent care to a psychiatric patient
- Liability exposure for ED if patient is sent to urgent care clinic

ED LEGAL LETTER™



# CME/CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.

2. Log on to **AHCMedia.com** and click on My Account. First-time users will have to register on the site using the eight-digit subscriber number printed on their mailing label, invoice, or renewal notice.

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the test, a credit letter will be emailed to you instantly.

5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

# CME/CE QUESTIONS

1. **Which of the following strategies is recommended to deal with unsolicited complaints from ED patients?**

   a. Remove signage encouraging patients to report concerns, since this results in higher frequency of frivolous litigation.
   b. Share patient complaints with EPs in a nonjudgmental way so as to promote reflection on how to fix the problem.
   c. Instruct individual EPs to handle all types of complaints that involve the department, including quality of care issues.
   d. Route all complaints involving any aspect of ED care to the practice setting in which they occurred.

2. **What is the best approach for contacting ED patients post-discharge?**

   a. Instruct all patients who report worsening symptoms to return to the ED.
   b. Instruct EPs to call only a subgroup of patients they're most concerned about, such as complex cases in which an evolving disease process is suspected.
   c. Contact all discharged ED patients the following day to ask if they're better, the same, or worse.
   d. Make EPs responsible for addressing complaints involving the staff or facility.

3. **Which of the following statements is true regarding the most effective approach to managing patient complaints in the ED?**

   a. Making a follow-up call within 72 hours of ED discharge to ask if the patient had any unresolved concerns seems to decrease the potential for litigation.
   b. EPs should, generally speaking, avoid addressing patients' dissatisfaction regarding previous ED visits for the same complaint so as to prevent misconceptions that the diagnosis was missed.
   c. EPs should prioritize follow-up calls to discharged patients based on the patient's presenting symptoms.
   d. The ideal timing for EPs to step in to address issues directly with unhappy patients is after hospital administrators receive a formal complaint.