

In Honor of Stella

The Development of the Physician-Patient Advocacy Program at the University of Miami Miller School of Medicine

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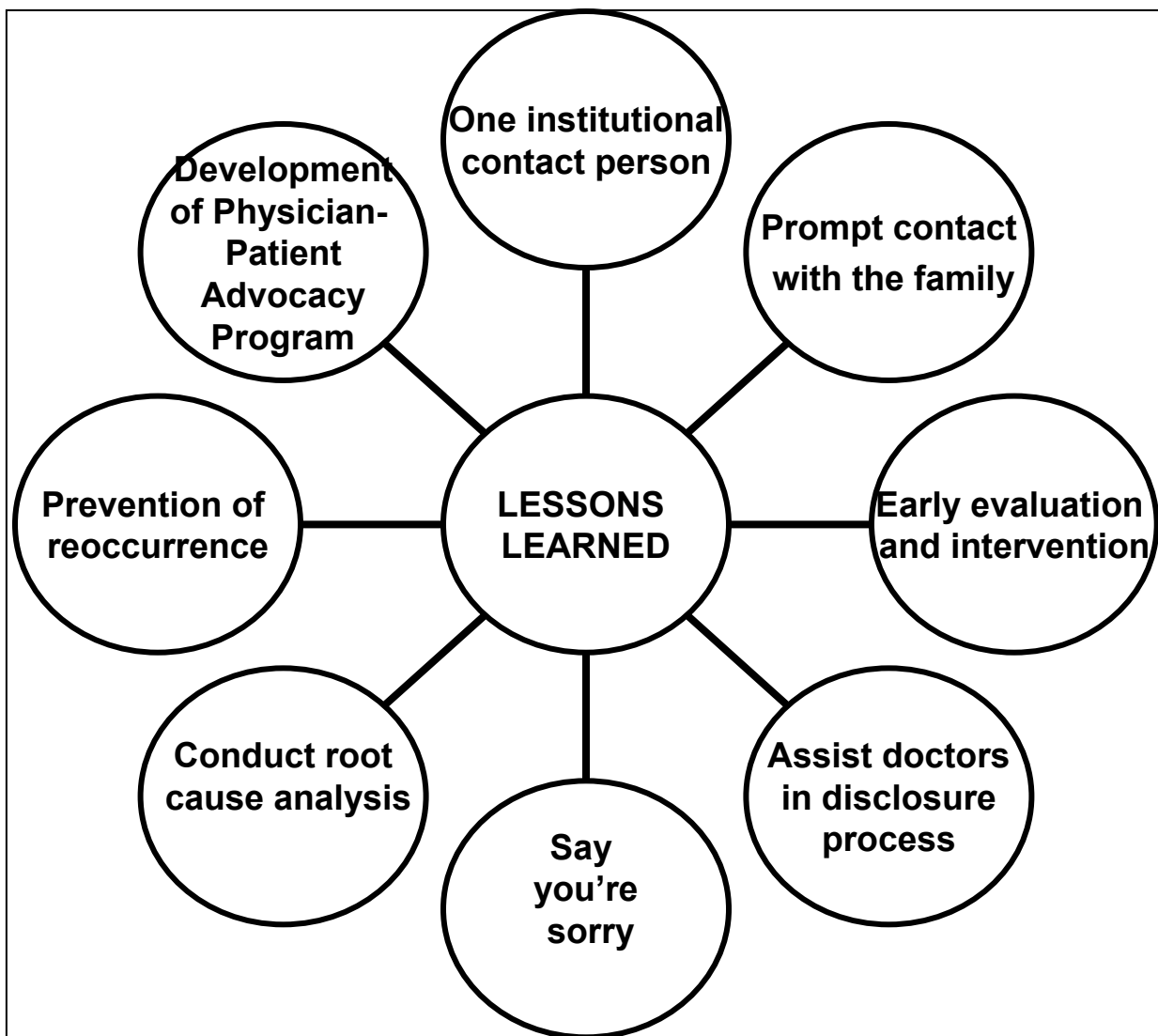
ABSTRACT

