

(Our next speaker is Gerald Hickson. Gerald is now the Associate Dean for Clinical Affairs and Director of the Center for Patient and Professional Advocacy at Vanderbilt University. He's a pediatrician by background and has done a great deal of research using malpractice claims as one mechanism for looking at patient safety issues. I would point out that there's one guest who didn't show up today. Jerry, I don't know if you knew that we invited Oprah to come. Yes, Oprah. We're in Chicago and Oprah is doing a program on patient safety within the next couple of weeks, as we understand, so we thought she ought to come to our meeting and find out what it's all about. She didn't take us up on it, Gerald, so you're going to have to represent the patient perspective on your own. This is Gerald Hickson.)

**Engaging Patients in
Promoting Safety**

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I refuse to stand behind a lectern, and hope I'm not going to obstruct anyone's view. I will try to move around and

maybe play a little Oprah. Later on I may come and put the mike in your face. It is an honor to be here because I think what is going on nationally in terms of our focus on safety and improving the quality of care is way overdue. Individuals in this room are going to be instrumental in helping to transform medicine to make it safer and kinder for our patients.

Before I start I am going to offer an apology. My background is as a malpractice researcher, and the question should be asked, "Why in the world would a group interested in safety invite a malpractice researcher?" In many of the safety forums we've sort of been absent, but I'm going to suggest there's a lot to learn from those who have examined malpractice over the past 20 years. Also, I'm going to suggest that some of the landmark studies that focused the nation on safety occurred as a result of the third national malpractice crisis. I'm also going to suggest many malpractice researchers have focused on how we bring patients into the equation to help identify and deal with recurring malpractice risk and make medicine safer. We are now fully committed to the notion that patients give us the ability to identify our colleagues who stand out from a malpractice standpoint. There are small numbers of physicians in every single discipline, including family medicine, that nail us into the ground and keep us from moving quality forward. It may be contrary to some individuals notion of a quality

model because the model suggests that to improve quality we have to move the whole bell-shaped curve forward. You should not focus on the few, but the population in general. However, in medicine we have some colleagues who are so stuck with disruptive behaviors that when we identify issues that need to be addressed, they just to hold us back. Unless we develop effective strategies for identification and intervention with our challenging colleagues, our progress is going to be held back. I also want to encourage you to think about replicating the work our research group has done in engaging and listening to families. We are fully convinced that patients have been undervalued in terms of their ability to identify medical errors and adverse events. We believe that families are critical elements in terms of reporting medical errors; we just have to figure out better ways of listening. Finally, I'm going to suggest that many of the things that we've learned that generate unnecessary malpractice claims fall into the category of communication failures, and such failures also are major predictors of patient non-adherence. Medication errors are incredibly important, and we need to deal with them, but I'm going to suggest that non-adherence is the single greatest threat to safety that exist in medical practice. Whatever we do that encourages patients to participate in care may have a profound impact on making medicine safer. For the next few minutes, I want to talk with you

about what we have learned in examining malpractice. I hope that you will bear with me. Throw a few stones, it's okay, I've learned to dodge over the years.

Our group has partnered with multiple institutions and as a result I get to read complaints from all over the country. I've read hundreds of thousands of complaint narratives. I had this presentation in mind when I read the following family observation:

"She walked into the hospital and now she's DEAD! We expected her to be here overnight...but something happened...started bleeding and they couldn't get it stopped. I know something went wrong and they aren't telling me."

This family called in to an unnamed Office of Patient Affairs and said about their loved one, "She walked in the hospital and now she's dead. We expected her to be here overnight but something happened. She started bleeding and they couldn't get it stopped. I know something went wrong and they aren't telling me." I can't tell you how often we read these kinds of statements. There are other statements that may also relate to safety.

“Dr. V used the word “compliance” in conjunction with her medical information... daughter asked Dr. V what he meant...Dr. V replied “go get a dictionary”.”

“Dr. V used the word *compliance* in connection with her medical information. The daughter asked Dr. V. what he meant. Dr. V. replied, “Well, go get a dictionary.” You could interpret this complaint in one of two ways. In the day of engaging patients, it’s good to promote education. But I’m going to suggest that Dr. V’s response may not have been motivated by desire to promote knowledge and could impact a patient’s willingness to follow instructions and, therefore, represents a threat to safety.

**Patient/Family Complaints
(observations of care)**

- Are complaints about care and treatment valid?
- What about other kinds of complaints?
- Can patient complaints serve a role in promoting a culture of safety?

I want to challenge you to think about

three questions today. Number one, and please, understand this is a talk about unsolicited complaints... are unsolicited complaints about care and treatment valid? Number two, what about other kinds of complaints? If a patient tells you that your office is disorganized; does that tell us something about the potential for errors and threats to safety within the practice? And finally, I’m going to ask, can patient complaints serve a role in promoting a culture of safety? I’m going to suggest they can.

Objectives

- My research background (medmal)
- Patient complaints and malpractice risk
- Complaints and surgical complication
- Complaints and adverse events/error identification

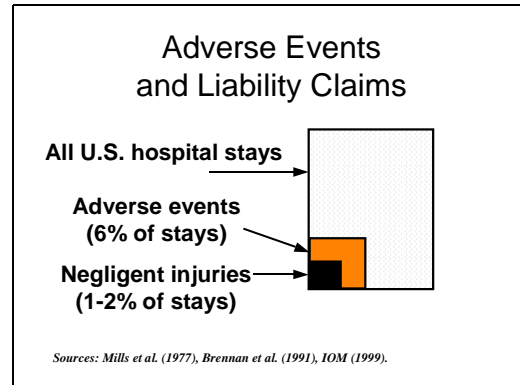
In addition, I have four objectives. First, I’m going to share with you, my research background in malpractice. Now you see I have malpractice in small letters. I am going to remind you, however, that one of the things holding the safety movement back is that sometimes we pretend this malpractice thing doesn’t exist. It’s like the 40-ton elephant in the room; we talk about reporting errors and about a blame-free reporting culture, but until we deal with the malpractice challenge

constructively, we have a problem.

