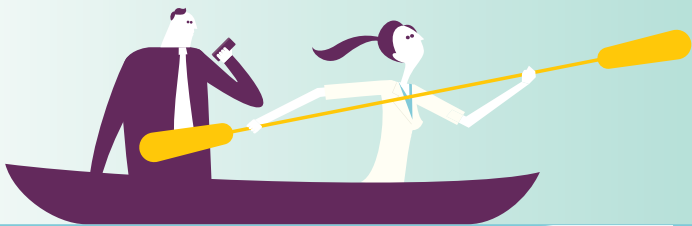


THE Physicians Report

SUMMER 2018 | PHYINS.COM

WHEN THINGS
GO WRONG

RESPONDING TO ADVERSE OUTCOMES



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Wrong On the Inside

A Better Way to Respond to Patient Harm

"If transparency were a medication, it would be a blockbuster, with billions of dollars in sales and accolades the world over."—Shining a Light: Safer Health Care through Transparency (report), National Patient Safety Foundation's Lucian Leape Institute, 2015, Executive Summary p. viii.

Communication and resolution programs (CRPs) address a problem that has existed since the first healer treated the first patient: despite everyone's best intentions, in health care, things don't always go as planned. How your practice or organization responds to a patient and their family in the wake of patient harm can make a big difference to them, and to you.

Research shows that what patients want most after an adverse event is information and support (Gallagher et al, 2003; Witman et al, 1996; Mazor et al, 2009). Specifically, they want answers to five questions: What happened? Why did it happen? Was it preventable? What impact will it have for my health and treatment? and How will care be improved to prevent another similar event in the future?

In addition to information, patients want a sincere apology. They want to be assured that the health-care provider or organization involved acknowledges and regrets the unintentional harm (Gallagher et al, 2003; Duclos et al, 2005; Mazor et al, 2003).

When providers honestly and compassionately offer information about the event and provide a sincere apology, patients experience less distress (Gallagher et al, 2003). An apology can help patients maintain a trusting relationship with their care providers.

Unfortunately, there is often a gap between what patients want and what they receive. Many providers withhold information and apologies out of a fear of litigation (Lamb et al, 2003). Ironically, research shows that people were more likely to sue their providers when they felt their providers deserted them, discounted their concerns, did not provide adequate information, and did not understand their (or their families') perspectives (Woods 2004).

A compassionate and proactive response to patients in the wake of an adverse outcome has other benefits in addition to reducing litigation

risk. Perhaps the most important benefit of taking a communication and resolution approach to adverse outcomes is increased patient safety. By encouraging the reporting of unanticipated outcomes, conducting robust investigations that incorporate information from patients and their families, analyzing event root causes with an emphasis on human factors, and implementing strong action plans to address systemic issues, providers can significantly improve the quality of their care and reduce risk to future patients.

Furthermore, providers may experience less emotional distress and increased job satisfaction if their work environments support the disclosure of adverse outcomes and offers care for caregivers (Supporting Second Victims [article], The Joint Commission, Quick Safety Issue 39 [2018]).

Good change takes time and nurturing. In my home state, the Oregon Patient Safety Commission (OPSC) and its partners, the Oregon Medical Association (OMA), Osteopathic Physicians and Surgeons of Oregon (OPSO), and Oregon Association of Hospitals and Health Systems (OAHHS), have sought to accelerate CRP adoption among interested health-care organizations by convening year-long learning collaboratives facilitated by national experts. OPSC has also created the Leading Through Transparency awards to recognize Oregon providers who demonstrate a commitment to communicating with patients and families following unexpected harm.

In a health-care universe increasingly focused on better patient care and reduced costs, "deny and defend" is a losing proposition. Erecting a wall of secrets between patients and their providers is inconsistent with good care; high litigation costs and recurring (preventable) system errors make it the more expensive choice as well. As state and local initiatives and the Collaborative for Accountability and Improvement continue to refine the CRP model, I believe it will soon become the standard response to adverse outcomes.



Beth Kaye

JD, Director of Early Discussion and Resolution at the Oregon Patient Safety Commission

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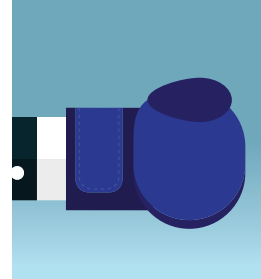


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WHEN THINGS
GO WRONG

RESPONDING TO ADVERSE OUTCOMES

by Thomas H. Gallagher, MD

MOMENTUM IS GROWING FOR COMMUNICATION AND RESOLUTION PROGRAMS

While effective disclosure of adverse events is not a new practice, the momentum for it is growing.

Over the past decade, the case for effective disclosure of adverse events has been gaining ground among various institutions. Oregon and Washington have both developed systems of early disclosure: in Washington, the program is named Communication and Resolution Programs (CRPs); in Oregon, it is known as Early Discussion and Resolution (EDR). For simplification purposes, this article will refer to both as CRPs. CRPs are comprehensive, principled, and systematic, and are meant to enable a more effective response to,

and in some cases prevent, adverse events. CRPs emphasize early, transparent communication with patients who have experienced an unexpected outcome, and provide patients who have been harmed by their medical care with an apology and prompt and compassionate explanations for what happened, along with information about how recurrences will be prevented, when possible. For those medical injuries caused by unreasonable care, CRPs also provide patients with proactive offers of financial compensation, without requiring the patient to file a lawsuit. It cannot be overemphasized that a CRP's central focus is on improving patient safety, and any such compensation is entirely voluntary.

CRPS ON THE MOVE

Over the last two years, there has been a concerted effort by health-care advocates to accelerate the adoption of CRPs. The positive messaging surrounding CRPs has garnered support from a wide variety of stakeholders, including health-care institutions and providers, patient advocates, professional-liability insurers, health insurers, regulators, policymakers, and defense attorneys.

Elements within the medical profession have advocated a different response to adverse events for several decades. Much of their early advocacy centered on the importance of disclosing medical errors to patients, and apologizing for those errors. Yet multiple research studies suggested that the medical profession struggled to turn this principle of disclosure into practice. More often than not, patients were not informed about medical errors, and when these conversations did occur, they were handled unskillfully—thereby exacerbating the patient's suffering. Research studies at this time also documented patients' strong expectation that medical errors should be handled not only with transparency, but also with learning.

Early communication programs found roots in health-care systems in which a hospital employs and self-insures all providers who practice within its system. The University of Michigan and the Lexington Kentucky Veterans Affairs Hospital were pioneers in the CRP process. They began experimenting with a different approach in 2004, emphasizing transparency but also espousing proactive offers of compensation to patients when the adverse event was due to unreasonable care. As these programs developed, emphasis was increasingly placed on the patient-safety dimension of this work, ensuring that the lessons learned were identified and implemented to reduce the chances that the adverse event would recur.

HISTORICAL VS. CRP RESPONSE

Over the last decade, this work has evolved into the CRP model that is used today. The key elements of a CRP, and how they represent a change from the traditional model, are listed in the table below.

	Historical Response	CRP Response
Incident reporting by clinicians	Delayed, often absent	Immediate
Communication with patient, family	Deny/defend	Transparent, ongoing
Event analysis	Physician, nurse are root cause	Focus on "Just Culture," systemic and human factors
Quality improvement	Provider training	Drive value through system solutions, disseminated learning
Financial resolution	Only if family prevails on a malpractice claim	Proactive offers, addressing patient/family needs
Care for the caregivers	None	Offered immediately
Patient, family involvement	Little to none	Extensive, ongoing

(Continued on page 18)

THE NATIONAL PRACTITIONER DATA BANK

DEMYSTIFIED

Perhaps you're wondering: What is the National Practitioner Data Bank, and how does it apply to you?

The mission of the National Practitioner Data Bank (NPDB) is "to improve health care quality, protect the public, and reduce health care fraud and abuse in the United States." The organization was established by Congress in 1986 to prevent practitioners from moving between states without disclosing previous indemnity payments or performance concerns. Only eligible entities, such as credentialing bodies and state agencies, have access to the NPDB.

If a settlement is made on your behalf (which could be part of an early-resolution program such as a CRP) from your medical-professional liability policy, for care you provided, then this payment must be reported to the NPDB.

The NPDB guidebook states that to be reported to the NPDB, a medical-malpractice payment must be the result of a written complaint or a written claim demanding monetary payment for damages. Early-resolution programs do not change federal reporting requirements.



Alternative Dispute Resolution

Thinking Outside the Courtroom

When it comes to resolving medical disputes, traditional courtroom trials and newer models like communication and resolution programs (CRPs) aren't always the right fit. Trials are famously long and costly, while hospital-based CRPs may not suit complex cases involving practitioners from more than one organization. In certain circumstances, alternative methods of dispute resolution can better serve the needs of all involved parties and bring disputes to a swift, satisfactory close. Here, we take a closer look at two methods of alternative dispute resolution: arbitration and private trial.

Q: HOW DOES ARBITRATION DIFFER FROM PRIVATE TRIAL?

A: Both arbitration and private trial take place outside the courtroom and are often quicker, less expensive, and less formal than a traditional jury trial. In medical settings, arbitration is typically outlined in a contractual agreement that the patient accepts before treatment. Arbitrations are taken to a neutral third-party arbitrator—a professional trained in dispute resolution and mediation—while private trials are presided over by a retired judge or another individual with industry expertise.

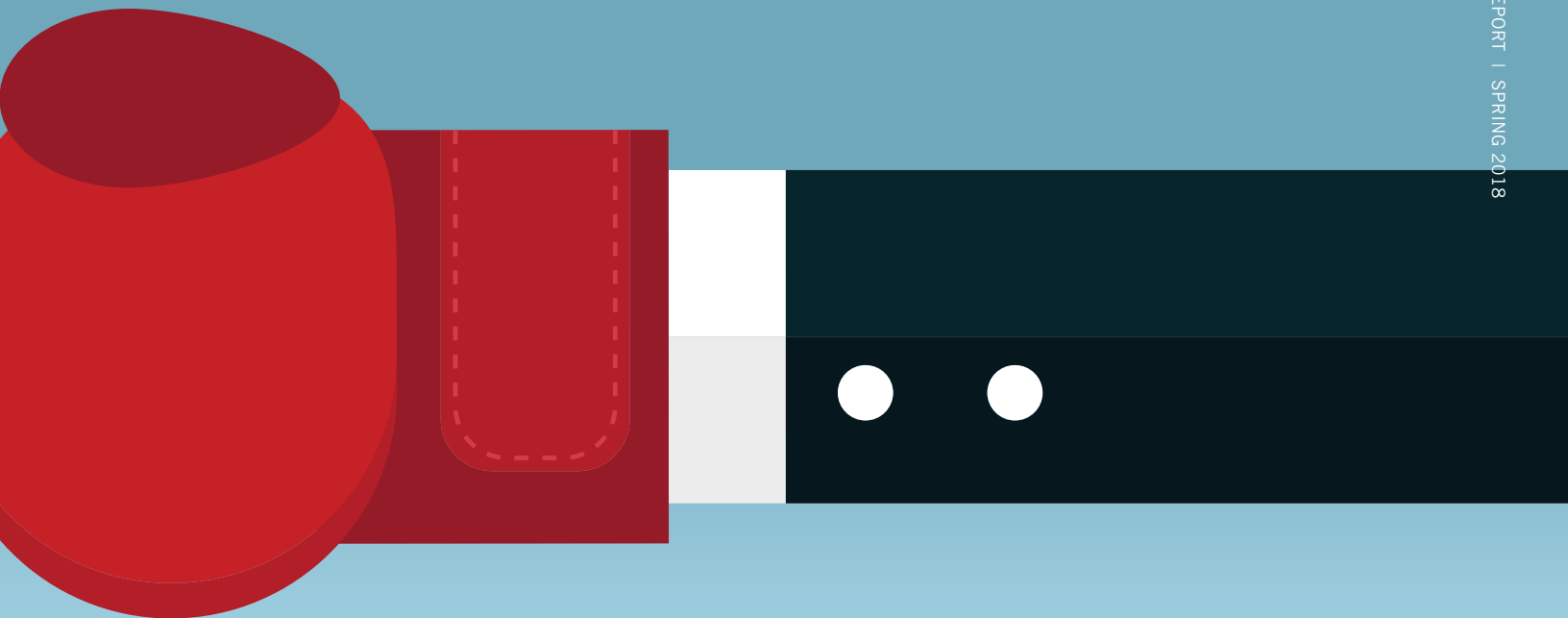
Q: CAN EITHER PARTY APPEAL THE RESULT OF A PRIVATE TRIAL OR ARBITRATION?