On August 9, 2003, Stella died within hours after the performance of an elective procedure at our institution. Under ordinary circumstances, Stella's family would have been given some limited comfort and then sent home with many questions unasked and even more questions unanswered. Under ordinary circumstances, that lack of answers might have resulted in anger, frustration, and possibly the hiring of a lawyer to help find those answers. Under ordinary circumstances, the family and the institution might have spent years of expensive and frustrating litigation that may have answered one question but would never provide the comfort and the healing that both the family and the institution truly desired. Fortunately, this was no ordinary circumstance, because this was no ordinary family. They challenged us to meet with them and answer their questions. They reviewed records and asked the hard questions. They spoke with the physicians, the Director of Nursing, the Patient Safety Officer, the facility Risk Managers, and internal legal counsel in meetings facilitated by a clinical psychologist with experience in health care risk management. Over many weeks and even months a story began to unfold and an understanding began to emerge. More importantly, however, a relationship began to develop. Although initially uneasy and often frustrating, that relationship brought back some of the trust that had been lost. It resulted in the resolution of the eventual claim. It resulted in a substantial donation by the family to establish a memorial fund in honor of the patient to promote health care improvement initiatives. It became the motivating force in the development of the Physician-Patient Advocacy Program as part of the formation of the Office of Patient Protection and Risk Prevention at the University of Miami/Miller School of Medicine.

***Summary of Project/Initiative** – This Poster details the process of discovery and disclosure, both from the perspective of the family and from the perspectives of the health care providers. It shows the contrast between the beliefs of the family and the perceptions of the providers as it relates to information in the medical record. It sets forth the lessons learned and the contributions made to the development of the University's disclosure program. In addition, the two measures developed in a research project on disclosure for the Physician-Patient Advocacy Program are provided as an educational tool for teaching effective disclosure and essential documentation on the disclosure of unanticipated outcomes. This first research measure is used to exam types of adverse events required to be reported in the State of Florida. The second measure is used to assess the medical chart documentation on disclosing unanticipated outcomes. This research project is currently underway at the University of Miami analyzing the types of serious incidents and the appropriate documentation indicating that these incidents have been properly disclosed to the patient and family.*

