The Best Advice - Say Nothing

By Kathleen W. Smith, JD

“If you can’t say anything nice, then just don’t say anything at all.” My mother gave me this advice – fairly frequently – during my childhood, when reprimanding me for arguing with my younger sister. My sister and I would raise our voices and yell ugly things at each other (although, to be honest, I was responsible for more of the yelling, delivered with that particular level of meanness reserved for a younger sibling). Implicit in my mother’s advice was this: just don’t say the mean thing, the hurtful thing, the hateful thing. Instead, simply say nothing. Even though my mother’s advice was given in childhood as a solution for childish sibling arguments, her advice stayed with me as I grew older and my conversations matured in meaning and consequence. It is solid advice. It is advice that Cardiologist A should have followed in this closed case. Had she, she probably could have prevented the lawsuit in the first place.

On October 2, 2012, Mr. Jones[1] underwent a left heart catheterization by Cardiologist A. After the uneventful catheterization procedure, Mr. Jones was transferred to the cardiac floor for an overnight stay. The sheath was left in place and was pulled by a nurse on the cardiac floor without any reported complication. Pressure was applied to the area, and no

bleeding was noted. As the evening progressed, Mr. Jones complained increasingly of headache. His blood pressure was also poorly controlled. Mr. Jones then began complaining of nausea, which culminated in an episode of vomiting. With the nausea and vomiting, he was unable to remain still in bed. Approximately 2 ½ hours after the sheath was pulled, Mr. Jones was first noted to be bleeding from the access site. Nursing efforts to stop the bleeding were not successful, and a hematoma developed. Thirty minutes after the bleeding was first noted, the nurse called Cardiologist B, who was on call for her partner, Cardiologist A, and reported the hematoma. Cardiologist B ordered a bedside ultrasound and gave additional instructions for the nurses to better control the hematoma. Once the ultrasound results were reported to Cardiologist B, the vascular surgeon was notified and was at Mr. Jones' bedside within an hour. Mr. Jones was promptly taken to surgery, where the hematoma was successfully evacuated. He experienced a full recovery from these events.

When Cardiologist A returned to the scene later in the morning on the day after the heart catheterization procedure, instead of being reassured that the complication had been successfully managed, she responded by blaming the nurse for causing the complication in the first place, due to her poor sheath-pulling technique. According to the nurse's testimony in the lawsuit that was subsequently filed, Cardiologist A called her to Mr. Jones' bedside and "loudly and irrationally" voiced her blame. Cardiologist A then proceeded to document in the Discharge Summary that the hematoma was caused by the nurse's poor sheath-pulling technique.

Not surprisingly, Mr. Jones filed a lawsuit alleging that the hematoma occurred because of negligent medical care. Cardiologist A was named as a defendant to the lawsuit, as was her partner, Cardiologist B, their medical practice, and the hospital.

There are several lessons to be learned from this closed case.

1. Cardiologist A's comment was likely written in anger and was overly influenced by emotion, not facts.

Unanticipated complications can cause emotions to flare, especially when the complication is serious or time-sensitive. When other caregivers are involved with the patient, human nature can cause one to blame the other caregiver. Here, Cardiologist A was very quick to judge what happened, immediately blaming the nurse. She jumped to her conclusion without first learning the relevant facts. A better reaction from Cardiologist A would have been to first inquire about Mr. Jones' condition after the sheath was pulled and until the bleeding was first discovered. Cardiologist A would have then learned that the access site was stable for 2 ½ hours after the sheath was pulled. Bleeding was not noted until after escalating complaints of headache in the setting of uncontrolled blood pressure and nausea that culminated in an episode of vomiting wherein Mr. Jones was noted to be moving around significantly in bed. Any of these factors, alone or combined, could have caused or contributed to the development of the hematoma. Instead of reacting calmly and investigating what happened, Cardiologist A jumped straight to blame. As it turned out, her conclusion was inconsistent with the key facts.