Second, I want to talk about our work in linking unsolicited patient complaints to malpractice risks. Patient complaints help us identify individuals who sometimes keep us from moving the culture forward. Finally, I want to talk about two new studies. One involves linking unsolicited patient complaints with surgical complication rates. Low and behold, surgeons who generate more unsolicited complaints are also more likely to have higher surgical complication rates. I wonder why? The second study is designed to look at unsolicited patient complaints as predictors of adverse events, and errors in emergency medicine settings.

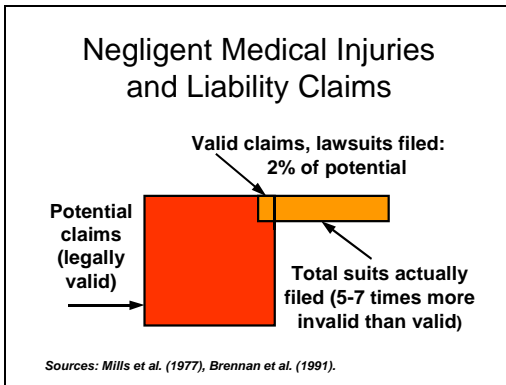
What do we know about
adverse events, negligent
adverse events and decisions
to file suit?

I've always tried to frame my research by asking questions. So what do we know about adverse events, negligent adverse events, and families' decisions to file suit?



The first set of studies, are summarized on the next slide. The studies, conducted by Mills and Brennan, and colleagues were based on chart reviews and required identification of an adverse event at the time of hospital discharge. These studies, done almost 14 years apart were then repeated in Colorado and Utah, with similar findings. Taken together, the three studies suggest that among hospitalized patients; perhaps 6% of individuals who enter the hospital will have an adverse event. About a third of those adverse events will be related to acts of omission or commission. Again, you saw the estimates in Dr. Burstin's talk about the number of deaths nationally from medical errors. One of the problems with all estimates of negligent events, however, was covered by Thomas in an article in *Annals of Internal Medicine*. The problem is that when you ask two physician reviewers to assess a case, they don't necessarily agree. And one of the important challenges that we have in

safety is that well-meaning medical reviewers don't necessarily see eye-to-eye. Consequently we must take all estimates of the magnitude of injuries from medical errors with a few grains of salt. But if we do, and accept that, perhaps 1% to 2% of hospitalized patients are injured by negligence, the next question is: how many of these individuals file suit?



If you look at New York state data and say that this gold box represents the universe of individuals who have been injured by medical care, then perhaps only 2% of those individuals ever choose to file suit. Now that's interesting. It isn't to say there aren't lots of suits. If you look at the data, you see that there are many individuals who file suit, maybe five to seven times more individuals who have experienced adverse events not judged, at least in the New York State study, to represent negligent-driven injuries but who chose to file.

Why do patients and their families sue their doctors?

So why do families file suit? To answer this question our team conducted interviews with Florida families who had filed suit against their obstetricians alleging malfeasance in labor and delivery. One approach that we like is to simply ask questions. Why did you go to an attorney in the first place? We recorded families' responses verbatim, and then analyzed the content of those narratives.

Reasons Parents Sued

	% Expressing Concern
λ Advised to sue by influential other	32
λ Needed money	24
λ Believed there was a cover-up	24
λ Child would have no future	23
λ Needed information	20
λ Wanted revenge, license	19

Hickson GB, Clayton EW, et al. JAMA 1992; 267:1359-63.

Before we examine the results, I want to assure you that our research team can count to 100. Some respondents gave

more than one reason for filing. About a third of individuals interviewed said that they filed suit because someone, whose opinion they valued, told them that the care received was substandard.

Advised By Others

"I went to a cerebral palsy support group meeting and asked a doctor what could have happened to cause the CP. After the meeting an attorney who I thought was one of the parents came up to me, asked me what happened, and it went from there."

A second reason that families offered was they needed money. Number three, we still live in the age of Richard Nixon, and individuals in society believe that those of us who practice medicine know things but were not telling. Whenever patients have a sense that information has not been forthcoming, some become concerned. One in five told us that "the only reason we ever filed suit is that nobody would ever tell us what happened." That's important as we think about creation of educational programs about disclosure. One reason we fail to do a very good job with sharing in the face of an adverse outcome is that we've not trained people adequately. Oh, it's relatively easy to teach disclosure about circumstances when someone operates on the wrong extremity. The issue is

how do you disclose when medical professionals disagree or don't have all the information? That becomes a challenge, and that's what ought to be in our curriculum.

Finally, about one in five families stated: "we didn't want the money; we wanted his license so that he couldn't harm anyone else." Money is important in families deciding to file suit but so many decisions appear driven by non-economic reasons as well. This is especially important when you consider how few individuals file suit in relationship to those who are judged to have received injuries through negligence.

So who were those influential individuals encouraging families' to file? Were they plaintiff attorneys? Friends and family?