Differing Perspectives

Facts	Family Perspective	Institution Perspective
Pre-Surgery		
<ul style="list-style-type: none"> • Failure to obtain and review complete medical chart • Failure to include family in plan of care • Double booking surgery- Discovered by both families in waiting area • Not calling patient to remind her to discontinue medications prior to surgery • Two surgical reschedules: meds not stopped; upper-respiratory infection • Inadequate disclosure of surgical risks • Prior lab results expired; no repeat lab work ordered 	<ul style="list-style-type: none"> • Surgeon's responsibility • Aging parent with special needs • Someone else was going to perform Mom's surgery • Needs of aging patient not considered • A sign that surgery was not meant to be • "If we knew that she could die, we all would have been there." • Lack of coordination 	<ul style="list-style-type: none"> • Patient's responsibility • HIPAA restrictions • Surgery cancelled • Patient's Responsibility • Safety of patient; followed standard policies • Surgeon did not feel the need to disclose all possible risks • Chart oversight; policy violation; low risk to patient
Surgery		
<ul style="list-style-type: none"> • Surgical incision on opposite side of surgical site • Intra-operative change of procedure • Duration of surgery exceeded expectations • Miscount; X-ray • Anesthesia note: "pt. to ICU" --Surgeon note: "pt. to floor" 	<ul style="list-style-type: none"> • Possible wrong site surgery • Procedure different from consent • Potential complications • Possible retention of foreign object • Inappropriate level of care; medical team does not communicate 	<ul style="list-style-type: none"> • Required surgical technique • Appropriate intra-operative decision • Within normal limits • Policy appropriately followed • Anesthesia- recommended transfer to ICU; Surgeon-unnecessary use of ICU bed
Post-Surgery		
<ul style="list-style-type: none"> • Receptionist watching TV. Family inadvertently received information about another patient • Nurse late and not prepared to receive patient on floor • Compression boots were not reconnected after arrival. discovered 3 hours later • RN refused pain medication • No post-surgical orders for lab work or closer monitoring • Sporadic nursing rounds 	<ul style="list-style-type: none"> • Staff not professionally trained • Nurse irritable and incompetent • Nurse overwhelmed; not thorough • Staff rude and inattentive; Poor quality of care • Surgeon and fellow not communicating well • Inattentive nursing 	<ul style="list-style-type: none"> • HIPAA Violation • Recurring handoff issues • Floor adequately staffed • Compliance with surgeon's orders • Routine post-surgical order; results received late • No previous complaint about specific nurse
Code		
<ul style="list-style-type: none"> • Physician paged 3 times • Staff called security officer to escort husband from room • Code time: 1 hr 18 min • Surgeon arrived after code and requested autopsy 	<ul style="list-style-type: none"> • Delayed resuscitation • Excessive and offensive • Dad was left alone and uninformed • Family dispute regarding necessity 	<ul style="list-style-type: none"> • Policy is to page 3X. Code team promptly responded • Hospital policy followed • Valiant efforts to revive • Routine Request
Disclosure		
<ul style="list-style-type: none"> • Risk management prohibited surgeon from meeting with patient's family at their home • Institution took months to fulfill families request for medical records • Several meetings to determine cause of death • Lab results first reviewed several months after incident revealed that patient was bleeding post-surgically • Legal counsel and risk manager attended meetings 	<ul style="list-style-type: none"> • Possible cover-up • Unacceptable delay in obtaining information • Family believed it was a preventable pulmonary embolism • Family refused to believe that bleeding was the probable cause of death • We don't want to sue; we just want the truth 	<ul style="list-style-type: none"> • Acceptable risk management • Production within reasonable time frame • Physician believed it was an unpreventable PE • Physician refused to believe that bleeding was even a possible cause of death • Why are we continuing to meet; they are going to sue us anyway



Notable Quotes“

“Why not send her to the ICU?” –Family

“ICU beds are scarce, we try to use them appropriately.” –Surgeon

“ I did not know I was getting another one [patient]” –Nurse

“Admitted to floor, pain scale is 9.” -Nurse

“Don’t call us if she is not in pain. I am not giving her pain medication. We have to wait for 3 hours” –Nurse

“Next appointment for visiting is 8pm, you can’t go in now.” –Staff

“Oh, the boots are not connected!” –Nurse

“I have other patients.” –Nurse

“I paged the MD 3 times (during code)” –Nurse

“Given mother’s history, precautionary measures should have been taken to protect her.” –Family

“The death certificate was filled out wrong.” –Patient Safety Officer

“She suffered enough, you don’t want to do an autopsy. Embolism was the cause of death.” –AIC

“How does the hospital ensure that staff is competent?” –Family

“She [the nurse] is lying.” – Family

Disclosure Requirements

456.0575, Florida Statutes: Duty to Notify Patients

Every licensed health care practitioner shall inform a patient, or an individual identified pursuant to s.765.401(1), IN PERSON about adverse event that result in serious harm to the patient. Notification of outcomes of care that result in harm to the patient under this this section shall not constitute an acknowledge of admission of liability nor can such notifications be introduced as evidence.

RI.1.2.2, JCAHO Standard Disclosure of unanticipated outcomes is required

“The responsible licensed independent practitioner or his or her designee clearly explains the outcome of any treatment or procedure to the patient and, when appropriate, the family, whenever those outcomes differ significantly from the anticipated outcomes.”