2. Cardiologist A's comment gave life to nursing standard of care and causation theories that might not otherwise have been viable.

In a medical negligence case, the plaintiff must establish by expert medical proof both (1) that the care at issue deviated from the standard of care, and (2) that the outcome was caused by the negligent care. Hematoma is a recognized complication of a cardiac catheterization procedure. It can occur for a number of reasons and in the absence of negligence. It is an unfortunate, but non-negligent, defensible complication. Arguably, Mr. Jones' claim was without merit because he experienced a known, recognized complication of the procedure. However, with one sentence in the Discharge Summary, Cardiologist A gave Mr. Jones both (1) a standard of care criticism of the nurse's care and (2) an explanation of the negligence that caused the complication to occur. The comment was certainly relied upon by Mr. Jones and his experts to further his position in the case. Additionally, the defense was put in the awkward position of presenting alternative theories to refute Cardiologist A's comment and providing alternate, non-negligent explanations of what caused the hematoma. Cardiologist A's comment ended up fueling Mr. Jones' case against all defendants. Without it, Mr. Jones's case would have remained what it always was -- an unfortunate but recognized complication that occurred in the absence of medical negligence.

3. Cardiologist A's comment resulted in this prolonged lawsuit filed against herself and others.

Not only did this unfortunate comment negatively impact its author, but it had far-reaching implications to others; and it took years for the matter to resolve. In addition to Cardiologist A, partner Cardiologist B, their joint medical practice, and the hospital where both physicians practiced were named as defendants to the lawsuit. It is reasonable to assume that there were business ramifications felt by Cardiologist A's private practice and hospital practice as a result of this situation. Further, the lawsuit was quite long-lasting, taking six years and significant procedural ups and downs to eventually resolve. After some time, the

original lawsuit was dismissed without prejudice by Mr. Jones, who subsequently refiled it. Fortunately, the defendants were granted summary judgment (the trial judge determined the plaintiff's evidence was insufficient to establish a claim of negligence) in the refiled lawsuit. However, Mr. Jones appealed the grant of summary judgment to the defendants. It took more than one year of waiting before the summary judgment was affirmed on appeal, and the case was concluded. Although it was ultimately a happy litigation ending for the defendants, this came after six years of dealing with all the stress, all the hassle, all the disruption of a lawsuit that might otherwise never have been filed.

The key takeaway from this closed case is to think before you speak – think before you dictate that note that is critical of another provider's care; think before you speak critically of another provider to a patient or their family; think before you accuse another provider of doing something wrong when caring for a mutual patient. Once you have a clearer and calmer head, you will likely regret your criticism and blame, and, as Cardiologist A experienced, it might end up hurting you more than anyone else. Sometimes, the best advice is to just say nothing.

[1] The patient's name has been changed.

Quality Payment Program Deadline Looming - and Change is Afoot

By Elizabeth Woodcock, MBA, FACMPE, CPC

8:00 p.m. EST on March 31, 2020 is the final deadline for submitting your 2019 performance data for the Quality Payment Program (QPP). Many physicians participate in the QPP through the Merit-based Incentive Payment System (MIPS) track, which requires reporting on Quality, Promoting Interoperability, and Improvement Activities.

If you have joined an Accountable Care Organization, don't ignore this deadline. Even MIPS ACO participants must report a portion of the data – for example, Promoting Interoperability - directly on CMS' reporting platform. It pays to verify your reporting status, as the penalty for failing to participate is a whopping 7%, which will be imposed on your 2021 Medicare reimbursement.

If you are in a small practice – defined by the Centers for Medicare & Medicaid Services as 15 clinicians or less – there are key "flexible" options to reduce your reporting burden; be sure to take advantage of them: https://qpp.cms.gov/about/small-underserved-rural-practices

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All QPP participants may benefit from the government's recent announcement about future program changes. On February 21, the Department of Health and Human Services (HHS) released the report titled: "Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs." HHS declared its intention to simplify the Promoting Interoperability scoring model of the MIPS program. No details were provided about the expected changes; be on the lookout for near-term announcements likely to come this summer.