Most Frequent: One MD/RN "Jousting"/Criticizing Another

- λ "My son's doctors told me that he had gotten the initial infection in the OR and that it was probably from an employee who did not wash hands well after having a BM."
- λ "He ordered *what???*"

Look at the next slide. One parent shared with our research group: "My son's doctors told me that he had gotten the initial infection in the OR and that it

was probably from an employee who did not wash hands well after having a BM.” Sometimes such disclosures are correct, sometimes they’re not but the influential other is almost always a physician.

Complaints Involving “Jousting”/Criticizing Another

- λ “The mother reports that the doctor in the ED told her that her child wasn’t being cared for properly by her pediatrician.”
- λ Dr. J told the pt, “It will probably take a week to get your blood work back. This place is very inefficient, you know. You can’t imagine how inefficient this place is.”

Look at the next slide. Sometimes medical professionals disclose in advance. I love this last quote. Dr. J. told the patient, “It’ll probably take a week to get your blood work back, this place is so inefficient, you know. You can’t imagine how inefficient this place is.” And then the patient suffers an adverse event and all the family remembers is, “Dr. J. told me...” Physicians and all health care professionals have a moral and ethical duty to be honest and committed to full disclosure. Unfortunately, sometimes we disclose without all the data or expertise.”

What do we know about the distribution of lawsuits within groups of physicians?

When we finished the studies asking families why they filed, we turned our attention to the question: What do we know about suits within groups of physicians?

Malpractice Risk

- λ Malpractice activity is disproportionate among physicians by discipline
- λ 75% - 85% of awards, settlement costs over a 5-year period made on behalf of
 - 1.8% of internists
 - 6.0% of obstetricians
 - 8.0% of surgeons
- λ High risk today = high risk tomorrow

Sloan et al. (JAMA, 1989), Bovbjerg (JAMA, 1994)

I am here today with a distinguished group of family physicians who, by definition, have very low malpractice risk. However, all family physicians are not created equal from a malpractice standpoint. For every discipline analyzed, you can define three groups of physicians. There are a large number of individuals who never darken the door of risk management. We find another

group that attracts a random hit. Stuff happens. As a malpractice researcher, it completed my education when I was sued. It was a wonderful experience. I needed experiential knowledge, and was so thankful. It took five years and a lot of money before the case was thrown out, but, it was surely educational. Consequently, I personally fall into the random hit group.

But for every discipline; pediatrics, general internal medicine, and family medicine, we find 2% to 8% of physicians who are involved in perhaps 20% to 40% of all claims and account for up to 85% of all dollars spent on awards and settlements. It's amazing. The next obvious question was, why?

Why do some physicians seem to attract a disproportionate share of malpractice claims?

Why is it that certain physicians attract a disproportionate share of malpractice claims? We could think of four hypotheses.

Four Hypotheses

Physicians who attract a disproportionate share of malpractice claims:

- λ Attract a litigation-prone population
- λ Attract medically high-risk patients
- λ Are technically incompetent
- λ Have difficulty "connecting" with pts

First, everyone knows that there are these litigation-prone patients. I practice pediatrics in Tennessee; I get sued on average 0.4 suits per practice year, which makes me very high risk. Clearly, I need to do something so . I decide to move to Chicago and, low and behold, those same patients follow me here (laughter).

Several investigators have examined the socio-demographic characteristics of families who file suit. The people sitting in this room are eight times more likely to sue than individuals who are poor. Be assured, however, that high risk status is not explained by the socio-demographic characteristics of the patients served. I use that last word "served" with some caution.

The second hypothesis I lovingly call the "Vanderbilt" hypothesis. Everybody knows that our patients are sicker than everybody else's patients. It's just amazing that we save any as sick as they are when they arrive. We hear this

assertion over and over again. Some of our Vanderbilt colleagues examined this question in obstetrics. Variation in the claims experience of an individual physician had nothing to do with complexity of care delivered as measured by the percentage of high risk deliveries.

The third hypothesis is that high malpractice risk physicians are technically incompetent. We sought to explore this hypothesis based upon chart reviews involving 500 pregnancies with bad infant outcomes. A physician panel was constituted to review records. We were unable to discriminate high malpractice risk physicians from those with no risk based upon any of the measures we assessed including legibility of documentation, compliance with ACOG guidelines, and identification of sentinel events and avoidability of adverse outcomes. Remember, however, that assessments were based upon chart reviews and sometimes when “stuff” happens it does not find its way into the medical record. Number two, this study was potentially open to a Type-2 error. Perhaps if we’d looked at 5000 records, not 500, we might have identified differences in physicians by risk group. There are physicians who are technically challenged, but by and large they do not explain the significant variations observed in individual claims experience, at least based on our assessment.

The final hypothesis is not the notion that physicians are technically incompetent, but, as we lovingly say, they are interpersonally challenged.

To assess this possibility, we interviewed families in the state of Florida who had normal outcome pregnancies. Over 1000 births were pulled at random from Florida Vital Statistics. Each pregnancy could be linked to the doctor who delivered the baby. The malpractice status of each obstetrician was determined from state insurance files. Parents were asked, “Were there any aspects of the care you received that you were not satisfied with?” Simple question. Once again we collected responses in an open-ended fashion and then coded the content.

Complaints About Communication

- λ “You do a very poor job of communicating. You do not do what you say you will do. You discount anything that the patient and family say as though we were brainless turds that just happen to be in the way during your busy day.”
- λ “Dr. X offered no information. I felt he was hiding information. Never even tried to speak to my husband.”