A: Most often, they can't. Many arbitration clauses specify that the results of the arbitration are binding. In private trials, appellate rights are usually negotiated ahead of time. Appellate courts need an official record to review on appeal, which means evidence must be formally marked and admitted, and a court reporter must record testimony. In many cases, parties in a private trial waive the right to appeal in order to lower the costs associated with recording and preserving evidence.

Q: WHAT ARE THE KEYS TO A SUCCESSFUL ARBITRATION?

A: The groundwork for a successful arbitration is laid before a patient ever receives care. In a patient-provider healthcare setting, an arbitration clause is typically outlined in a contractual agreement that the patient reviews and signs before undergoing treatment.

Accordingly, a well-crafted patient agreement can provide a framework for smoother, faster dispute resolution. When health-



care organizations include an arbitration clause in their patient agreements, it is important that the arbitration clause is clearly outlined, not buried, so patients understand the dispute-resolution process they're entering.

Q: WHAT ARE SOME ADVANTAGES TO A PRIVATE TRIAL?


A: Private trials can greatly reduce the costs involved in litigation in several ways. Jury trials can last for weeks, requiring physicians to spend significant time in the courtroom and away from their practices, with a steep associated cost in both lost income and legal fees. By contrast, a private trial is a less formal process and can typically be completed in one week or less. Also, in a private trial, a physician's presence may not be required for the entire time, and the physician may be able to return

to work much sooner than they would with a jury trial.

Because private trials are less formal, there are many cost-saving alternatives for presenting evidence. For example, expert witness testimony can be presented by video or even by written declaration, which can result in significant savings for both plaintiffs and defendants when compared to the travel expenses and fees for presentation of live testimony at a jury trial. Because private trials are governed by a contract between the two parties, there is flexibility in the terms that can be negotiated. When it is appropriate, these contracts can, for example, be used to cap the damages that can be recovered by plaintiffs, limit discovery during the case, or limit the number of experts called at trial, which can result in further cost savings over a public trial.

Q: WHEN MIGHT PRIVATE TRIAL BE LESS ADVANTAGEOUS?

A: Both parties must agree to resolve their dispute in a private trial. When that agreement can't be reached, or some aspect of the case lends itself to a courtroom setting, a jury trial may be the better option for both parties. In medical cases involving juries, properly educating the jury about the complexities of the case can help support a fair resolution.

At Physicians Insurance, we feel confident about our ability to work toward a fair outcome, whether the parties involved choose traditional or alternative means of dispute resolution. 

Sources

Eric A. Norman, civil litigation attorney with FAVROS Law in Seattle; Beth Cooper, Physicians Insurance senior claims representative.

BREAKING IT DOWN



Your Guidelines to Disclosure and Apology

By Deborah Lessard, RN, BSN, MA, JD, CPHRM, FASHRM

**“Science is difficult. Business is complicated.
Accountability is not.”**

—Hank McKinnell, Pfizer CEO, 2003

In health care, accountability after an error or adverse event is difficult, complicated, and uncomfortable, and can pose legal challenges. This article addresses the steps in the disclosure and apology process after an error or adverse event. It also provides components for effective interpersonal communication, as well as practical application tips.

The process of disclosure and apology started in 1987 at the Veterans Affairs Medical Center in Lexington, Kentucky. The VAMC's program was untried and untested, and was launched as a proactive approach to medical errors after the organization lost two large malpractice claims. Since that time, multiple programs have proven that disclosures and apologies work to improve patient safety. Disclosure/apology literature demonstrates that patients want accurate

information, compassion, and emotional support following an adverse event. Studies associate a decrease in claim processing time and litigation volume with these programs; however, the experts who conducted those studies believe that financial gain is a byproduct of the programs' better approach to patient communication, and should not represent their primary driver. Disclosure/apology processes, in other words, have evolved from a risk-management strategy into an expectation of high-quality health care.

The overarching goals of disclosure/apology are to:

- ✓ Meet patients' needs at a crucial time
- ✓ Express concern, empathy, regret, and (when appropriate) apology
- ✓ Encourage open and honest communication
- ✓ Preserve and protect the integrity of the physician/patient relationship

To achieve those goals, the following four steps are implemented in the disclosure/apology process:

1. Preparation
2. Discussion
3. Documentation
4. Follow-up

PREPARATION

In preparation for a disclosure/apology communication, medical records will need to be reviewed and discussed with the involved providers and staff.

Explanations should be prepared for every issue, breakdown, or situation. Patient questions and concerns should be known or anticipated, and addressed. If possible, these conversations should take place within a pre-established quality-improvement program to minimize the risk of litigation discovery and to encourage frank and honest dialogue.

At the outset, there should be a determination of who should be present at the discussion, and why. If, during preparation, a provider expresses discomfort or appears defensive, it is important that this be discussed with leadership, and that the provider either be given coaching or appointed a proxy to step in for them. Proxies should be considered whenever a provider is unable to deliver an authentic disclosure/apology, or is so uncomfortable with delivering it that honest and transparent communication is impossible. Proxies should be administrative leaders, such as chief medical officers or chief operations officers.

All parties should meet and agree on their roles and what will be discussed. This step should involve either role-play or facilitated coaching, usually managed by an individual who has been trained in medical disclosure/apology and conducted on a one-to-one basis. Coaching is more effective when conducted in person, but can also be accomplished via voice or video call; it includes assistance with the preparation of the actual discussion, observation and feedback on nonverbal language, and, if more than one professional is involved in the communication, planning of the sequencing and interactions between the parties.

Agreement on where and when communication will take place should occur between all health-care parties and the patient, including anyone who

New Communication Planning Resource Available

Effective communication is a core clinical competency and a key to patient satisfaction. This competency is necessary to build and sustain relationships, to enable patient engagement, and to optimize patient adherence, all of which have a direct impact on patient outcomes. Communication skills don't always come naturally for most people. They are learned and strengthened through practice, metacognitive exercise, and solicited feedback.

Physicians Insurance now offers a communication-planning document, developed by Deb Lessard, that focuses on interpersonal communication and can be applied in a variety of practice situations.

To learn more about the plan, contact your risk management consultant.

will be accompanying the patient. The entire communication process could be jeopardized if any party shows up late or to the wrong location.

The "welcome," "disclosure/apology introduction," and "small talk" portions of the conversation should be discussed and prepared in advance, keeping in mind that:

- The purpose of the "welcome" is to put the patient at ease by identifying the parties and their roles, addressing the importance of the conversation, and encouraging the patient to express any concerns and ask any questions they may have.
- The "disclosure/apology introduction" frames the conversation by identifying its purpose and providing an outline of what will be discussed.

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Validation statements like,
"I hear you," or,
***"I understand that you
 are frustrated,"***
 are the best responses to
 a patient's expressions of
 frustration and anger.



*(Breaking It Down, continued
 from page 9)*

- Small talk includes any conversation that may have to occur if one or more of the parties is late. This conversation should be carefully thought out in advance, in order to identify appropriate and inappropriate topics beforehand. It may also be inappropriate to engage in small talk at all, which must be decided on an individual basis and in light of variables like the severity of the outcome of the error or adverse event, the comfort level of the provider, and the mindset of the patient and their family.

Three important additional points are, first, that a hold should be placed on billing for the treatment provided, until the investigation is concluded and the provider and administrative leadership are in agreement on how to proceed; the provider should not independently make agreements with or assurances to the patient; and providers are encouraged to notify Physicians Insurance Risk Management consultants and Claims staff immediately, who should also participate in the preparation process.

DISCUSSION

While it is impossible to provide guidance on the specifics or particular sequence of any given disclosure/apology communication with a patient—many providers ask for scripts, which are discouraged because they undercut patient engagement—there are a few general elements to keep in mind.

The discussion should occur promptly, within 24 to 48 hours after the discovery of an error or adverse event if possible. The discussion should only include known facts. If there has not been an investigation into the facts of a situation, the discussion about it should not include an apology, though it is still important that sympathy and regret be expressed.

The general elements of a disclosure/apology discussion include:

- Expression of empathy. An expression of empathy is different from an apology. Empathy conveys regret that an event happened, while an apology assumes responsibility and offers to make amends for it. Both expressions include the words, "I am sorry," but empathy is based on feelings, whereas apologies are based on admission of fault.
- Acknowledgement of the error or adverse event.
- Expression of sympathy or regret. If an investigation into the facts has not yet occurred, an apology is premature and inappropriate. Instead, it is appropriate to express sympathy or regret, and share that an investigation will occur and that the provider will follow up after it is completed.
- Identification of the process of investigation—that is, what has already been done or will be done by the provider(s) in order to understand and analyze what occurred.
- A general and/or specific apology, if an investigation has occurred and it is determined that responsibility lies with the provider.
- Identification (potentially) of what could have been done differently in order to prevent the error or adverse event.
- Sharing of actions already taken, or that will be taken, in order to prevent a future occurrence.
- Encouragement of the patient to ask questions. Open-ended questions should be used, such as:
 - "Is there something you would like to ask?"
 - "What else would you like to talk about?"
 - "Can I provide you with more information?"
- Encouragement of the patient to express their feelings, frustrations, and anger.
- Discussion of follow-up, including those accountable for it and the time frame within which it will occur. It is important to provide realistic and achievable time frames for any follow-up actions, as failure to meet agreed-upon time frames may further damage the relationship with the patient.




- Summary of the entire discussion, including contact information for all parties.

It is important to keep from becoming defensive, and to allow the patient to express his or her feelings. Validation statements like, “I hear you,” or, “I understand that you are frustrated,” are the best responses to a patient’s expressions of frustration and anger. It is important not to engage in an argument or begin blaming others or the system, even in response to what may feel like an attack from a patient.

DOCUMENTATION

Documentation of the disclosure/apology communication should include the location of the communication, the length of time it took, who was present at it, and a summary of the communication, including patient concerns, requests, and demands and the agreed-upon follow-up plan. This documentation should be maintained in a separate file outside of the medical record.

FOLLOW-UP

If follow-up is decided upon, a plan should be drafted for it, including the specific steps or actions it will involve, who will undertake them, who is accountable for seeing follow-up through, and the time frame within which the patient should expect to hear from him or her. 



Essential Elements of Disclosure and Apology

Though the purpose of a disclosure/apology communication with a patient is of course disclosure and apology, it should be focused not simply on those elements, but also on informational exchange.