The 73-page report also addressed HHS' intentions to promulgate standards that support multi-payer, real-time, prior authorizations; to establish a framework for consistent standards for EHR systems to "better align EHR design with real-world clinical workflow;" and to pressure vendors to foster interoperability. These are simply recommendations but put a spotlight on where the federal government is placing its efforts in 2020 with regards to healthcare information technology.

Counselor's Corner: The Missed Conversation in Primary Care

By Nita Byrne, LCSW

Recently I began seeing a new primary care provider. As an ovarian cancer survivor, I realize that I am not the easiest new patient to accept. Not only am I a cancer survivor, I am a psychotherapist. Right off the bat, I was very impressed by the provider's combination of clinical expertise and genuine care and concern. Most of all, she maintained eye contact and listened to me. She created an environment in which I felt as if I could have disclosed most anything. I am thankful that providers and patients have done such an incredible job at destigmatizing cancer.

After I left her office, I was reminded of the enormous responsibility that healthcare providers carry in the world. I view a primary care provider as an "air traffic controller" to a larger healthcare system. PCPs are often the first point of contact for many patients, and their role is essential to all of us.

In my practice, I specialize in treating addictions. I rely heavily on healthcare providers

who are identifying patients with a substance use disorder (SUD). I have all the respect in the world for them because I realize that this is not an easy population to treat. They have the ideal opportunity to positively impact patients through screening, feedback, and referral. You may have heard the acronym SBIRT (Screening, Brief Intervention, Referral, Treatment).

I spent ten years as a Licensed Clinical Social Worker (LCSW) in a Level I Trauma Emergency Room in San Antonio, Texas. Many patients were referred to me because providers felt they lacked the knowledge and the necessary communication skills to address addictive disorders. They were more comfortable treating the physical manifestations of these disorders. It was my experience that some providers had a strong bias against people with addictions, viewing these patients as weak and immoral. Some providers also perceived them as manipulative and difficult to treat. No doubt, a high relapse rate and the complexities of co-occurring mental health disorders make this population challenging to treat. Due to the missed opportunity to effectively address addiction, I began to research ways for providers to reach these patients. I began providing in-service education to teach providers effective techniques to boost confidence in treating the underlying addiction as well as the presenting condition.

Education included teaching motivational interviewing and a brief, patient-centered approach that helps individuals overcome ambivalence and build motivation for treatment. Patients struggling with substance abuse are experiencing conflicting emotions, and motivational interviewing concentrates on improving and strengthening the patient's individual motivators for change. It involves being empathic through reflective listening and avoiding arguments or direct confrontation, thus helping the patient recognize the discrepancy between their goals and their current behavior. This modality is not a psychotherapy session and can be conducted effectively in a short period of time. The guiding principle for this intervention is represented by the acronym RULE.

Resist the righting reflex

Understand the patient's motivations

Listen with empathy

Empower the patient

The righting reflex is the human tendency to "try and make things right" but debating the seriousness of the substance use with an ambivalent patient typically ends in a pointless dialogue. I remember when the consensus recommended providers be directive and confrontational with patients with substance use disorders. I was working in an outpatient treatment center, and this method felt like the wrong approach. Because this is a shame-based disease, I could not comprehend the effectiveness of berating patients with SUD. Most of them have already been confronted and criticized by loved ones, friends, and many others without a positive effect on them. Thankfully, this mindset has shifted now to a more compassionate and supportive model, assisting patients in finding internal

motivations for their own recovery.

I now work in private practice and try to suggest ways that providers can best screen their patients for substance use disorder. I recommend ways to begin that conversation with patients. Some providers tell me they use behavioral questionnaires that the patient completes upon arrival. This is helpful, but I still believe it is essential to have that all-important conversation with patients. They might lie or underestimate their use of substances. It is common for people with such problems to face stigmatization and discrimination if their problems become public knowledge. There might be other adverse consequences if they are fully truthful.