Our team collected a number of observations about communication. One parent stated: “You do a very poor job of communicating. You do not do what you say you’ll do. You discount anything that the patient and family say

as though we were brainless and that just happened to be in your way during your busy day.” We talked to another mother who said, “Dr. X. offered no information,” and look at this linkage – “I felt he was hiding something.” I can’t tell you how often we found those constructs linked. The team also got complaints that physicians failed to express concern for their patients.

Complaints About Concern

- λ “He didn’t pay any attention to me. I disturbed his golf game.”
- λ “Dr. Y was rude. She was nasty that I started labor on the 4th of July...gave snappy and smart answers.”

One mother replied: “He didn’t pay any attention to me. I disturbed his golf game.”

Complaints About Access and Availability

- λ “...never gives me more than 5 minutes.”
- λ “He was terrible with this pregnancy and was even worse (if it’s possible) with the next one, but the HMO said I had to stay with him. I kept hoping to get his partner, but never lucked out. I’m not getting pregnant any more because of him.”

Look at the next slide. I love this one. “He was terrible with this pregnancy

and was even worse (if it’s possible), with the next one, but the HMO said I had to stay with him. I kept hoping to get his partner, but never lucked out. I’m not getting pregnant anymore because of him.”

Perceptions of Care During Labor and Delivery
 (Open-Ended Questions)

Patient Concerns (%)	MD Lawsuit Hx		
	0	1-3	Freq
Communication	8	18	27*
Care/treatment	5	15	22*
Access/availability	7	11	15*
Humaneness of MD	5	6	17*

* Statistically significant difference
 Hickson GB, et al. JAMA 1994; 272:1583-1587.

Each complaint captured by the group was linked to the pregnancy and the pregnancy to the physician who attended the delivery. The information was sorted into the three malpractice risk groups – no claims,... intermediate hit group, and our high flyers. What this slide illustrates is that 8% of patients seeing obstetricians who were never sued complained that their physician didn’t provide explanations in ways that they understood or would not answer questions. Five percent complained about care and treatment; most of those complaints were failures to follow up on lab results. Seven percent said “I couldn’t get an appointment,” or “nobody would return my phone call,” and 5% said “I was not respected as a

human being.” Look at our high flyers. They represent 6% of Florida obstetricians. We cannot demonstrate technical differences in the care they delivered, but look at the percentage of their patients with normal outcomes who complain.

From a malpractice standpoint, this is not rocket science. We understand that bad outcomes occur and some occur because medical care, as we say in Tennessee, could have been “more better”. However far too often we superimpose an unexpected adverse outcome unrelated to issues of technical competence on a practice defined by poor relationships. You tell me who’s going to get sued.

When we talk about malpractice, physicians, in general, bristle claiming the system is unfair. But I’m going to suggest that examination of the data suggests that certain aspects of practice must be addressed if we are to move the discussion from malpractice to safety. What we have from a malpractice standpoint is a cycle. We know that errors occur. As John Nance says, “As long as carbon-based units are involved in the practice of medicine, errors will occur.”

What We Know

- λ Errors occur; pts are injured; good communication, concern are important.
- λ Poor comm. prompts some pts to sue, compounding errors' potential impact.
- λ Small numbers of MDs attract disproportionate shares of suits (and errors?).
- λ By and large, more pts complain about these MDs' communication; so when adverse outcomes and....

And as a result, some patients are injured. We know that good communication and concern are important, they’re more important before than after recognition of an unexpected adverse event. We know that a small number of physicians attract a disproportionate share of suits, and in a second, I’m going to suggest they are more likely to be involved in errors, as well. Also, it may be that individuals who can’t play well with patients may not play well with other members of the medical team. And until we develop strategies to deal with our high malpractice risk colleagues, it’s going to be slow going in making medicine safer. Even in disciplines like general pediatrics and family medicine, we’ve got colleagues who can thwart progress, and we must have good and constructive ways to deal professionally with each other.

When we first started talking about some kind of intervention with our high

malpractice risk colleagues, I put together a group of thoughtful individuals at Vanderbilt to think about what to do. One of my distinguished surgeon colleagues said, "This is easy, we just shoot them." Perhaps this is not a socially acceptable option. In addition, it represents a failure. One of our early studies involved assessing physicians' self-perceived risk of lawsuit. We sent letters to high malpractice risk obstetricians in Florida and asked: "What's your personal risk of being sued? In responding we asked the subjects to consider other physicians with practices just like theirs. Not a single respondent declared that they were in the high malpractice risk group. Does that surprise you? It does not surprise me. One of the things that we have failed to do in risk management is to provide feedback and physicians make assumptions. Do you go to your colleagues in the physicians lounge and ask, "Well, I've been sued twice this year, how about you?" Consequently, physicians remain blind about important issues like relative malpractice risk. You don't move a culture forward without providing feedback. So I'm going to suggest for the safety movement we must develop the means to do that. In the malpractice arena we must be able to do that, and I'm going to suggest that patients allow us to deal constructively with malpractice risk.

Our most recent studies have focused on the question, "Can we identify and

intervene, with high malpractice risk physicians? One notion was that we simply count lawsuits, but thought "no, that won't work". We identified a surgeon as being at high risk. When confronted he wanted us to know that he'd only been sued seven times in the past five years, and not a single suit was valid. He probably was correct. At least at that moment, there seemed little interest in doing a self assessment of the question: "Why am I such a lightning rod for suits?" Consequently we rejected the notion of using actual lawsuits.

General Questions

- λ Can we identify high lawsuit frequency physicians with another variable besides lawsuits?
- λ If so, can we do something constructive with the data?