Patients in such situations often expect explanations, and express concerns, beyond those specifically related to the error or adverse event at hand. Consequently, enabling and empowering patient engagement in the disclosure/apology process, and allowing the patient to direct the conversation, will result in a far more successful communication overall.

Understanding that the provider and patient generally operate within different frameworks enables the provider to better plan for a disclosure/apology communication. The provider likely operates within a disease framework, which focuses on the patient’s history, treatment plan, and care management. The patient, on the other hand, often operates within an illness framework, which includes expectations, fears,

anxieties, and perceptions (and misperceptions) about their illness, the health-care system, and health insurance at large.

Effective interpersonal communication includes an understanding of the following:

- It’s not what you say—it’s what the patient hears.
- It’s crucial to understand that when words leave your mouth, they no longer belong to you—that ultimately, you have no control over how those words are heard, interpreted, and understood. In effect, the act of speaking involves surrender on the part of the speaker, and it is up to the listener—in this case the patient and/or their family—to determine the meaning.

(Continued on page 28)

To Apologize or Not Experts Weigh In



Whether medical practitioners should apologize after an adverse medical event is a question both philosophical and practical.

As with any quandary with such serious implications, there are sound points on both sides of the issue, says Jeffery Street, a medical-malpractice attorney in Portland, Oregon.

WHEN APOLOGIES HELP

"The potential benefit of apologizing is to help open the door to understanding, resolution, and closure," Street says. "It is good for people to talk, to heal, and to be open. Health-care providers are typically compassionate people, so why shouldn't that compassion extend to an apology?"

An emotionally satisfying apology can offer practical benefits, too. "Psychologists and others believe that medical apologies can lead to fewer claims," Street continues. "Often when a patient is deposed, we find that they sued because nobody apologized or contacted them to offer empathy or talk about next steps."

In recent decades, this emerging understanding of the benefits of apology brought new legal protections for these types of communications. According to the National Conference of State Legislatures, most states have laws in place to protect apologies from providers after adverse medical events. Medical apologies are

protected by law in Physicians Insurance's member states of Alaska, Idaho, Oregon, Washington, and Wyoming.

Broadly, this means that when apologies made by health-care practitioners or organizations to an affected person or their family meet certain criteria, these statements are inadmissible in court, and thus can't be used against the provider or organization in a legal setting. By protecting health-care workers who apologize to patients or their families, these laws help to break down longstanding barriers discouraging communication between doctors and patients after an adverse event.

Though slight differences may exist between state statutes, they are mostly similar in their intent and their content, says Mark Louvier, a medical-malpractice attorney in Spokane, Washington. When guided by legal counsel with a current understanding of the state's current medical-apology laws, apologies can benefit both parties.

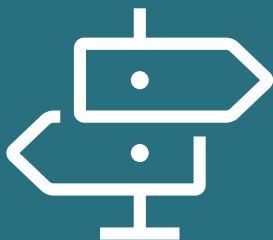
Physicians can follow established guidelines to craft an effective, empathetic apology without opening the door to legal repercussions, Louvier says. He recommends that providers engage a malpractice attorney before issuing any apology, that they craft an apology that offers empathy without assigning fault or blame, and that they consider using a written apology that's been reviewed by counsel, as opposed to a verbal apology. "Compared to verbal apologies, written apologies can help avoid ambiguous language, and they can be reviewed by an attorney before they're given to the patient," he says.

WHEN APOLOGY HURTS

Of course, an apology after an adverse event can impede rather than foster resolution, particularly when it doesn't meet a state's criteria for legal protection. "Skeptics say apology doesn't reduce the

chance of litigation; rather, it can be used against the provider," Street says.

Indeed, apology-protection statutes do not protect every expression of remorse or regret on behalf of providers. For example, protected apologies must be made by and to the appropriate parties—or the statements may be admissible in court.



"Compared to verbal apologies, written apologies can help avoid ambiguous language, and they can be reviewed by an attorney before they're given to the patient."

MARK LOUVIER,
MEDICAL-MALPRACTICE
ATTORNEY

In general, apologies made by a health-care provider or organization to a patient or a patient's friends and family are protected by law, while statements of apology made to other people are not. "This means that if a provider expresses remorse about an adverse event to someone completely unrelated to the event, that could be admissible in court," says Louvier.

To qualify for legal protection, apologies are required by most states to be made to the patient or someone close to the patient, like a family member, friend, or domestic partner. While some states, including Wyoming, extend apology protection to apologies made to a patient's attorney, many states' statutes do not have this provision.

Timely apology is also important, notes Street. In Washington, for example, protected apologies must be made within 30 days of the discovery of alleged negligence. Late apologies—even those that meet the other criteria for protection—may be admissible in court.

When a poor outcome impacts a patient and their family, apologizing often feels like the right thing to do, says Street. With appropriate guidance from the right experts—an attorney skilled in medical malpractice, an insurance-claims representative, and risk-management personnel—apology can promote compassion, empathy, and healing for all people involved in a medical error, without leading to further complications. ^{PR}

MORE APOLOGY INFORMATION

Washington: <https://tinyurl.com/yato3mbx>
Oregon: <https://tinyurl.com/y7ul3co2>
Idaho: <https://tinyurl.com/yd6c5loz>
Wyoming: <https://tinyurl.com/ychbc6kl>
Alaska: <https://tinyurl.com/yaqq9mx6>

Sources

Jeffery Street, medical-malpractice attorney in Portland, Oregon

Mark Louvier, medical-malpractice attorney in Spokane, Washington

WHEN THINGS GO WRONG... **ON THE INSIDE**

HELPING
PHYSICIANS
ACHIEVE
WELLBEING
AT WORK
AND HOME



Physicians routinely overcome so much in a day, a week, a year—from overstuffed patient panels to electronic records documentation, preauthorization headaches, and conflicting insurer metrics. So when something goes wrong—whether it's a simple, inadvertent mistake or a patient fatality—it can be overwhelming when added to the other stresses of the job, especially when the proper support is lacking. Sometimes that results simply in a loss of wellbeing or increase of family stress; sometimes it can lead to early retirement, even at the peak of a career, due to burnout.

It's critical for physicians to be supported during such times, no matter where they are in their careers, says Dr. Claudia Finkelstein, director of faculty wellness programs for the University of Washington School of Medicine in Seattle. Dr. Finkelstein, an internist, specializes in physician wellbeing, and she fervently believes that well-adjusted, resilient physicians provide better care to patients and better teaching and mentorship to doctors-in-training, and are better, more positive family members.

"Everyone in health care, from doctors to nurses to therapists, should be operating under conditions that allow them to reach their maximum potential," says Finkelstein, who also co-chairs the UW's Faculty Wellness Committee, heads its Peer Support Program, and directs an educational outreach program. Her outreach series includes workshops and two extended-training series: Mindfulness and Compassion Cultivation Training.

STRESS, DEPRESSION, EVEN SUICIDE

Too often, balance doesn't come easily to physicians, according to Stanford Health Care, which is also tackling the problem. Nationally, according to Stanford experts, up to 40 percent of physicians report being burnt out. As many as 400 physicians commit suicide

"There are so many things that just feel like hoops to jump through, as opposed to patient care. People say to me, 'I used to be a doctor—now I'm just a typist.'"

DR. CLAUDIA FINKELSTEIN

each year; among medical-school students, suicide is the second most common cause of death. And it's clearly more than simply a personal problem for physicians and their families: such distress can lead to major medical errors, poorer patient care, and more lawsuits against physicians, Finkelstein says.

It also drives up the cost of health care. The Mayo Clinic estimates that physician burnout adds more than \$3.4 billion annually to the U.S. health-care system's expenses. Within the Mayo Clinic's own Department of Medicine, it costs an estimated \$1.5 to \$2.5 million a year in decreased productivity.

The problem is not a lack of dedication on the part of physicians. "It's the

circumstances under which one works," Finkelstein says. "It's about the prior authorizations, and feeling every day like you're typing forever. There are so many things that just feel like hoops to jump through, as opposed to patient care. People say to me, 'I used to be a doctor—now I'm just a typist.' In what other profession do the highest-paid workers do the data entry? Adding to the pressure on physicians is the fact that the whole concept of the chart has gone from a narrative of a patient's experience by a doctor to a billing document. It's nonsensical."

LIVING AND WORKING WITH SATISFACTION AND SUPPORT

At the heart of professional fulfillment in medicine, there are three key areas, Finkelstein says:

- **Professional fulfillment**—finding your life's purpose in healing
- **Practice efficiency**—ensuring your day isn't eaten by clerical tasks
- **A culture of wellness**—ensuring your personal needs are met

Individual professional fulfillment can mean many different things to different people.

(Continued on page 24)

CRP Leaders

Best Practices in Communication and Resolution Programs Nationwide



Communication and resolution programs are the emerging best practice for more effectively addressing patient harm and preventing it in the future. As CRPs gain traction nationwide, several standout states share what's working.

OREGON: TWO-WAY COMMUNICATION

Oregon was one of the first states in the country to pass a law (Oregon Laws 2013, Chap. 5) promoting open, transparent communication between health-care providers and patients and families across all health-care settings—what is now Oregon's Early Discussion and Resolution (EDR) program. The EDR program, which is voluntary, offers support and legal protections for these important communications. EDR communications between patients and providers are protected by state law. Oregon remains the only state to allow both patients and health-care providers to initiate these types of conversations; similar programs in other states only allow provider initiation. The EDR statute also covers a very broad range of providers, from podiatrists to dentists to pharmacists. The Oregon Patient Safety Commission collects de-identified data through a voluntary survey after EDR

communications have concluded. Over time, OSPC will be able to use this rich data set to offer guidance to providers on how to more effectively address and resolve adverse events across Oregon.

Beth Kaye, Director, Early Discussion and Resolution Program, Oregon Patient Safety Commission

www.theoma.org/node/3807

MICHIGAN: INTEGRATED IMPROVEMENTS

In the old-school risk-management model of "deny and defend," communication often halts, and everyone goes to his or her separate corner, the moment a patient gets hurt. Providers are forced to abandon their clinical mission and stay silent until the deposition. There are strict walls between hospitals' quality-and-safety and risk-management groups. In 2001, I suggested three foundational principles to guide our response to injured patients and improve communication and resolution, and one was that we learn from all patient experiences, good and bad. Our priority is the patient we haven't hurt yet: how do we improve and keep a given adverse event

from happening again? Many organizations are trying to proactively get in front of patient injuries, but too often they are largely reactive instead, and very few seem to understand that our driving fundamental aim is keeping preventable injuries from happening in the first place. The beauty of this approach is that it has fueled all sorts of good things that were frustrated in "deny and defend." We've seen the broad growth of evidence-based peer review, improvements in informed consent, and other clinical improvements not likely in a defensive culture, while the number of patient claims has fallen by over two-thirds.

