

Closed Claim Abstract

CASE #1

A hospitalist discharged a 40-year-old female from the hospital on Coumadin therapy. She was not advised to see her primary care doctor in one week, nor was the primary care physician informed that she would be in charge of the patient's anticoagulation. The patient's INR became very high because she continued to take her discharge dose. She fell and suffered a hemorrhagic head injury which resulted in severe brain damage. A life care plan was part of the multimillion dollar settlement for the patient's long-term care.

CASE #2

A 30-year-old female was admitted under the care of the hospitalist for severe, intermittent shortness of breath. The hospitalist did not communicate with the primary care physician; then he was replaced by another hospitalist. The patient failed to report prior treatment for Wolf-Parkinson-White Syndrome and cocaine abuse. She was treated aggressively for asthma as her arrhythmia did not show up on her initial EKG, and her cardiac enzymes were negative. On the third night of hospitalization, the nursing staff found her unresponsive. Resuscitation attempts were unsuccessful. The family successfully sued the hospital, the primary care physician and the hospitalists.

Don't Fumble the Handoff

Inpatient Providers, Specialists, Hospitalists, Intensivists and the Primary Care Physician: A medical care delivery system with benefits and complex risks

By Catherine Andrews M.D. and Susan Millar R.N.

Some healthcare systems and managed care plans are emphasizing the use of hospitalist and intensivist physicians for inpatient care. At MAG Mutual, we recognize that there may be benefits to hospital-based care. One downside is the potential gap in patient care caused by a lack of communication between the primary care physician and the inpatient providers. In 2004, The American Medical Association published policy statements and guidelines that address the use of hospitalists.¹

This article addresses the potential risks to physicians when transferring patient care from outpatient to inpatient physicians and vice versa. After reviewing MAG Mutual's claims history, it is evident that **lack of communication is the single most common root cause factor that led to claims resulting from a transfer of patient care.** "Informed and documented transfer of care," is the patient's best friend when it comes to safety.

Appropriate communication between inpatient and outpatient physicians is essential to preserve the continuity of care. When communication is poor, patients will perceive that one hand

doesn't know what the other is doing. This perceived disconnect may cause the patient to question the very quality of care they receive. These problems and perceptions can be remedied by frequent and thorough communication between all physicians and the patient.

Key Handoff Information Checklist

The following checklist includes information that should be discussed by the hospitalist with the patient's primary care physician at various stages of the patient's care.

At Admission:

- History of illness
- Current medications
- Recent relevant test results
- Pending tests
- Advance directives
- Living circumstances (i.e., social support)
- Family issues

During hospitalization:

- Important change in management strategy
- Condition downgrade
- Transfer to critical care unit
- Death

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Don't Fumble the Handoff

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- At discharge
- Known and pending test results
- Discharge medications
- Medical equipment ordered
- Consultations
- Visiting nurse services requested
- Recommended follow-up²

The goals of inpatient physician programs should include providing better patient care and more cost-effective care in the inpatient and outpatient settings. Yet, every group has different needs. Some physicians provide only inpatient care, while other groups rotate inpatient duties. Facilities may also hire or contract with physicians to provide full-time coverage or to provide only night and/or weekend coverage.³

Since communication is so vital even between inpatient physicians, many hospitalist practices change rotations at midweek so other physicians involved in the patient's care are readily available for consult. Changing rotations on the weekend may result in on-call coverage provided by doctors who have not had actual contact with the patient.

The patient

- Telling the patient to "follow up with your primary care physician" a week after discharge is not sufficient
- A patient should not leave the hospital without a clear understanding of which physician will be following his or her care
- Physicians should clearly communicate to the patient what to expect and what their responsibilities will be



Frequently Asked Questions

Question:

When I am advised by an attorney that I am a non-party to a lawsuit involving my patient, how should I respond to his requests for "off the record" consultations.

Answer:

No conversation with an attorney on either side is really "off the record".

A physician should not talk to an attorney concerning a patient without calling a MAG Mutual claims representative. We can help you evaluate your need for legal support. At worst, you may find yourself added to the lawsuit. At best, you may become an unpaid expert witness.