Instead, we began looking for a surrogate; something that occurred with greater frequency than a claim but somehow linked. What we found is that patients can play a key role.

Multiple Complaints

Shortly after beginning my daughter's appointment, Dr. _____ was called to the telephone. I am not aware of what transpired on the phone. After the call, however, he threw her medical records on the floor while screaming: "I CAN'T BE IN TWO F***ING PLACES AT ONE TIME." He never attempted to continue or apologize for his behavior.

Focus on the following complaint from a family about a care experience. "Shortly after beginning my daughter's appointment, the Dr. was called to the telephone. I'm not aware of what transpired. After the call, however, he threw her medical records on the floor while screaming, 'I can't be in two places at one time.' He never even tried to apologize. Our team began to wonder, however, if such stories might somehow serve as surrogates for lawsuits. About that time, I personally received a letter from our Office of Patient Affairs about me. Pediatricians always exaggerate, but I'm sure I'd seen at least 80 patients one day during flu season. At least it seemed like 80. When I got back to my office, very late, there was a stack of mail to be opened including a letter from our Office of Patient Affairs director, Jean Gault-Jager. Jean is one of those saints who listens to patients, attempts service recovery and provides a report to the involved parties. I opened and read the complaint about my care.

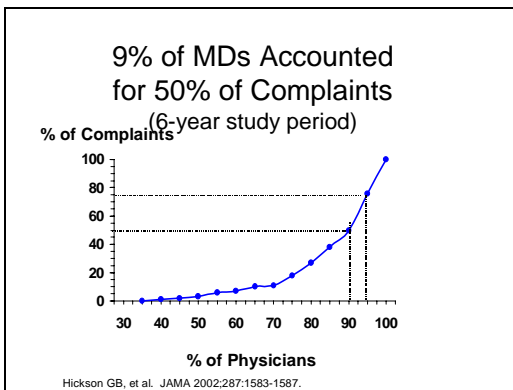
It seemed that a parent was frustrated that I was unable to resolve her child's problem with recurrent bouts of acute otitis media. I hurt her child every time I performed an exam and she didn't want that "pink" medication anymore. Like many, I wadded the letter up and deposited it in the round file. However, for several days I was bothered by the content and so I finally decided I would learn a little more about how our Patient Affairs Office worked. I met with Jean and asked, "Jean, what you do?" She said, "Well, occasionally people feel the need to express a complaint to an authority figure. I record the stories and forward a narrative to the parties involved." And then I said, "Well, Jean, what happens then?" She responded, "I'm afraid most people wad them up and throw them away." And I said, "Jean, how could anybody ever do that?" (laughter) I discovered that she had, at that point, five years of data, with nearly 12,000 complaint narratives. Our team, directed by Dr. Jim Pichert, created a system for reliably taking the content of those complaints, coding them for complaint type, and, in a very reliable way, assigning them to the person involved.

PARS®
 (Pt. Advocates Reporting System)
Coding Patient Complaints

- λ 6 major complaint categories:
Tx, communication, access, etc.
- λ 35 specific subcategories:
Rudeness, jousting, diagnosis, etc.
- λ Code locations and persons associated with complaints
- λ Good inter-rater and test-retest r's

Hickson, et al, *Law and Contemporary Problem*, 1998

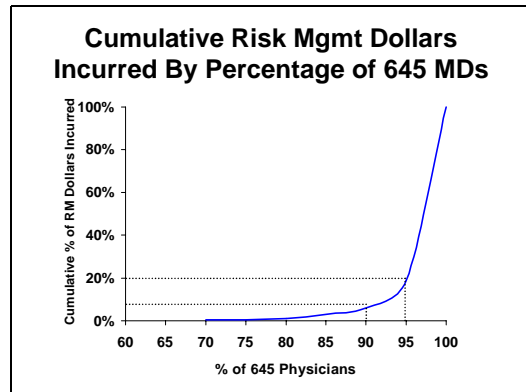
We wondered how among members of a medical group such complaints would be distributed. Would they be distributed randomly or would some people attract more complaints than others?" We've conducted this analysis now in multiple institutions, from south Alabama to Chicago and in between. Every institution appears to have the distribution that is illustrated in the next slide.



In every institution, 35% to 50% of physicians generate no unsolicited patient complaints in any three- to six-

year period. Then there appears to be what we call a random hit group. Anyone, including myself, can generate a few complaints. But then we find that about 10% of physicians generate nearly half of all complaints and about 4% generate 35% of all unsolicited complaints

We then proceeded to ask the next question: "I wonder how these physicians' claims experiences might be illustrated?" The next slide illustrates the calculative risk management dollars incurred by percentage for the 645 physician members of the target group.



Once again, most physicians incurred no dollars for any risk management activity including case investigation, expert review, legal cost or anything for awards or settlements. Some group members incurred a few dollars. Five percent of the group, however, was involved with 80% of all risk management expenditures over the 60

month target period. The curves looked similar but are they related?

Physician Cohort Members Openings vs. Complaints*						
		Complaints				
		0-1	2-6	7-14	15-	24+
RM File Openings	0	223	92	44	9	3
	1	38	38	27	13	6
	2	9	17	13	14	11
	3+	6	13	12	21	36

*Openings and complaint counts grouped for optimum cell size chi square with 12 d. f. = 274 (P<.001)

For every single medical group we've examined, we find substantial numbers of physicians who generate no unsolicited complaints and have almost no risk management activity during a three to six-year period. On the other hand, in the unnamed institution where I work, there were 36 physicians that account for a lot of complaints and a lot of risk management activities including lawsuits. One possibility was that all 36 were in high risk surgical specialties or perhaps they were the busiest physicians in the medical group. To answer these questions we conducted a series of logistic regressions seeking predictors of risk outcomes. I want you to look at the last logistic regression in which we sought to identify predictors of multiple-suit physicians.