Richard Boothman, JD, Chief Risk Officer, University of Michigan Health System

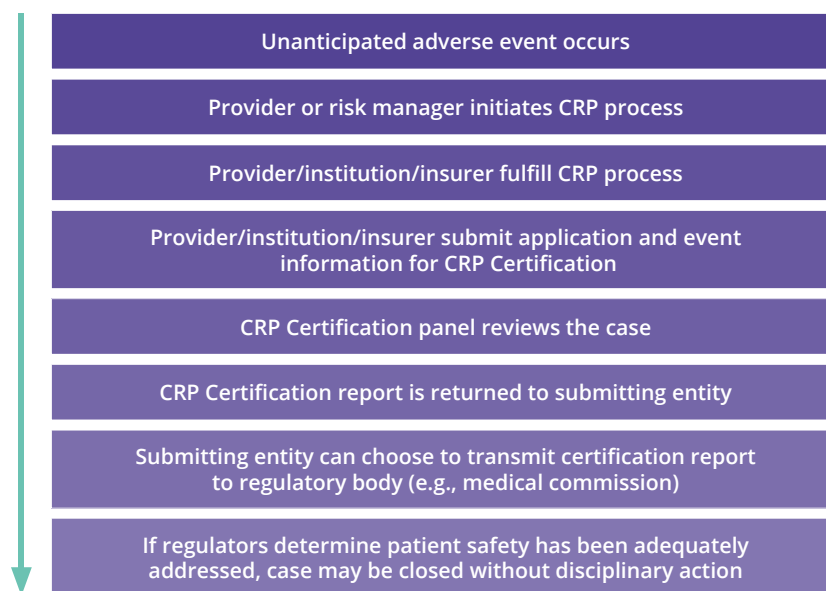
www.uofmhealth.org/michigan-model-medical-malpractice-and-patient-safety-umhs

MASSACHUSETTS: EVIDENCE-BASED CHANGE

When I started, we wanted to provide a better alternative than litigation for resolving adverse outcomes. Massachusetts was the first to do this as a statewide initiative instead of as a closed system.

CRP Certification

Important collaboration has been taking place for several years with regulators in Washington, including the CRP Certification program developed in collaboration with the Medical Quality Assurance Commission. The CRP Certification program allows institutions and physicians who have used a CRP in responding to an adverse event to submit an application describing how the event was handled to a neutral expert-review panel based at the Foundation for Health Care Quality.



To facilitate this, we negotiated and enacted enabling legislation in 2012, which established a six-month pre-litigation resolution period, appropriate protections for apology, the requirement to share all pertinent medical records, and the obligation to disclose significant adverse events. We learned that many patients don't want compensation—they want open, honest communication, a sincere apology for avoidable injury, and an assurance of what's being done to prevent any recurrence. Research shows us that apology is extremely important for patients in dealing with their anger, and for providers in dealing with their grief. Ultimately, this approach is about taking responsibility for our adverse outcomes, and doing what is morally and ethically right for patients, providers, and the health-care system as a whole. It allows our providers to practice evidence-based medicine, not defensive medicine, and to focus on health-care safety, ultimately saving lives.

Alan Woodward, MD, Emergency Physician and Chair, Committee on Professional Liability, Massachusetts Medical Society

tinyurl.com/ycxne3pm

The benefits of participating in CRP Certification are widespread. The key benefits of CRP Certification for each unique stakeholder group are listed in the table below.

Institutional Benefits	Risk Benefits	Provider Benefits
Gain a seal of approval that your institution carried out all of the essential CRP steps	Demonstrate to regulators that your team took the right steps to resolve an adverse event and prevent recurrences	Regulatory bodies may reduce disciplinary action if an event is certified
Receive feedback on how to improve your institution's CRP	Help ensure that your providers are on top of patient safety and medical errors are not repeated	Recognize providers who handled a different event well
Contribute to a case database house at FHCQ. Lessons learned will be periodically distributed based on case submissions and results	Potentially reduce chances of litigation and lower liability costs	Contribute to statewide/national learning

Additional information about the CRP Certification process can be found on the Foundation for Health Care Quality's website at www.crp.qualityhealth.org.

(When Things Go Wrong, continued from page 5)

High-functioning CRPs have several important characteristics. First, they are used for all adverse events, regardless of whether the patient knows the event has occurred, or how likely the patient would be to receive compensation through the traditional legal system. Second, they are comprehensive, with all departments and involved individuals working together to communicate (both with the patient and with involved providers), to investigate the situation, and to determine the proper resolution. Third, they are systematic, with each of these elements being hard-wired and inherently linked to the remaining components.

The current state of CRPs reflects not only the pioneering work done in Michigan and Kentucky, but also outstanding initiatives at the University of Illinois at Chicago and Stanford University, and, more recently, statewide initiatives in Oregon and Massachusetts. Much of this work has been supported through grants from the federal Agency for Healthcare Research and Quality, which funded large-scale planning and demonstration grants and developed an extensive suite of CRP tools known as the CANDOR toolkit (<https://tinyurl.com/ydc6loz5l>).

The Massachusetts Alliance for Communication and Resolution after Medical Injury (MACRMI) is a stellar example of how CRPs can be beneficial for the patient and the provider alike. MACRMI represents a diverse coalition of stakeholders, including the Massachusetts Bar Association, leading health-care organizations, liability insurers, regulators, health-plan representatives, and others, all coming together to advance CRPs in Massachusetts. The MACRMI website has a lot of great resources, as well as reports presenting data from the MACRMI experience.

BREAKING THROUGH BARRIERS


While the progress in the CRP field is exciting, several challenges remain. One

important barrier relates to institutions' inconsistent use of the CRP model, using the CRP approach for some cases but not others, or using some elements of the CRP, but not the entire approach, for an individual adverse event. This inconsistent implementation is worrisome, and threatens the long-term success of this work. Metrics and standards are being developed to support institutions in their development of a high-functioning CRP that adheres to this model in a comprehensive, principled, and systematic way.

Another issue that can cause hurdles to arise in the effective use of CRPs is how a health-care institution works with providers who are not employed and/or insured by the facility. CRP success requires that all providers who have a stake in the outcome be represented during the entirety of the process. This ensures that if financial remuneration is offered on behalf of a physician, it is done with the physician's written consent—which can only be obtained if the physician is aware of and able to participate in the process. (Written consent from the provider is often required prior to monetary compensation being offered under a CRP.)

Some critics also worry that CRPs have the potential to take advantage of patients, especially in cases in which an offer of compensation is made to an unrepresented patient at a lower amount than what the patient deserves, and the patient accepts the offer and signs a release of their right to sue without recognizing that a higher level of compensation was warranted. This, too, is an area where robust metrics and standards, along with rigorous externally conducted research on the nature of financial offers made as part of a CRP, will be important. This concern is one reason why high-functioning CRPs strongly recommend to patients that they obtain legal advice in most cases.

CRPs have the potential to improve the response to adverse events in health

care, addressing the patient's needs for transparency and accountability while promoting disseminated learning and improved quality. For CRPs to achieve their true potential, however, all CRP stakeholders should educate themselves about what CRPs are and how they work, and participate in ongoing conversations about opportunities to improve the process. 



Dr. Gallagher is a general internist, professor, and associate chair in the Department of Medicine at the University of Washington. He is a nationally known patient-safety expert and

the 2017 recipient of the John M. Eisenberg Award for Career Achievement in Patient Safety from the National Quality Forum and The Joint Commission. He was a principal investigator in a demonstration project to determine the feasibility of CRP implementation in health-care systems, and formed the Collaborative for Accountability & Improvement, a national coalition of stakeholders dedicated to improving CRP adoption.

Learn More About CRP

Talk to your risk manager or director or Physicians Insurance Claims representative, who can offer valuable resources and discuss with you whether such a program may be right for your practice.

Other resources include:

Collaborative for Accountability and Improvement

<https://tinyurl.com/ydGeeqyp0/>

Agency for Healthcare Research and Quality's CANDOR toolkit

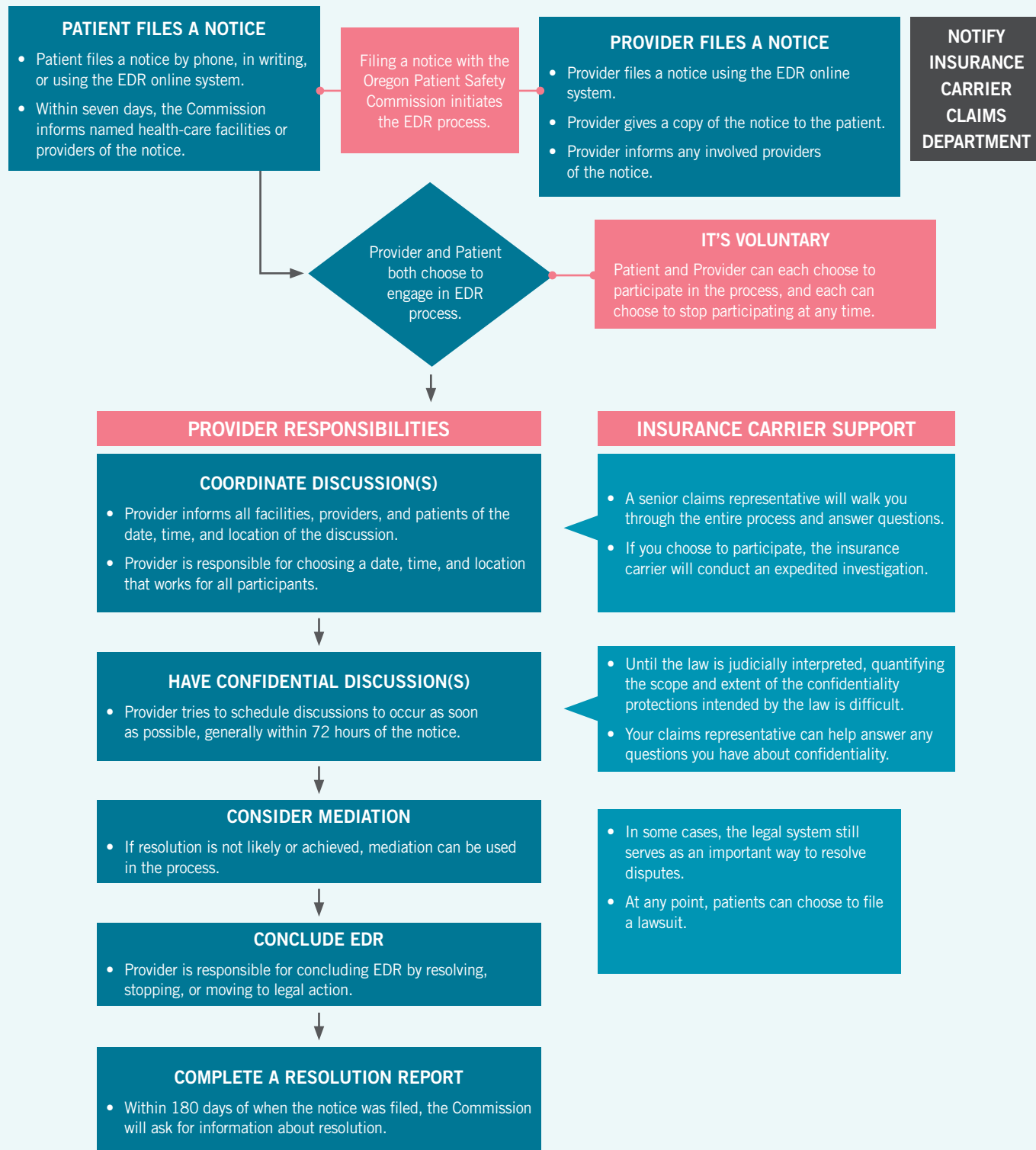
<https://tinyurl.com/y9ymzm8>

Oregon Patient Safety Commission Early Discussion and Resolution program

<https://tinyurl.com/y92utflp>

Early Discussion and Resolution (EDR) Process

This flow chart was developed in cooperation with the Oregon Patient Safety Commission.



