

PATIENT SATISFACTION: a measure of risk management success



by Linda M. Greenwald, editor of risk management publications for ProMutual Group in Boston. Reprinted with permission.

According to an adage whose truth has been proven over time, the person who has a good experience tells one person about it; the person who has a bad experience shares it with five others. In health care, certain elements have been found to provide a “good experience” for almost all patients in the office setting: clinical competency, the physician’s

sharing of information about health-related issues, his/her demonstrating care for the patient, and his/her openness to allowing the patient to participate in health care decisions.

In the cases presented below, some or all of these concerns were not met. In each instance, the ultimate burden for the patient’s dissatisfaction was borne by the physician or the practice. In each case, the reputation of the physician or practice had a shadow cast across it; the physician or practice was left open to a claim or suit from a patient who considered him/herself treated so shabbily that a minor professional transgression in the future might trigger a disproportionately angry response; and potential revenue was lost from the five or more people who might have selected that physician or practice if they had been told about a good experience.

The risk management recommendations that follow each case suggest ways in which physicians and their practices can maximize their patients’ satisfaction with their medical care.

Case 1

A woman experienced two episodes of rectal bleeding. She called her physician’s office and twice in three hours was put through to an answering machine. The next morning, she called to make an appointment and was told the appointment secretary was on vacation. The only option she was offered was to leave a message or voice mail. An hour later, a nurse from the practice called and advised the patient, “Let it go and call us if it happens again.” When the patient expressed concern about cancer, the nurse said, “Cancer doesn’t start that way.”

Patients want access. Staff members and physicians often assume the role of

“gatekeeper.” In order to grant patients access to the practice:

- Develop a policy addressing the triaging of routine telephone calls, the handling of angry calls, repeat calls, and calls requesting medical advice.
- Develop and implement a policy concerning telephone calls received by triage agencies whose services are purchased by the practice.
- Make sure that there is backup for staff members who are absent.
- Develop a policy concerning the giving of a medical diagnosis or advice over the telephone. The policy should address, at a minimum, what diagnoses or advice might be given, under what circumstances, and by whom.

Patients want human contact. A patient always wants and may need to speak with a person, not a machine.

- Develop a policy concerning the use of answering machines in the office. The policy should address, at a minimum, when an answering machine may be used and who will transcribe the messages.
- Consider keeping a list of “trigger words” and phrases that will guarantee a patient the right to be transferred immediately to a person, not a taped message.
- Triage phone calls, returning all that you can and most assuredly those that are important within that business day. If calls are not returned immediately, consider having a staff member contact the patient to let him/her know approximately when you will return the call.
- Consider setting aside a specific time to return phone calls and let patients know that you will be calling them during that time.
- Respond to letters written by patients. If a letter is angry, consider

patient satisfaction (continued)

calling or inviting the writer into the office for a discussion about the matter.

- Do what you say you're going to do (for instance, look up the information you said you were going to find for a patient).
- Don't make promises you can't keep.

Case 2

A young man complained of abdominal pain of two weeks duration. After waits of 40 minutes in his physician's waiting room and 20 minutes in an examination room, he found his visit with the physician interrupted when the physician accepted several telephone calls from other physicians. In each case, the subject of the call was another patient whose name and diagnosis were openly discussed in front of the patient in the room. At the end of the office visit, which included a "baseline" EKG and the drawing of two tubes of blood, the patient was handed a bill for \$345.

Patients want attention. The physician who does not devote his/her full attention to a patient betrays the trust of that patient.

- Allow little, if anything, to interrupt the time you spend with a patient.
- Minimize the time you spend away from the patient once you have entered his/her presence.
- Listen to the patient before making a diagnosis.

Patients want respect. In a world that seems increasingly callous, physicians and patients alike need to feel respected.

- Treat the patient and encourage the staff to treat the patient as a person, not a statistic.
- Devote full attention to the patient when you are with him/her and convey the sense that he/she matters and what he/she says is important.
- Schedule office visits in such a way that waiting time, except in emergency situations, is minimized.
- Try to avoid double booking, a system that may result in lengthy delays in the waiting room and anger and frustration for the patient.