Predictors of Risk Outcomes (logistic regression)					
Dependent Variables	Predictor Variables				Predictive Cncrdnce %
	Spec	Complts	Activity	Sex	
RMFs	20.0**	27.3**	54.1**	4.8*	84
At least 1 suit	16.4**	8.3**	33.4**	3.7	81
Multiple suits	14.8**	14.9**	3.8	1.6	87

Wald, ² for predictor variables, *p<.05; **p<.01
 Hickson GB, et al. JAMA 2002;287:1583-1587.

Only two factors that relate to high risk of litigation included discipline and unsolicited patient complaints. Somewhat surprising RVU production as a measure of being busy dropped out and had no role in identifying multiple suit physicians.

Using the second logistic model we assigned each physician member of the group a "risk score" and clustered physicians into five predictive risk categories.

Incurred \$\$ By Risk Category				
Pred Risk Category	# (%) MDs	Mean \$ Paid*	% of Tot. \$	Mean # Cmplts
1 (low)	318 (49)	1	4%	2
2	147 (23)	6	13%	6
3	76 (12)	4	4%	10
4	52 (8)	42	29%	16
5 (hi)	51 (8)	73	50%	42
Total	644 (100)	1	100%	

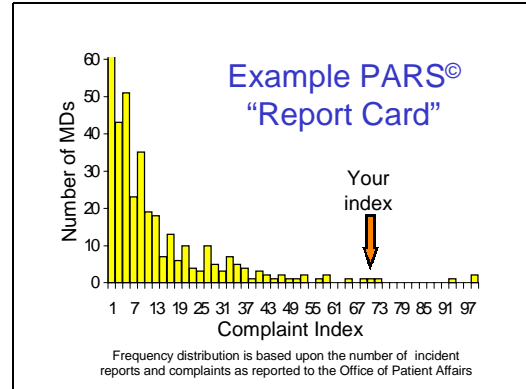
* In multiples of lowest risk group

Look at the first predictive risk category. This cluster includes about half the physicians, accounting for about 4% of risk management dollars. Note that physicians in Category 1 almost never get an unsolicited complaint. Down at the bottom you see risk Category 5, which includes 51 physicians representing 8% of the group. The mean dollars paid per individual is 73 times those dollars that are paid for the members of Group 1; these physicians represent 50% of total cost and each member averages 42 unsolicited complaints for the target period.

Research Question

Do interventions based on aggregated, unsolicited patient complaints reduce future complaints and risk management activities against high risk MDs?

We then proceeded to the hard question: “Do interventions based on aggregated, unsolicited patient complaints reduce future complaints and risk management activities against high risk MDs?” How can we make individuals aware of their risk status? We first thought about sending a message in the mail. No, people throw letters away. Use a consistent approach whatever is better.



A second approach would be to find a nurse to deliver the message. No, we have a nursing shortage, that’s a major threat to safety. We can’t afford to lose good nursing colleagues. What we can afford to do is to send a peer. Peers nominated because they are respected members of the group and committed to confidentiality, are trained concerning how to share complaint report cards in a non-judgmental way. High complaint generating physicians receive letters in the mail from their “peer mentors” requesting face-to-face visits. At the visit the “at risk physician” receives a “report card” illustrating where he/she stands. A complaint type summary is presented along with every complaint narrative received during the target period. The peer acknowledges the high complaint generating physician’s contribution to the group, encourages that he or she should review the data and stories and reflects on why. Finally, the peer reminds the colleague that this represents an ongoing effort and that

they are sure that the profile will look better at the time of the follow-up visit.

Complaint Type	Your Complaints	Mean For Non-Surg	Your %	% For Non-Surg
Communic'n	3	1.3	8.8	15.1
Care & Tx	10	1.4	29.4	40.0
Humaneness	2	0.7	5.9	8.4
Accessibility	17	1.0	47.1	23.9
Environment	0	0.0	0.0	0.1
Money/Paymt	2	1.0	5.9	12.0
Total Compls	34	5.5	100	100

- ### Interim Observations
- λ ~Over 300 interventions completed
 - λ No one killed (yet)
 - λ 4 (<2%) responded with hostility
 - λ Professional:
 - ✓ Asked PAO to shadow, give ideas
 - ✓ Went to Chief: Asked for resources
 - ✓ Reorganized the unit
 - λ Phase II Interventions needed
 - λ Follow-ups ongoing

To this point we have completed over 300 interventions in multiple institutions. Nobody's been killed yet. About 4% of the time the mentor is greeted with hostility. Peer mentors at least initially use a messenger model only, which represents an approach that is adaptable to the safety movement. As we think about moving people forward,

whether we're thinking about safety or reducing malpractice risk, we have to have data and stories which can be delivered via a messenger. We have to train medical professionals how to accomplish the task.

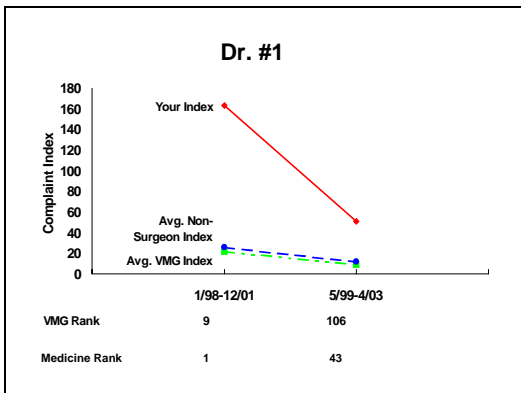
What Have We Learned Based on Experiences at Institutions Participating in PARS® Projects?