A Just Culture

Reducing Errors and Clearing the Way for Improvements

Everyone hates errors in medical care, from nurses administering medications, to surgeons installing stents, to aides taking blood pressure.

But often, when errors are discovered in many organizations, disciplinary action can be humiliating or even harsh. That can make employees afraid to report errors made by themselves or by colleagues.

But a new way of approaching the issue, known as “Just Culture,” replaces that harshness with a holistic, team-based methodology that encourages openness about errors, coupled with enhanced training and supervision for when mistakes do occur. In short, it’s about building trust among staff and examining inevitable mistakes from a number of perspectives before forming judgments about their causes. The approach is picking up converts, and you can count The Vancouver Clinic among them.

HONEST MISTAKES VERSUS PURPOSEFUL ERRORS

This fresh way of thinking about errors doesn’t mean that people aren’t held accountable for willful safety violations or big-time negligence, says Alfred Seekamp, MD, chief medical officer of The Vancouver Clinic. No one is above the law. What it does mean is that people aren’t blamed for honest errors, some of which occur because of systemic issues in an organization or because of other factors outside their control. Everyone in an organization that employs Just Culture principles should, through training, be able to recognize what acceptable and unacceptable behaviors look like.

“We want safe processes,” says Dr. Seekamp. “So we in health care need to look at how we can eliminate variations and create processes that are safe. And one of the ways to do that is to foster a culture in our organization where people feel comfortable reporting things, whether it’s an error or a near miss.”

Just Culture is all about creating a system that encourages people to inform their organization about problems and hazards without fear of punishment or prosecution, Seekamp says. Too often, he says, a lack of trust prevents employees from telling management about risks, which means that safety issues go unchanged or unchallenged.

Some things remain fluid as the program rolls out. Determining exactly what should be reported remains an important and fundamental question. For example, double-checking insulin doses is a standard process of care. If a second nurse finds an error, is this a reportable event? Officials at The Vancouver Clinic say they're seeking more clarity on exactly what workers should report, so they're not buried in data. They're also drilling down on the level of detail required, and how long people should take to report events.

ENGINEERING PRINCIPLES ADAPTED FOR HEALTH CARE

Intertwined with the notion of Just Culture at The Vancouver Clinic is that of "Lean" engineering principles. Made famous by Toyota, Lean principles generally embrace system improvements by adopting processes that add value, while at the same time reducing anything that adds waste. Continuous improvement, learning, and adaptability are the keys to success under Lean principles.

"It's all a part of our innate culture, which is patient-focused," Seekamp says. "We promote the voice of every team member, to make sure everyone is heard."

The Vancouver Clinic began it all with a pilot project on how to best capture adverse events. Data gathered through the pilot were used to identify safety hazards, and develop interventions to

mitigate those hazards and evaluate whether the interventions actually reduced harm. Incident reports initially came from departments that included Ob-Gyn, sleep medicine, urgent care, the patient-service center, the ambulatory-surgery center, and the laboratory.

"We look at any potential trouble and do problem-solving in the huddles. If something can't be solved there, it gets elevated to the managers, then all the way up the line, from the IT department to the CEO if necessary."

ALFRED SEEKAMP, MD,
CHIEF MEDICAL OFFICER,
THE VANCOUVER CLINIC

AN ASSIST FROM AVIATION

In health-care organizations employing Just Culture, employees are encouraged—and sometimes even rewarded—when they report safety issues and errors. That philosophy grew out of a similar movement in aviation safety, where even a minor error can prove catastrophic.

Medicine is increasingly about teamwork, Dr. Seekamp says. That teamwork starts with providers, who gather in morning huddles held before the workday begins. In those huddles, staff members go over how the day is looking, and identify any lingering issues from the day before.

"We look at any potential trouble and do problem-solving in the huddles," Dr. Seekamp says. "If something can't be solved there, it gets elevated to the managers, then all the way up the line, from the IT department to the CEO if necessary."

They want to solve individual problems, of course, but also implement solutions across the organization that will improve quality, outcomes and patient safety. "If there was a mistake made—say the wrong medicine was prescribed to a patient—we want to console the person who made the mistake, coach them if their behavior was part of the issue, and then figure out a solution so it doesn't happen again, if appropriate," Seekamp says.

Take something as easy, and as crucial, as handwashing. "We want to support people," Seekamp says—and if people aren't washing up per the policy, the organization wants to figure out the problem, rather than play "gotcha."

"If people are not doing washing," Seekamp says, "we will have a conversation with them about the risk of illness. But we'll also do a deeper dive: are we making it easy for people to sanitize their hands? We look at the reasons why it might not be happening, and we fix it if there are issues. However, once you coach someone and they keep not doing it, you do need to hold people responsible."

The Just Culture principles will be part of the job from the earliest days for

(Continued on page 26)



CASE STUDY

Operation CRP

How Confluence Health Launched Their Communication and Resolution Program



Building a communication and resolution program (CRP) from the ground up is a challenge that requires a strategic, coordinated approach. Just ask the team at Confluence Health, an integrated health-care system in North Central Washington with 270 physicians and 150 advanced-practice clinicians. When its leaders set out to create a CRP in 2016, they sought expert advice, listened to employee input, and tackled tasks one by one. Their efforts launched a robust, well-received program in August 2017 that's still growing.

Taking a system-wide initiative from concept to initial rollout in six months is a monumental endeavor. But in this case, the task was made manageable by the team's careful, step-by-step approach. Here, Confluence's Medical Director of Quality, Randal Moseley, MD; and Risk Manager, Leslie Robinson, CPHRM, share notes about planning, implementing, and growing their CRP.

STEP ONE: SEEK EXPERT ADVICE

In February 2016, we attended a workshop hosted by the Collaborative for

Accountability and Improvement. That was our first exposure to CRP as a blueprint for how to conduct business. It was career-changing for me. That comprehensive two-day workshop served as a roadmap for everything we subsequently did to revamp our process for response to harm events. The workshop also provided the foundation for BESIDE, our colleague-care program.

We worked with Dr. Thomas Gallagher, executive director of the Collaborative for Accountability and Improvement and Associate Chair of the Department of Medicine at the University of Washington, in the early stages, and we've continued to seek input from his group through this process. We also worked with Dr. Tim McDonald, director of the Center for Open and Honest Communication at the MedStar Institute for Quality and Safety. The Washington Patient Safety Coalition and the US Department of Health and Human Services Agency for Healthcare Research and "CANDOR" toolkit (<https://tinyurl.com/y9yjmzm8>) were also great resources.

—Randal Moseley, MD



"If you don't have your leadership behind you, I don't know how you can do this."

RANDAL MOSELEY, MD,
MEDICAL DIRECTOR OF QUALITY,
CONFLUENCE HEALTH



STEP TWO: FOSTER ORGANIZATIONAL BUY-IN

Soon after, we got our bearings together and approached our leadership team about establishing a CRP at Confluence. We worked with our chief medical officer, our senior leadership team, and ultimately our board. This step is critical. If you don't have your leadership behind you, I don't know how you can do this.

Ultimately, it didn't take much convincing. Right away, we were able to build support for a CRP and begin the process of implementation. We already had a multidisciplinary Culture of Safety Committee, and this initiative tied in with the mission of that group. By involving that group right away, we made this a multidisciplinary project that received input from throughout the organization at the outset. We really felt that to be successful with this, we'd need to start with our culture of safety, so this group was going to be important in helping the initiative move forward.

—Randal Moseley, MD

STEP THREE: ESTABLISH METRICS

Determining how we'd measure success was an important piece of this process, and we struggled a bit because we're still gathering data for our first year. We launched in August 2017, and this August we'll have a year's worth of data for evaluation. Right now, we're looking at total liability costs, requests for records or letters from attorneys, time to closure, and employee retention, and our early feedback is positive.

—Leslie Robinson, CPHRM

STEP FOUR: IMPROVE REPORTING

Before rolling out a CRP, you need a robust state-of-the-art investigation system for root cause analysis (RCA2) to facilitate greater understanding of how and why an event occurred. So we first established RCA2 based on the model provided by the National Patient Safety Foundation. This led to a key change in the way we handle information gathering after an event. Previously, interviews of those involved took place at the same time in one room. Under RCA2, we conduct one-on-one interviews in a safe environment. We were surprised by how much more effective this was. We get a much broader scope of information, which allows for more accuracy and a faster resolution.

—Randal Moseley, MD

STEP FIVE: CARE FOR COLLEAGUES

We already had an active burnout-prevention program for our physicians, so we knew communication and resolution was a factor in their wellbeing and retention. After we implemented RCA2, we created our colleaguecare program, Bringing Encouragement and Support in Difficult Events (BESIDE). We have a psychologist on staff to meet with providers confidentially after an adverse event to provide support; as far as we know, we're the only health-care system in Washington to do that. But we've found that after an adverse event, people's first preference is to meet with a peer. Right now we are training eight peer supporters,




"I think a lot of systems try to do it all at once, and that's difficult. We're focusing on individual pieces, and on getting each one right."

LESLIE ROBINSON, CPHRM,
RISK MANAGER,
CONFLUENCE HEALTH

Confluence employees who can meet with physicians one-on-one after an event to provide support. We've had a lot of our providers reaching out to us about this program. I've been surprised by the positive impact it's had already.

—Leslie Robinson, CPHRM

A FEW MORE LESSONS LEARNED

The team's best advice to other systems just starting CRP initiatives? Make incremental changes, seek feedback, and learn as you go. "I think a lot of systems try to do it all at once, and that's difficult," says Robinson. "We're focusing on individual pieces, and on getting each one right." 



(When Things Go Wrong...On the Inside, continued from page 15)

For many physicians, it can mean having the time and support to care for their patients in the way they think is necessary and effective.

As for practice efficiency, “If you need to type for three hours a day after seeing patients, well, that is going to impact you,” Finkelstein says. “When I go to work and my only ambition is to finish my charts on time, I likely will have a crappy time. But if I go to work and my goal is to relieve suffering, and I’m given the space to do that, I will have a great day.”

What constitutes a culture of wellness might well depend on where physicians are in their career. “It can mean that if you announce you’d like a parental leave, your colleagues offer their congratulations and you’re not worried about everyone having to cover for you,” Finkelstein says. “It also means you’re allowed to call in when you’re sick, and not feel that you’re putting undue pressure on colleagues. The culture of bravado in medicine simply doesn’t work anymore, that way of working through every obstacle. We all know that.”

WHY SHOULD YOU CALL?

In her work supporting physicians, Finkelstein is especially proud of having developed the UW’s Peer Support program, which she modeled after a similar program at the famed Brigham and Women’s Hospital in Boston.


“Sometimes, when something hasn’t gone exactly the way it should, whom can you talk to about it as a physician?” she asks. “We offer a peer to talk to, another physician with whom you can discuss the emotional impact of a problem. Sometimes it’s something difficult, like helping you understand not to expect absolution from a family. Our program is about being able to sit with someone and know you’re not alone, to have someone help with guilt and shame and depression. I frequently meet and chat with physicians after

issues crop up, and give them a list of resources, including a list of physicians and counselors they can draw upon. It’s very private. I meet people all over the place, and I’ve been around here for a long time, so other people don’t know why I’m meeting the people I meet. I’ve even met physicians at Starbucks.”

She adds that these meetings are always confidential. “I don’t report anything to anyone,” she says. “Only if it’s a mandated report—I would have to report someone I knew was impaired and unable to care for patients, for instance.”