I encourage providers to empathically ask a few questions about the patient's use of alcohol and drugs and whether they think that they could benefit from counseling or treatment. Patients are more likely to be honest if they feel that their responses will be kept confidential. Consider keeping business cards of therapists specializing in addictions to hand to your patient. I find it essential that you meet these providers in person before referring your patients to them. This will help you, and it will help your patients.

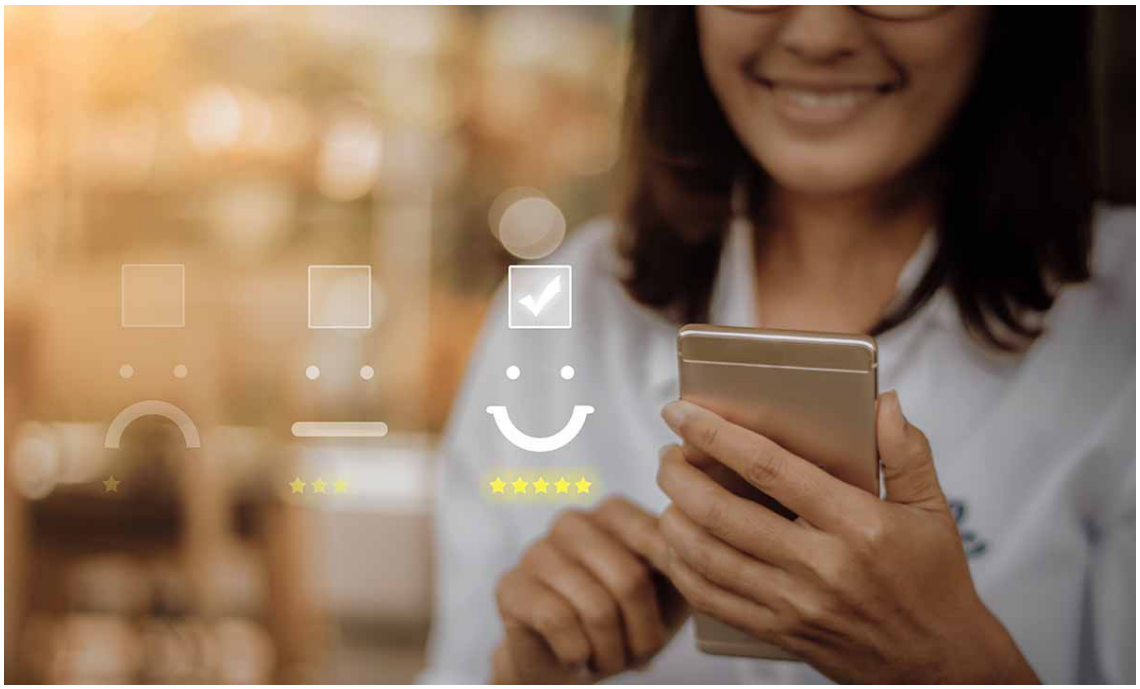
Clients often tell me that their provider didn't ask any initial questions about substance use at all. I believe that providers have an ethical responsibility to treat their patients with substance use disorder with dignity and respect and to try to establish a therapeutic alliance with them. This all begins with having the "missed conversation with patients" to assess substance use and readiness for treatment. It also involves familiarizing themselves with resources available in their community that will allow them to effectively refer patients for treatment. Treating addiction is complicated and unique to each individual who has different needs. Developing cultural competence will also benefit your patients. There may be significant racial and ethnic disparities in treatment centers, and cultural competence is part of the solution.