So what have we learned from the interventions?

- ### Complaints about Dr. "1"
- I wasn't answering fast enough. He began making motions with his hands that I should hurry. He demanded "How much weight have you gained in the last few months?" As I was trying to figure it out he shouted "20,30,40,50, ..what is it?" Without doing anything for my [medical problem], he got rude and said "Go home and lose 100 lbs." Then he scolded my daughter with "And you lose 100 lbs. too."

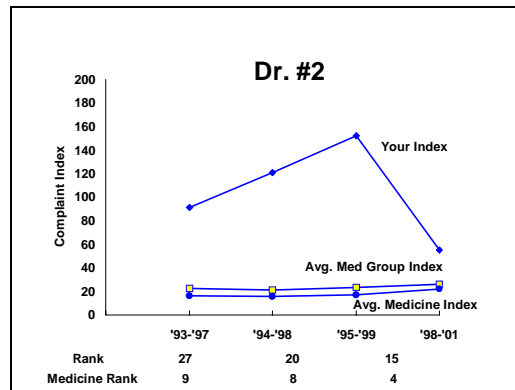
Let's look at Dr. "1". A patient reported to Patient Affairs: "I wasn't answering fast enough..." "He began making motions with his hands saying I

should hurry. He demanded, ‘How much weight have you gained in the past few months?’ As I was trying to figure it out he shouted, ‘20, 30, 40, 50 lbs, what is it?’ Without doing anything for my medical problem, he got rude and said, ‘Go home and lose 100 pounds.’ And then her daughter was there and he looked at her and said, ‘You go home and lose 100 pounds as well.’” It is amazing the barriers that we can create for good, safe medical practice by behaviors that go on routinely in our practices.



The next slide represents where Dr. #1 resided. He had a risk index almost off the scale. He was number nine overall and number one in medicine. Each point on the slide represents an intervention. For the two meetings, Dr. #1 received information about his score as well as normative data for the group. We find that 60 to 70% of all physicians respond to the messenger model alone. You provide bright physicians with data

delivered by a peer and you tell them that you’re coming back. “Dr. # 1, this is part of an ongoing process and I know when I come to visit with you again in x months that your profile is going to look much better.” “I really appreciate your time today, and thank you for listening to me.”



We also find that by using the methodology, we identify systems issues. Here’s an individual, Dr. #2. His peer mentor, the person who initially delivered these data, responded to me after the first visit: “I don’t think this person is going to get any better.” He feels a moral and ethical duty to see every patient.” Dr. #2 was one of those physicians that came in at six AM every morning, started seeing patients, did not leave until 10 at night, and would say yes to anyone who called. Unfortunately, the staff had learned how to solve the problem, just don’t let messages through. He would say to a patient, I want to see you in a month. The patient would go to the front desk,

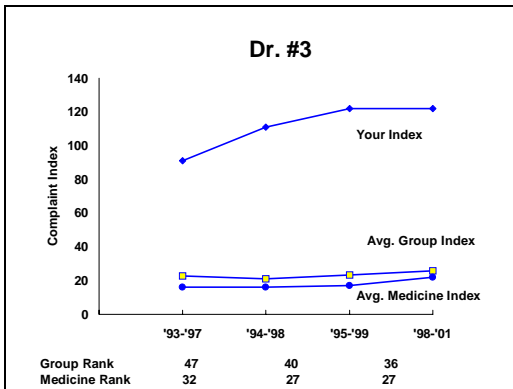
and the staff would give a 3-month follow-up visit. Patients would call in with questions, but never get through. Dr. #2 was trapped. His institution did not recognize it needed to double capacity. However, when presented with the profile, a decision was made to act. What is illustrated is the dramatic fall in complaints when a colleague was recruited to join Dr. #2. Patients blamed Dr. #2 for not being able to get in. They understood that the system did not support good care; but many blamed Dr. #2, not the system. Patient complaints represent an opportunity to get a sense of what's going on within an organization in ways that other measures may fail to detect.

whatever reason.

Summary

- λ Pt complaints delivered one-at-a-time provide no comparative feedback
- λ Single complaints may be dismissed
- λ Unsolicited pt complaints offer rich info about a medical group or med center
- λ Complaints may be captured, stored, coded, aggregated, fed back to staff
- λ Process, tools can help promote change

As malpractice researchers, we have realized that patients can help us identify and intervene with our high risk colleagues. From our studies, we have come to believe that there are even more important roles that patients can play in our efforts to improve the safety of care.



Finally, review the data for Dr. #3. We have individuals who just don't or can't respond. You will find that you identify individuals who have special needs, substance abuse, and personality disorders, but again as we think about the safety agenda, we have to help our colleagues who may be impaired for

Are patient observations of care related to adverse outcomes/errors?

Focus on the complaint illustrated on this next slide.

"Dr. X. said that he was going to check for hernias and repair them. Instead he repaired the same one he had previously. I think he poked a hole at that spot when he did the last surgery. I haven't seen him to talk to him. I can get a hold of GOD easier than I can get a hold of him!"

"Dr. X said that he was going to check for hernias and repair them. Instead he repaired the same one he had previously. I think he poked a hole in that spot where he did the last surgery. I haven't seen him to talk to him. I can get a hold of God easier than I can get a hold of him." "Is this patient correct?"