For information about Physicians Insurance’s Peer and Provider Support Resources, see “Responding to Adverse Events: Implications and Resources for Providers” on page 27.

LIFE AND WORK IN BALANCE

At the end of the day, Finkelstein says, what physicians need is a sense that their best self is showing up to work, so they can flourish in the office and at home. “It is such a great joy to have a profession with a purpose that is to connect with and help people,” she says. “When your own light goes out a bit, though, it’s much harder to provide that connection with patients. I’m just so passionate about this because it’s a big, big problem affecting not only individual physicians, but also their patients and families, and workplaces. Everyone needs some form of support.” 



“The culture of bravado in medicine simply doesn’t work anymore, that way of working through every obstacle. We all know that.”

DR. CLAUDIA FINKELSTEIN

ONLINE CME

An Intraoperative Disaster: Responding to Adverse Outcomes in Anesthesiology

Suited for anesthesiologists.

The case discussed in this one-hour webinar really happened, both in the operating room and in the courtroom. Anesthesiologist Eric Stoler draws on his experience reviewing malpractice claims to guide you through the dos and don'ts of responding to a bad outcome. From what to say to the patient and their family to resources for personal and professional support, this webinar gives you the key communication and documentation skills that can prevent a lawsuit or otherwise bolster your defense. You will leave the course feeling assured and empowered to handle an adverse outcome, should one occur. This activity has been approved for *AMA PRA Category 1 Credit™*.

tinyurl.com/yaqbyufm

Managing Physician Stress, Preventing Burnout (1-credit video)

Suited for physicians of all specialties

Learning Objectives: Upon completion, participants should be able to:

1. Explain the effects of chronic stress and physician burnout on physician health and patient care.
2. Describe the impact of litigation-stress management.
3. State several characteristic behaviors of the Harvard study respondents who have lived happier, longer, healthier lives than their peers.
4. Suggest several stress-reduction strategies to their patients.

tinyurl.com/y8ck58ux

Disclosure of Medical Error: A Physician RM Guide

Suited for physicians of all specialties in the hospital, clinic and office settings. Other interested health-care practitioners are also welcome to participate.

Discussing adverse medical events with patients and families is perhaps the most difficult task physicians will undertake. Too often, physicians will postpone, delegate or avoid these difficult conversations as a result. Prompt, empathic communication initiated by the physician is the best way to safeguard the doctor-patient relationship and reduce the risk of malpractice claims. However, there are many barriers to doing so.

This mixed-media online/enduring material will present risk-management recommendations on how to communicate with patients and families about adverse events, as well as a model for reducing risk through disclosure of error. It includes a panel discussion on formal disclosure programs implemented at such institutions as the Veterans Administration and the University of Michigan. This activity has been approved for *AMA PRA Category 1 Credit™*.

tinyurl.com/ycldzzp8

Who Heals the Healer? Improving Physician Health and Quality of Care (1-credit video)

Suited for physicians of all specialties. Other interested health-care providers are also welcome to participate.

Recent large-scale surveys of physicians show high numbers of respondents endorsing statements of stress and burnout. This video presentation by an emergency-medicine physician examines the quantifiable effects of physician stress on the physician's physiology and on the patient's quality of care. Dr. Drill-Mellum offers strategies and techniques for building resilience and emphasizes the responsibility of the physician to actively manage stress.

Learning Objectives: Upon completion, participants should be able to:

1. List the ways in which stress and sleeplessness impair physicians' health.
2. Describe how physician stress and burnout affect the quality of care rendered.
3. Implement one or more techniques for managing their own stress.
4. Teach one or more techniques for managing stress to another physician, healthcare provider, or patient.

tinyurl.com/y9odmlag

Visit www.phyins.com/cme to learn about the CME that is included with your Physicians Insurance policy at no additional cost.



(A Just Culture, continued from page 21)

all employees—all new hires will be trained in it. Every current employee will be trained in it as well.

A LABORATORY FOR CHANGE THAT'S JUST THE RIGHT SIZE

The Just Culture philosophy appears to be working well for The Vancouver Clinic. “We’re uniquely positioned to try it,” Seekamp says. “We’re physician-owned, and we’re large but not huge, with 300 providers and 1,000 staff. We’re small enough that we can really develop an integrated culture. Providers join us because they believe in the group model. It’s much like a family, and in a family, people think about their kids and spouses before their own self-interest. That’s really what we want to promote, and it’s how we get better. And it’s part of the professionalism in medicine, of continually working to get better.”

Gayle Seifullin, Director of Quality and Medical Affairs for The Vancouver Clinic, recalls one concrete example of Just Culture in action that began on the clinic floors, among frontline staff.


“We had difficulty with a syringe we were using—it was leaking,” Seifullin says. Rather than staff just living with it or being afraid of being accused of using the syringe incorrectly,

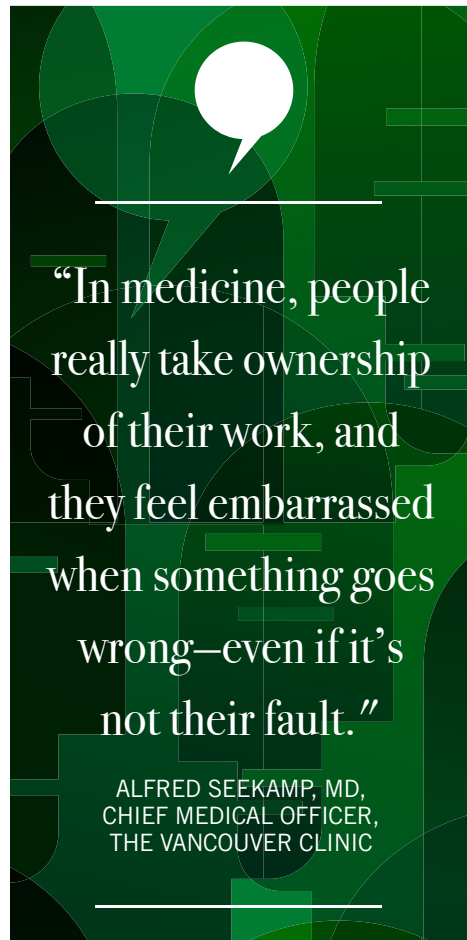
they reported the issue, which was eventually escalated to the highest levels of the organization. A task force

would take more time. As the task force worked, they reported their findings and thoughts so those investigating the problem knew where the issue stood. Eventually, clinic staff worked with the vendor and removed the faulty syringe, replacing it with a better model.

“That’s a true model of a culture that encourages reporting,” Seifullin says. “Is everything solvable? That I can’t speak to. But this is how our Just Culture model works.”

It’s not always straightforward, Seekamp concedes. “Culture work is always difficult,” he says. “In medicine, people really take ownership of their work, and they feel embarrassed when something goes wrong—even if it’s not their fault. But when we dig deeper into an incident, we can see process issues, and that can let us solve problems across the organization. If it’s a problem in surgery, it’s probably also a problem in internal medicine or in Ob-Gyn. We want to solve these problems across the organization, because when we do, we improve quality, outcomes, and patient safety.

“We’re always a work in progress, continually evolving, and this is just another part of how we’re trying to get better.” 



was assigned to investigate the problem and determine if it could be quickly solved, or if it was something that

Responding to Adverse Events: Implications and Resources for Providers



Things don't always go as planned. And when they don't, you are not on your own. There is an entire community of physicians who are pulling for you, wanting to offer support during this challenging time.

So we created the Physicians Insurance Peer Support Program.

Your peer support consultant is...

- A volunteer member physician
- Compassionate, thoughtful, discreet
- Specially trained in peer support
- Ready to listen

Your peer support consultant is not...

- A counselor or therapist
- Reviewing medical records or giving clinical opinions
- Sharing your confidential discussions

Many of your peers have dealt with the aftermath of unanticipated outcomes of patient care. These seasoned and compassionate professionals are ready to talk with you, confidentially, peer-to-peer. They know how helpful it is to share the experience with someone who has already walked this path. Physicians Insurance's Peer Support Program is offered as part of our Claims Department services to help members deal with the impact of adverse events. Our consultants are volunteer member physicians. They understand the impact on your personal and professional life, and have been trained to reach out to colleagues following an unanticipated outcome. This support is confidential and meant to help you process the effects of an unanticipated outcome. Participation is voluntary and members are free to request or decline this support as they wish.

GET MORE INFORMATION

Visit our website for additional information on provider support and learn about

common symptoms after an adverse event, such as fatigue, intrusive thoughts, insomnia, and more.

www.phyins.com/providersupport

OTHER RESOURCES

Litigation Support

Stress is an almost inevitable component of litigation. A physician survey indicates that stress has manifestations in the physician's physical health that may include fatigue, anxiety, and loss of sleep. In addition, other areas affected by litigation may include income, relationships with peers, and productivity.

Physicians Insurance offers a unique service to policyholders: the Provider

Support Program. In the event you become a defendant in a medical-malpractice lawsuit, you will have access to our support services to help you manage the stress of litigation. In addition, all discussions of support are privileged communications, and confidential.

Read real stories of how Physicians Insurance approaches claims, and how we support our policyholders.

www.phyins.com/realpeople

The Value of Provider Support

Check out our provider support guide at: tinyurl.com/ybjxwwbq

OR RESOURCES

Oregon Patient Safety Commission
"Care for the Caregiver" program
www.oregonpatientsafety.org/health-professional-resources/

ID RESOURCES

Idaho Physician Recovery Network
www.southworthassociates.net/monitoring-physician-recovery-network

AK RESOURCES

Alaska Federation of State Physician Health Programs Resources
www.fsphp.org/resources

WY RESOURCES

Wyoming Professional Assistance Program
www.fsphp.org/state-php/wyoming

ADDITIONAL RESOURCES

Washington Physicians Health Program

The Washington Physicians Health Program is an independent, physician-led, non-profit organization intended

to assist health-care professionals with medical conditions that may affect their ability to practice medicine safely. These conditions may include substance abuse, behavioral health disorders, and physical and cognitive disorders. The WPHP is a confidential resource to the maximum extent provided by law.

Among the wellness services offered:

- Mindfulness for health-care professionals
- Compassion-cultivation training
- Mind-body medicine

Additional services include providing education and support for the community, including:

- Family services and support
- Speaking engagements
- Literature and publications
- Other resources and content

For more information about WPHP, visit www.wphp.org/.

(Essential Elements of Disclosure and Apology, continued from page 11)

- To maximize a patient's understanding of what is being said requires that the provider do more than deliver an explanation: the provider must engage the patient in the conversation. Engaging the patient changes the patient from passive listener to active participant, which associates the conversation with a feeling and results in the patient remembering how they felt during it.
- Engaging the patient in conversation enables and empowers the patient to feel a sense of control—which is exactly what the error or adverse event made them feel they lost. This recovery of control is ultimately what helps the patient heal, and allows them to remember the experience positively.
- Verbal communication represents 7 percent of communication—the other 93 percent of communication is made and interpreted nonverbally.
- Although just 7 percent of a provider's message, impact, or influence is determined by words, the words still matter. They should be kept simple: the tense should be active and not passive, and the phrases concise and to the point. “Non-words” or fillers like “uh,” “um,” and “so” can convey a lack of confidence or even the avoidance of truthfulness, so they should be avoided. Instead of these non-words, use pauses. Pauses and silence convey confidence and leadership, and can be used to create contrast and emphasis among the words chosen.
- Nonverbal language, which includes vocal elements (pitch, inflection, tone, rhythm, tempo, and pronunciation), visual appearances,

Among adults, if nonverbal language is inconsistent with verbal language, the listener tends to give more credit to the nonverbal language, and may even disbelieve the spoken word altogether.

olefactions (smells and scents), posture, eye contact, facial expressions, body movements and gestures, proxemics (uses of space and distance), and haptics (touch cues), is a major determinant of meaning. Among adults, if nonverbal language is inconsistent with verbal language, the listener tends to give more credit to the nonverbal language, and may even disbelieve the spoken word altogether.