Helpful Tips I've Learned the Hard Way

1. 12-step meetings support many individuals but are not a “one size fits all” solution. Some people do not connect with the 12-step philosophy. They might need alternative recovery support such as Women for Sobriety or SMART (Self-Management and Recovery Training)
2. Not everyone needs medical detox.
3. Not everyone needs inpatient treatment. Research shows that outpatient treatment can be just as effective for many. There are intensive outpatient programs that are beneficial.
4. Develop or enhance cultural competence in your practice.
5. Not all complaints are drug-seeking behavior.
6. Recovery doesn’t mean that a person has stopped using alcohol/drugs.
7. Addiction is a brain disease, not a moral failing or a lack of willpower.
8. Addiction has both biological and behavioral components.
9. Many patients have co-occurring mental and substance use disorders. Depression and anxiety disorders often present as fatigue, headaches and pain.

Public awareness that addiction is a disease that can be successfully treated and managed offers a vital opportunity for healthcare providers to have the “missed conversation with patients.” Begin by familiarizing yourself with resources available in your facility or community. Assess patients for substance use and readiness for treatment. Become comfortable discussing referrals with your patients. Both you and your patients will reap the benefits of recognizing and effectively addressing addiction.

Use LEARN When Patients Complain



By Elizabeth Woodcock, MBA, FACMPE, CPC

As perceptions of value becomes ever-more important to your medical practice, now is a good time to review how you and your staff handle patient concerns and complaints about scheduling, billing, and other administrative functions. There may well be little that you can do to resolve some complaints, but a well-executed response will go a long way in boosting your practice's service reputation and keeping patients happy.

Think of complaint resolution as a multi-step effort centered around the LEARN process, which consists of listening, empathizing, apologizing, executing, resolving and (acting) now. Share this simple acronym – and the associated tips – with your team:

LISTEN. Hear patients out and try to understand why they have concerns. Avoid making a rapid, dismissive response such as "we aren't allowed to do that" (even if that is actually the case). Pay attention to the fundamentals of positive body language, such as making eye contact and leaning towards (versus away from) the patient.

EMPATHIZE. After listening to the patient's concerns, show empathy. It will help create a bond between you and your patients, giving them assurance that they've been heard and

that you are going to work with them to resolve the issue as best you can. Again, the complaint may be about something you cannot resolve, such as a provider running late, but showing you care with your body language and words can quickly reverse hard feelings.

APOLOGIZE (even if it's not really your fault) and offer a solution. Keep the focus on what you *can* do as opposed to what you *cannot*. It may not be exactly what the patient wanted but at least you have offered a solution. Sometimes, just pointing out that there is another option can remedy the situation.

RESOLVE the problem, or at least enact the alternative proposed solution.

NOW, follow-up! Don't neglect this final step in the LEARN processes. Follow-up with complaining patients by telephone to make sure that they are satisfied with your solution to their concerns. If the complaint was about something under your control, such as lengthy waits on hold when calling the practice, then take steps to repair that function -— likely it has been annoying other patients too. Consider sending a hand-written note in follow-up to really "wow" your patients: "Ms. Jones, thank you so much for bringing your concerns to our attention. We appreciate you." You'll turn an exasperated patient into a loyal one.

Successful resolution of complaints, not to mention avoiding complaints altogether, hinges on something else that is DIRECTLY under your control: the quality of your staff and your internal processes.

Try and head off service complaints altogether by giving patients ways to help themselves, such as secure online options to schedule appointments, request medication renewals, make payments, and ask questions about billing.

When hiring new staff, look for evidence that the person embraces a professional commitment to delivering high quality service. Remember that professionalism is more than creating a positive impression through eye contact and body language, it's taking responsibility to be the patient's advocate on even the smallest details, like getting the right form completed or making them feel welcome in the practice.

Commit to reinforcing your customer service expectations through constant repetition. Devote time at meetings to discuss ways to improve service. Raise awareness by asking staff to describe situations in which they have experienced poor customer service themselves; turn those anecdotes from restaurants, hotels, stores, or other companies into learning moments. Do the same by debriefing and addressing your practice's customer service meltdowns without blame to the staff involved.

If you don't care *about* the patient, you can't care *for* the patient; allow your team to LEARN from one another.