Some facilities have developed physician notification policies and related protocols to ensure that communication between the various physicians and the patient does not fall through the cracks.

Increased use of electronic medical records may facilitate timely and more efficient exchange of clinical information between the hospital and outpatient settings, allowing physicians to communicate quickly and better document their efforts.

In summary, the availability of inpatient physicians and hospitalists may enhance inpatient care but without safeguards and appropriate attention to the details (such as communication), the hospitalist system is fraught with patient safety concerns. The hand-off of the patient to the primary care physician upon discharge is the make or break point in regard to continuity of care.⁴ To keep your patients safe, the discharge plan should be clear to the patient and to the physician accepting the hand-off.

Footnotes

1. <http://www.ama-assn.org/meetings/public/annual05/bot15a05.pdf>
2. Lucas BD. Working with the hospitalists to improve continuity of care. *Patient Care* 2000 Jan 15; 34(1):138-42.
3. *Family Practice Management* - November/December 1997 Leigh Ann Henry
4. <http://www.cogenthealthcare.com/29a2%20-%2020020101%20The%20Hospitalist.pdf>

Developing Transcultural Competency in the Treatment of Hispanic/Latino Patients

By E. Scott King, President, Atlanta Academy of Language Learning

It should be of no surprise to any one in the medical profession that developing better transcultural competency would benefit both physicians and their staff when treating the Spanish language-only speaking patient. This article is intended to provide an overview and to stimulate your interest in learning how to address these challenges.

Cultural Mix

You should be aware that, Spanish speakers tend to be very nationalistic and are extremely proud of their country or state of origin. Many countries are represented in the “cultural mix” of Latino patients. These include Mexico, Colombia, Perú, Honduras, Ecuador, Venezuela, Nicaragua and El Salvador. Each regional group brings with it many unique linguistic characteristics and cultural heritages.

For example, Mexican immigrants tend to be more accustomed to a rather direct and blunt rhetorical communication style. This same rhetorical style leaves the Ecuadorian or Peruvian quite offended, as the style used in their culture is very indirect. In general, the further the distance from the United States to the patient’s country of origin, the greater the chance of cultural barriers that might interfere with effective communication.

Directive Healthcare

Spanish-speakers often expect “directive healthcare.” They may view the presentation of treatment options as a sign that the physician lacks medical expertise. They generally expect (however unrealistic it may seem) the physician to tell them exactly what is wrong and to provide an immediate cure or treatment.

On the other hand, they often view the physician who is more directive in his/her approach with such high esteem that they fear any discussion or questioning of their treatment would certainly offend the physician.

Never assume that quiet responses equal affirmative responses.

Body Language, Gestures & Personal Space

Body language also varies tremendously among cultures, and among Latinos/Hispanics. While a simple nod of the head signifies agreement to us, it is simply a signal of polite listening to the Spanish-speaker. Nodding the head in response to conversation simply acknowledges the Latino listener’s attention to the speaker and does not necessarily indicate any degree of understanding or agreement!

Gestures common in this country may have totally different meanings in other cultures. The crooked “come here!” finger gesture used in this country is considered vulgar in some Latin countries!



In the United States a “personal space” of at least the length of an arm is expected during conversation. However, for most Spanish-speakers, the proximity that seems natural when speaking to others may be as close as the length of a hand. Ironically, this expectation tends to give Latino patients the impression that Anglo physicians, nurses and other healthcare professionals are a bit “cold,” “distant” or “standoffish” as they continue to back away when approached closely.

Home Remedies

We usually ask all patients if they are taking herbal medicines or supplements. Be aware that Latino patients may also include folkloric medicines, superstitions, home remedies and herbal treatments. Many Latin physicians and nurses routinely ask patients about such home remedies, or “remedios caseros.” These are quite common in Mexico and other Latin countries. Such treatments may or may not interfere with physician orders.

Curanderos, or folk healers, are in abundant supply here and may be consulted to add their advice to that of the physician’s. This is a particularly common practice when the family members have doubts about the efficacy of treatment plans.