- It's critical to establish an emotional connection.
- Failing to establish initial rapport with the patient and/or their family represents a common and significant communication problem. Providers must deliver a clear explanation of what occurred, and how it resulted in an error or adverse event. Words are certainly used to do this—the left side of the brain is engaged when a person prepares to deliver this type of communication. However, words and conversation do not always result in communication on their own, and emotional connection is

necessary for true communication to occur. To establish this kind of connection requires engagement of the right side of the brain, which is often a challenge for highly trained technical professionals like health-care providers.

- “E=MC³” is an easy mnemonic to help remember to establish an emotional connection. It stands for “Emotion=Message with Contrast, Content, and Context.” Without these elements present, a disclosure/apology communication cannot be expected to resonate effectively with a patient.
- Multigenerational communication is also key.
- Providers and patients alike span generations, so it is imperative that generational communication preferences are understood in order to remove any barriers. While there is no formula for effective and successful multigenerational communication, it generally requires an understanding of generational values and communication preferences. Ask your risk-management consultant about additional multigenerational communication resources that may be available to Physicians Insurance members.
- Gender is a crucial consideration in communication.
- Sex (which is biological) and gender (which reflects a psychological orientation) both influence communication. One useful way to conceptualize gender as it applies to communication is to use two continua representing assertiveness and responsiveness to understand gender as a social style, rather than trying to communicate to gender as it



E=MC³ Defined

Establishing or maintaining an emotional connection with a patient after an adverse event has occurred may come naturally to a provider, or may be difficult. Even if the provider genuinely wants to express empathy and apologize, they may be perceived as inauthentic for a variety of reasons. Authentic and influential communication has been studied from multiple perspectives, and the most common element identified in effective communication is that it begins with establishing an emotional connection through contrast, content, and context.

- **Contrast** is established when you differentiate yourself (and your means of communication) from others. For health-care providers, the most important differentiating factor to establish is your investment in how the patient feels. The patient has just

had an adverse event occur, in an unfamiliar or uncomfortable setting where they feel little or no control. Communication after the event has likely been minimal, disconnected, defensive and/or delivered from the perspective of the provider or health-care system. Providers can accomplish contrast by demonstrating that they understand the situation from the patient perspective. In general, this means acknowledging that patients are scared and angry, and that they have questions that go beyond a traditional explanation of what and how. What's next for them? Will they return to their normal self? What are the financial costs and other issues that they will encounter? The provider's attention to contrast allows them to address these concerns from the patient's perspective, in real time, rather than just providing an


explanation. It makes them humble, and prepares them to be vulnerable rather than defensive. The patient may not remember all of what they hear from such a provider—but they will remember how different that provider was from others involved in their care, in terms of how the provider made them feel.

- **Content** refers to the facts of what has happened—essentially an objective description of the adverse event.
- **Context** is what humanizes the event. It refers to why and how the event happened, and provides both subjective explanations and objective descriptions of it. Context is also what provides the basis for an apology, in those cases in which particular responsibility is assumed.

may (or may not) relate to sex. Social style, or where a person is situated on these continua, is roughly reducible to four major “gender” types, which relate to how other people perceive that person's behavior. These four social styles are:

- Amicable
- Analytical
- Driver
- Expressive
- Intercultural sensitivity matters, too.
 - The three most significant barriers related to intercultural communication are lack of understanding of the cultural aspects of a patient's health, verbal language barriers, and nonverbal language barriers.

- Culture includes traditions, customs, norms, beliefs, values, and thought patterns that are passed down throughout generations, and a lack of cultural knowledge represents a level of disrespect for the patient.

Accountability after an error or adverse event is a difficult, complicated, and uncomfortable subject to address—and may present legal challenges. We at Physicians Insurance encourage our providers to contact us immediately after the discovery of an error or adverse event, so that we can help you prepare for this conversation and coach you through the components of successful interpersonal communication. 



Deborah Lessard is a nurse-attorney who has a graduate degree in organizational communication with a focus on patient/provider communication. She has 30 years of experience in combining law, nursing,

risk management, decision science/analysis, change management, and communication. She teaches risk management and communication in doctoral programs, has developed disclosure/apology processes and communication-resolution programs for liability carriers and health-care systems, and is an external contractor serving as a senior risk-management consultant for Physicians Insurance.

Compass Oncology

Navigating a Clear Path to Hope and Healing



Alison Andre enjoys solving puzzles.

Crossword, Sudoku, Rubik's Cubes, all kinds. As the executive director of Compass Oncology, she approaches health care today like a giant puzzle.

"Like many of us, people important to me have been touched by cancer," she says. "That makes it personal. If I can use my talents to support a phenomenal group of providers in caring for cancer patients, the journey is worthwhile." She and her team operate on the principle of "Cancer Care Built Around You."

Compass Oncology is the largest independent cancer and hematology treatment practice in the greater Portland, Oregon/Vancouver, Washington metro area (population: 2.35 million people). Its 38 specialty-trained and board-certified physicians and 14 advanced-practice providers at five cancer treatment centers include gynecologic oncologists, radiation oncologists, breast surgeons, cancer pathologists, palliative-care physicians, and genetics counselors. Collectively, they treat every type of cancer, including rare malignancies.



TOP-NOTCH PHYSICIANS ARE KEY STRENGTH

Their strength is seen in physicians such as Lucy Langer, who has performed genetic research at Columbia University and UCLA, and is the national medical director for the U.S. Oncology Genetic Risk Assessment and Treatment (GREAT) Program, and David Smith, a leading national investigator for the U.S. Oncology Network's participation in Gene Related to Anergy in Lymphocyte (GRAIL) clinical studies. GRAIL seeks to develop a blood test to detect cancer early before symptoms appear.

"It is moving to me that many of the Compass team members are themselves cancer survivors," says Andre. "They know well what our patients need, what they are feeling, and the compassionate care they deserve."

It was that empathy that compelled many of the 380 Compass employees to the meaningful work of supporting others with cancer.

A SURVIVOR'S PERSPECTIVE

Jen Steen-Reavis is a breast-cancer nurse navigator. A nurse navigator's primary role is to focus on patients, as well as on their families and support members. Knowledgeable in breast cancer, the navigator encourages the patient to be proactive and to participate in their own care and treatment plan. The navigator helps to identify and remove any barriers to care, is a strong source of education for the patient and his or her family, and

FAST FACTS

LOCATIONS: Five cancer-treatment centers in the Portland, OR/Vancouver, WA metro area

MEDICAL STAFF: 38 specialty-trained and board-certified physicians, including gynecologic oncologists, radiation oncologists, breast surgeons, cancer pathologists, palliative-care physicians, and genetics counselors

PHYSICIANS INSURANCE MEMBER: Since 2010

follows patients through their journey from diagnosis through survivorship. "We live in a day and age in which cancer is now considered a chronic disease or illness." According to the U.S. National Center for Health Statistics, a chronic disease is one lasting three months or more. "In the past, when people were given a diagnosis of cancer, they believed they would die of the disease," says Steen-Reavis. "Many times they would." Now, she says, the National Cancer Institute reports there are over 3.1 million breast cancer survivors in the U.S., and the five-year survival rate for all breast cancers is nearly 90 percent. "We are curing people of breast cancer every day. Our screening is better, our treatment is better, and many women are living a long time, even with metastatic disease," she says. "I am hopeful people will start to see breast cancer as more of a chronic condition, rather than a death sentence."

Having survived cancer herself, Steen-Reavis says that her patients appreciate the perspective and empathy she brings to their

care. "When I was diagnosed 10 years ago, I shared in the same panic that anyone has when dealt the 'cancer card,'" she says. "I have learned through time, treatment, and survivorship that life really is all about what we make it, and not what has been handed to us. I am a better version of myself because of the experience. I live differently now, and I know what's important."

Andre's team of puzzle-solvers saw 4,221 new cancer patients in fiscal year 2018. They saw a few thousand more who do not have cancer but receive other services, such as those with a hematologic diagnosis or who seek genetic counseling.

A COMMITMENT TO COST-EFFECTIVE CARE

In the majority of cases, notes Andre, free-standing community-based centers like Compass provide cancer care at a lower cost than hospital outpatient facilities. "Our team-based care model helps us provide services without unnecessary redundancy, for instance in the ordering of duplicate scans or lab work," she says. "Also, a private practice does not have the overhead that most hospitals do, such as an emergency department. In most cases, chemo treatment is considerably less expensive at a community-based cancer center than at a hospital."

Further demonstrating that Compass Oncology is serious about making cancer therapies more affordable, the group joined the Oncology Care Model (OCM) when it began two years ago. The OCM Medicare demonstration project is focused on providing higher-quality, more highly coordinated oncology care at the same cost as Medicare, or lower.

A concerted focus on cost-effective care is, in part, why in 2017, after more than 20 years, Andre left Duke Cancer Center and her job as Assistant Vice President, and moved to the Pacific Northwest. "Health care is a rapidly changing landscape. I saw in Compass Oncology an organization



"It is moving to me that many of the Compass team members are themselves cancer survivors. They know well what our patients need, what they are feeling, and the compassionate care they deserve."

ALISON ANDRE,
EXECUTIVE DIRECTOR,
COMPASS ONCOLOGY

committed to providing the best possible cancer care in a cost-effective manner. And I saw that Compass physicians play a part in defining the future of cancer care through participation in clinical trials, which ensure that our patients have access to the latest therapies available."

The team's involvement in cancer research is another reason Andre joined Compass, where physicians have played an important role in the development of 60 cancer therapies. These include Durvalumab, a recently approved drug for patients with unresectable, stage 3, non-small-cell lung cancer, and Apalutamide, an approved drug for non-metastatic, castration-resistant prostate cancer.

(Continued on page 32)



Cancer has been called “the disease of moving parts,” an ever-changing puzzle that, as it grows and morphs over time, so do the types of personalized treatment that are most beneficial.



(Compass Oncology, continued from page 31)

Compass providers are no strangers to innovation—they were the first to introduce the Paxman Scalp Cooling System to patients in the Portland-Vancouver region. The system greatly reduces chemotherapy-induced alopecia. Compass surgeon Toni Storm-Dickerson is known for her innovative work in advancing breast surgery, such as using magnets to help pinpoint lesions in the breast.

FOUR PILLARS OF PATIENT CARE

This type of leading-edge success has helped bring Compass Oncology approximately 30 percent of market share in the region. So have the four pillars of patient care that drive their work:

- Answers
- Support
- Compassion
- Respect

Patient questions are encouraged. Educational opportunities are plentiful, as are an array of support groups, including groups devoted to journaling, nutrition, exercise, and stress reduction through the practice of Reiki. Special attention is given to “co-survivors,” the relatives and close friends who accompany the cancer patient on his or her journey.