Complaints and Surgical Complications

- λ Hypothesis: Poor team work with patients may predict poor team work with other medical professionals.

One of the studies that we are finishing is based upon the hypothesis that poor teamwork with patients may predict poor teamwork with other members of the medical team.

Complaints and Surgical Complications

- λ Surgical Cohort (N=558)
- λ OPA date
- λ Surgical Complications data set (lezzoni)

We are examining a cohort including 558 surgeons for whom we have unsolicited complaint data and a surgical complication data set. The question is whether there is a linkage between attracting unsolicited complaints and surgical complications rates.

Cohort by Patient

Characteristic	N= 29,387
Age, mean yrs (S.D.)	49 (± 18)
Gender, % Female (N)	51%
Severity Class	
% No comorbid	38%
% Moderate	18%
% Major	27%
% Catastrophic	17%

The data set included 29,000 surgical procedures. Thirty-eight percent of the patients had no comorbid conditions. .

Cohort by Admission	
Characteristic	
LOS, Median	4
Major Comp	11%
Minor Comp	3%
Adm, % Emergent	51%
Insurance Source	
% Medicaid	8%
% Medicare	29%
% Commercial	63%
Discharge Status	
% Home	87%
% Transferred	10%
% Death	3%

We examined the characteristics of patients at admission. What we were most interested in, however, was who complained and the linkage to surgical complication rates.

Complaints and Surgical Complications					
	COMPLICATIONS			Total	
	None	1-94%	>95%		
COMPLAINTS	None	312	2	0	314
1-94%	164	43	9	216	
95%	3	6	19	28	
Total	479	51	28	558	

P-value <0.0001

What I want you to focus on is complaints versus complications. There were 312 surgeons that generated no unsolicited complaints and had no surgical complications reported in the data set. On the other hand there were 19 surgeons who were within the top 5% group for complications per procedure and complaint generation.

Log Reg: Predictors of Surgical Complications		
Characteristics	OR (95% CI)	P-value
Complaints	5.4 (1.9, 15)	0.001
# of Procd	1.01 (1.01, 1.02)	<0.0001

Many of the complaints generated by these high risk surgeons were billing, others related to the patients belief that they were: “not respected as human beings.”

Patients may not know precisely what’s going on in a medical environment, but I’m going to suggest, tongue-in-cheek, that they understand that there’s a “disturbance in the force”.

Can patient’s observations about their care be used to augment existing systems of medical error/adverse event identification?

In another study that we’ve just started we are asking: “Can patients’ observations about their care experiences be used to augment existing

systems of medical error identification in emergency settings?”

“I brought my son to the ED...they planned to give phenergan...an nurse came in and did something to the IV...his regular nurse came in and gave phenergan...she (regular nurse) came back...she was freaked out...phenergan had already been started through the IV line but not noted...”

One patient remarked: “I brought my son to the ED. They planned to give him phenergan... a nurse came in, did something to the IV... his regular nurse came in and gave phenergan... she, the regular nurse, came back... She was freaked out. The phenergan had already been given through the IV but not noted...”

“She was embarrassed about the filthy condition of the ED. She said the chairs in the waiting area were soiled and stained so that she didn’t want to sit down on them...the area in the back was also dirty...”

Another parent remarked: “She was

embarrassed about the filthy conditions of the ED. She said the chairs in the waiting area were soiled and stained so that she didn’t want to sit down on them. The area in the back was also dirty.” I wonder if this complaint that has nothing to do with medical care could be a marker of a system at risk.

Complaints and Adverse Events

- λ Current systems of surveillance include incident reports, chart reviews, direct observation, e-surveillance
- λ Limits with all including expense, sensitivity and specificity, “can’t report what we are not aware of”

Our current system of surveillance for adverse events and errors includes incident reports, chart reviews, direct observation, and e-surveillance, but all are limited. They’re expensive, and medical professionals can never report events about which they are unaware. Some problems don’t become apparent until long after the patient has departed the office or health facility. Patients again may play a role in improving safety.

Complaints and Adverse Events

- λ Hypothesis: ED encounters that generate complaints are associated with adverse events/errors
- λ Identifications of cases and controls
- λ Pt/family interviews:
 - Perceptions of care
 - Outcomes
 - Follow up
 - Adherence

Complaints and Adverse Events

- λ Id of adverse events/errors
 - Chart reviews
- λ Analysis
 - Comp and adverse events/errors by total and type

 - Extent to which comp overlap with existing surveillance systems

Our hypothesis is that ED encounters that generate unsolicited complaints are more likely associated with adverse events and errors than visits unassociated with complaints. In this case-control study, families will be interviewed concerning their perceptions of care, the outcomes of care, follow-up, and adherence with medical recommendations.. I'm going to argue that in circumstances where patients are unhappy with their care experiences, they are less likely to adhere, which may be one of the greatest threats to safety that we experience.

We are identifying adverse outcomes using the Harvard Risk Management system with chart review. The analysis will examine complications and adverse events by total and type, and we will examine the extent to which complaints errors and overlap with existing surveillance systems.

Summary

- λ Errors and adverse events happen
- λ Public and policy makers are demanding action
- λ It is time to get patients and families involved

In summary, errors and adverse events happen. The public and our policy makers are demanding action to make medicine safer. , I'm going to suggest

that you think about what we've done in malpractice research and ask, "How is this adaptable to our focus on safety. I'm going to suggest that patients can play a major role if we let them.