Cultural Habits

Cultural habits differ by region but some, such as the way parents supervise their children, are common among many Latino societies. Parents tend to “bundle” young babies for fear of exposing the newborn to the “evil eye” or mal de ojo which is believed to be acquired when too much attention or praise is given to the infant. Latin parents tend to supervise older children with the underlying philosophy of “explore and learn” rather than the common “Anglo” approach of imitate under direct supervision.

Families tend to be matriafocal, and their elder female is the ultimate decision maker. Additionally, family support is intense and interactive among Latino/Hispanic patients and is expected within the culture. Large groups of concerned relatives and friends may accompany the patient to the healthcare facility, with relatively little sense of “personal privacy”. Also be aware that very few Latin females adopt the surname of their husbands when they marry. This can lead to a bit of confusion.

Psychological and Mental Health Services

These services are not exempt from the unique cultural aspects, which affect treatment of their Latino patients. For example, the susto, or “fright” and nervios (nerves) are frequently quoted as the main complaint by the patient or his/her family.

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Medical Interpretation

Often family members are relied upon to render interpretations, and it should be recognized that some family member's Spanish/English interpretation skills might be inadequate for medical situations. **Use caution when utilizing family members to interpret during medical encounters.**

In Latin cultures, the males are not usually allowed to ask, without experiencing great personal stress, questions related to "female health issues." It is important to realize that a male family member serving as the interpreter may not give totally accurate information about these topics.

Sometimes the language itself can help create misunderstandings. Owing to the fact that there are many similarities between English and Spanish words, assumptions can be made and meanings inferred incorrectly. Examples include Spanish words like constipado (nasal congestion!) and molestar (to annoy!) and pariente (relative, not parent!). A good, basic Medical Spanish class should cover these terms and allow the healthcare provider to be on the lookout for such easily mistaken Spanish terms.

Medical Interpretation is a very young profession, and as such, has encountered some significant problems. The majority of these problems concern issues of accuracy, regional dialects,

lack of familiarity with medical terminology, and availability of qualified and, eventually, certified professionals in the field. Continued development of resources and educational opportunities should encourage higher quality transcultural medical communication.

Following is a list of things to keep in mind when treating a Spanish-speaking patient:

- The population of Hispanic/Latino citizens is growing five times as fast as the general population in the US
- Be aware that senior female family members usually direct most healthcare decisions
- Remember, your competence may be judged by your demeanor
- Be aware that conversational distance is much closer in the Spanish speaking population
- Be aware that family members may not be competent interpreters, especially male for female or children for parents
- Don't assume; Spanish words may appear similar to English words, but have very different meanings
- It is helpful to have staff complete a basic medical Spanish class

If you would like to know more about the Hispanic/Latino cultures and learn more about the topic of treating the Hispanic/Latino patient please visit www.culturaldiversity.com on the web.

MARK YOUR CALENDAR

"Patient Safety Takes Wing"

A new MAG Mutual risk management program demonstrates how the teamwork and safety measures used in the airline industry can be adapted to help improve patient outcomes. The program will be offered at no charge to MAG Mutual professional liability policyholders and their office managers.

Macon - September 1 – Georgia Music Hall of Fame & Museum

Charlotte, NC - September 8 - Presbyterian Hospital

Atlanta - September 22 – Sheraton Buckhead Hotel Atlanta

Savannah - September 29 – Georgia Medical Society

Melbourne, FL - October 13 - Hilton Melbourne Rialto Place

Watch your mailbox for details or call Cheryl Winsett at **404-842-5681** or **800-282-4882, ext. 5681** for more information or to register.

MAG Mutual does not presume to establish any standard of care or establish rules for the practice of medicine. The particular patient-care strategies or range of patient-care strategies mentioned in this newsletter should be tempered by the physician's judgment. This publication is produced to inform you of issues relating to medical professional liability insurance and other matters of importance to physicians. Material given in this newsletter does not constitute legal advice or opinion. If you have questions in any of the areas discussed in this publication, you should seek a qualified legal opinion. ©2005 MAG Mutual Insurance Company



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P.O. Box 52979

Atlanta, GA 30355-0979

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