Andre says transparency is key in a patient’s care. Cross-disciplinary sharing of a patient’s progress is an important part of that. “The care team holds huddles in which key information is shared with the physician, nurse practitioner or physician assistant, medical assistant, social worker, nutritionist, and other team members to improve our care and ensure that the needs of the patient are met.”

VARIETY IS THE SPICE OF LIFE

One of the joys of Andre’s job is rarely doing the same thing two days in a row. The variety includes positioning Compass for the future and developing a strategic plan; searching out the best locations for care; holding open forums with staff to hear their perspectives; working with the finance team; interfacing with the larger medical community on comprehensive strategies to benefit shared patients; and keeping on top of the health-care payment landscape.

Born in California, raised in Louisiana, and having lived much of her adult life in Virginia and North Carolina, Andre is smitten with the natural beauty of the Pacific Northwest. Originally drawn to the region by its natural resources, she says she is kept here by the people and their friendly and independent spirit.

“Oregon and Washington are trailblazers in many areas of health policy,” Andre says. “I am learning much from the work done here.”

She, her husband Jeff, and their two children fell in love with the local foodie culture. They also skied Mount Hood this winter, and plan to raft the Deschutes River, hike the Columbia Gorge, and explore as much as they can.

But it is Compass’s operational principle to help patients find a clear path to hope and healing that drives her. “In the two years since we joined OCM, we have demonstrated agility by implementing changes to our practice in order to leverage the expertise of each team member to provide the best possible care,” she says.

Cancer has been called “the disease of moving parts,” an ever-changing puzzle that, as it grows and morphs over time, so do the types of personalized treatment that are most beneficial. Alison Andre and her team of puzzle solvers at Compass Oncology stay on top of the complexities for those who rely on them, ever mindful that “as every cancer is different, so is every patient.” [PR](#)

Patient Perspective: The Value of Proactive Approaches to Common Communication Barriers

We spoke with two people actively involved as patient advocates locally and nationally at medical organizations. The following are their views on how effective communication between patients and providers can ease anxiety, prevent errors, and improve outcomes.



Carole Hemmelgarn, a member of the board of directors for the Collaborative for Accountability and Improvement, draws on her background in health care to help bridge communication divides between patients and providers.

WHY IS COMMUNICATION A TOP BARRIER BETWEEN PATIENTS AND PROVIDERS?

When my daughter was treated for leukemia in 2007, I realized how confusing the medical world could be—even for someone like me with a background in health care. For most patients, “health-care speak,” using acronyms and big words, is completely foreign, and patients aren’t sure how they can change the dialogue.

WHEN ADVOCATING FOR A CHILD, WHY IS PATIENT-PROVIDER DIALOGUE PARTICULARLY IMPORTANT?

Parents know their children better than anyone else does. When parents sense that something is not right, it’s essential that a provider stop and listen. Parents

can remember the “CUS” patient-safety keywords: “I am concerned,” “I am uncomfortable,” and “this is a safety issue.” Providers are trained to listen when patients speak up in this way; using the right language helps trigger an appropriate response.

HOW CAN HEALTH-CARE ORGANIZATIONS IMPROVE COMMUNITY AROUND PATIENT SAFETY?

It’s vital to encourage bidirectional communication between patients and providers. Patients need to feel comfortable asking questions, and providers need to understand the generational and cultural barriers to effective communication. For example, in Latino culture, the term “diabetes” might not mean much, but “high blood sugar” does. Some patients might not feel comfortable requesting to see a different provider, or they may believe that offending their nurse or doctor could result in receiving lower-quality care. There’s a lot of fear out there. Providers need to understand that their responses to patient questions very much impact how the relationship proceeds.



Steve Lovell is a patient advocate who serves on the Seattle Cancer Care Alliance’s Patient, Quality, and Service and Falls Prevention Committees, and the Patient and Family Advisory Committee.

HOW CAN ORGANIZATIONS PROACTIVELY APPROACH PATIENT COMMUNICATION?

Lack of information fuels anxiety in patients. I saw this firsthand during my own treatment for myelodysplastic syndrome in 2010. When patients are sent for various scans and tests without understanding why, they can become unnecessarily anxious, which has a ripple effect that can impact their treatment. Making sure that patients and their family members have the information they need in terms they can understand can help prevent anxiety and miscommunication. Patients want and need to know what they can expect in terms of their health-care experience.

WHAT SHOULD PHYSICIANS REMEMBER WHEN COMMUNICATING WITH A PATIENT’S FAMILY OR CARETAKERS?

Patient-centered care centers around a patient, but also includes family and other advocates. Self-advocacy is important, but sometimes patients are too tired and drained to research all their options or stay on top of the information that’s coming their way. Often patients have others helping them, and it’s important for providers and patients alike to remember that they’re part of a care team.

HAS PATIENT-PROVIDER COMMUNICATION IMPROVED IN RECENT YEARS?

Absolutely. I’ve seen the needle move in a positive way, so to speak. Today more hospitals and clinics offer patient-navigation services, and organizations and insurance companies are working together on patient navigation. The Washington Patient Safety Council, Seattle Cancer Care Alliance and other groups are working to educate patients and providers about how better communication can prevent errors and improve outcomes, and helping all parties involved learn how to maintain open lines of communication. [PR](#)

GOVERNMENT RELATIONS UPDATE

MPL

MEDICAL PROFESSIONAL
LIABILITY ASSOCIATION



PIAA IS NOW THE MEDICAL PROFESSIONAL LIABILITY ASSOCIATION

PIAA, the leading national insurance trade association representing domestic and international medical-professional liability (MPL) insurance companies, risk-retention groups, captives, and other entities, changed its name to the Medical Professional Liability Association, or MPL Association. The change reflects its commitment to keep pace with the changes among its members and the evolving medical-professional liability community.



Mary-Lou Misrahy, President and CEO of Physicians Insurance, was recently selected by the Medical Professional Liability Association's Board of Directors to serve as its chair. Anne E. Bryant, Senior Director of Government Relations and in-house lobbyist for Physicians Insurance, currently chairs the MPL Association's Government Relations Committee.

See Press Release: tinyurl.com/y8kq8lze

CAPITOL HILL DAY FOCUSES ON MPL/HPL REFORMS AND PATIENT SAFETY

The Medical Professional Liability Association held its annual advocacy "Capitol Hill Day" in Washington, DC, on June 25 and June 26, 2018. The day began with a legislative briefing, followed by individual Congressional meetings. Anne E. Bryant, Senior Director of Government Relations for Physicians Insurance and Chair of the MPL Association's Government Relations Committee, met with select members of the Washington, Oregon, and Idaho delegations to discuss critical medical-professional liability reforms and continuing the focus on patient safety that benefits patients, physicians, and others devoted to improving the health-care system.

For the first time in nearly a decade, Congress is seriously considering federal MPL/HPL reform, in addition to other legislative matters critical to our industry. The Medical Professional Liability Association continues to build support for these bills through its federal advocacy campaign, an event that provides an opportunity for individual federal lawmakers to hear directly from their constituents. Physicians Insurance was pleased to join others in this effort by participating in this year's Capitol Hill Day discussions.

FOR MORE INFORMATION ON THE MPL ASSOCIATION:
www.mplassociation.org



ADVOCACY

As the only Northwest-based medical-professional liability carrier with a registered in-house lobbyist, we provide advocacy on challenges to the professional-liability industry that:

- Create new causes of action against health-care professionals
- Adversely alter the standard of care for physicians
- Create strict liability for performing or not performing care
- Impose onerous or unnecessary duties on its insureds

To learn more about our Government Relations Program, contact:

Anne E. Bryant,
Senior Director of
Government Relations
anne@phyins.com
206-343-6612

www.phyins.com/govt



Trial Results

The following summary is a Physicians Insurance case that has gone to trial and is public record. In reporting these legal results, it is our goal to inform members about issues that impact health-care professionals. While we share information we think may be informative, we choose not to disclose the names of plaintiffs or defendants when reporting these results.

FAILURE TO DIAGNOSE AND PROVIDE TIMELY TREATMENT OF CARDIOVASCULAR DISEASE

SPECIALTY: Physician's Assistant and Family Practice

ALLEGATION: An 80-year-old female alleged ongoing Achilles-tendon injury after taking 500 mg of Levaquin for a urinary-tract infection in 2009. Plaintiff alleged, first, that the provider should not have prescribed any antibiotic for the patient's confirmed urinary-tract infection; and second, that the provider failed to inform her of the risks associated with Levaquin and the alternatives to that medication. The patient claimed a myriad of ongoing symptoms and decreased mobility caused by the Levaquin.

PLAINTIFF ATTORNEY: James Dore, Kent, WA

PLAINTIFF EXPERT: Pobert Weber, MD, Cardiology, Culver City, CA, Samuel LeBaron, MD, Family Practice, Palo Alto, CA, Donald Schreiber, MD, Emergency Medicine, Stanford, CA


DEFENSE ATTORNEYS: Scott O'Halloran and Deanna White, Tacoma, WA

DEFENSE EXPERTS: Peter McGough, MD, Family Practice, Seattle, WA, Robert Bersin, MD, Cardiology, Seattle, WA, Jacob Heller, MD, Emergency Medicine, Seattle, WA

RESULT: Defense Verdict; Jury Trial

Physicians Insurance proudly supports the MPL Association's effort to promote national legislation to improve patient access to health-care services and provide improved medical care by reducing the excessive burden the liability system places on the health-care delivery system.

Physicians Insurance actively works to:

- Protect the provision that no new standard of care for medical-liability claims is created by the Affordable Care Act.
- Promote comprehensive legislation that improves the liability system and promotes meaningful patient-safety initiatives (improve Protecting Access to Care Act, H.R. 1215, passed House, 06/2017).
tinyurl.com/kbk6z6u
- Promote liability protection for health-care professionals and facilities that provide uncompensated services to victims of federally declared disasters (Good Samaritan Health Professionals Act, H.R. 1876).
tinyurl.com/yaw2m953
- Promote framework for legislation that addresses telemedicine liability concerns as telemedicine services expand. 





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THE PHYSICIANS REPORT | SUMMER 2018



THANKS FOR THE FEEDBACK!

Earlier this year, Physicians Insurance conducted a customer-satisfaction survey to gain insight into our members' perceptions of, and experience with, our company. The survey identified areas of strength, as well as areas for possible improvement. These insights will help us retain our existing customers and attract new members.

We'd like to thank those who took the survey. As a member-owned and -directed company, we consider your feedback invaluable—it's what enables us to uncover actionable new ways to engage our customers, and to improve how we anticipate and serve your needs.

The survey serves as a baseline of current satisfaction levels, and can be tracked to ensure that new initiatives are meeting your expectations for our service delivery.

Department heads from each service area are currently reviewing the data to identify new opportunities for improvement. Stay tuned for more information on the specific changes we are making to better serve you.

WELCOME TO OUR NEW MEMBERS!

MEDICAL-PROFESSIONAL LIABILITY

Curry Health Network
Gold Beach, OR

STOP-LOSS

Larson Motors, Inc.
Tacoma, WA

UNSURE ABOUT BUNDLED PAYMENTS? IT'S TIME TO EXPLORE YOUR OPTIONS



Are you considering whether or not the Bundled Payment Care Improvement Advanced initiative or other value-based payment arrangement is for you?

Do you need help evaluating the benefits and risks of participation?

Would a financial stop-loss product that limits your downside financial risk provide peace of mind?

Physicians Insurance can limit your financial downside risk with a stop-loss solution to fit your needs. Contact your account manager to learn more.