Patients want confidentiality. Patients need to know that whatever they tell their physician will be held in confidence.

- Never hold a telephone conversation

about one patient within hearing range of another.

- Hold all conversations and remind staff to hold all conversations about a patient's medical history, diagnosis, family situation, billing and any other personal matter in a place where others cannot overhear.
- Refrain from asking the patient personal questions at a reception area open to the waiting room.
- Do not use sign-in sheets that allow an incoming patient to see the names of all patients scheduled that day.

Patients want fairness in billing. There is little that can fuel a lawsuit as quickly as what the patient sees as unfair billing.

- Make the patient aware of fees, billing practices and payment expectations at the time of the first visit.
- Discuss costs and potential medical alternatives with the patient before performing or ordering tests that may be expensive and/or unnecessary.
- Consider flexibility in your willingness to negotiate payment arrangements with the patient who, for valid reasons, is having difficulty meeting your customary payment schedule.

Case 3

A 24-year-old woman complained to her internist of severe headaches. A CT scan was read as negative and the patient was told she needed to see a psychiatrist. She protested but began psychotherapy. The headaches persisted. A subsequent CT scan revealed a brain tumor that had been missed on the first scan.

Patients want to be taken seriously. They understandably recoil at being told "It's all in your head" when they sense there is something wrong.

- Try not to dismiss a patient or attribute his/her complaints to age, imagination or hypochondria before definitively ruling out physical causes for the presenting symptoms.
- Consider the worst until it is ruled out.
- Trust the patient first, for technology can fail, radiologic studies can be misread, and laboratory values can be skewed.
- Follow closely or refer the patient whose symptoms remain elusive.

Patients want to be listened to. Inadequate communication is the unexpressed allegation in many malpractice suits.

- Practice active listening, ridding your mind of all assumptions, pre-judgments and preoccupations, while the patient speaks.
- Keep your eyes at the same level as the patient's and maintain eye contact while speaking with or listening to him/her.
- Pay attention to verbal and non-verbal cues.
- Hear what the patient may be too afraid or too embarrassed to say.
- Use open-ended questions. They may uncover a hidden agenda.

Patients want honesty. Admitting what you don't know, acknowledging an error, or expressing sorrow for an adverse outcome are usually perceived by patients as signs of strength, not weakness.

- Acknowledge the patient's perspective as valid.
- Refer to another practitioner sooner rather than later.
- Talk with the patient and his/her family as soon as an unforeseen event or adverse outcome occurs.
- Never lie to the patient and his/her family about an adverse outcome. If they ask you what happened, tell them truthfully.
- Recognize the difference between expressing compassion and acknowledging guilt.

Conclusion

The building of patient satisfaction is not a complicated art. It takes awareness, it assumes trust, and it requires a commitment to the belief that we are all patients who are sometimes fearful, often vulnerable and frequently in need of some reaffirmation of our humanness in an increasingly depersonalized world.

Patient satisfaction is not the direct goal of clinical risk management. However, risk management's focus on the systems that make medical practices run more safely and smoothly ensure that increased patient satisfaction is one of the several benefits to be realized by a practice that develops and implements a good risk management program.

The management of medication samples

by Barbara Rose, Managing Editor

With the recent recall of Etodolac Capsules 300mg, lot number 9991052 by ESI Lederle, one is again reminded of the challenges for today's health care providers to remain current with the plethora of drugs available. Memory is still fresh for the recall of Rezulin and Propulsid.

What makes the recall of Etodolac unique is its application to one lot. If your practice accepts pharmaceutical samples of Etodolac, have you removed this lot number from your supply? Have you given this lot number to patients? Would your record keeping provide this information? The letter from ESI Lederle to health care providers states "ESI Lederle will be notifying wholesalers, pharmacies and health care providers of this recall. Notification of the recall will be taken to the consumer level, and patients will be advised to discuss this issue with their pharmacist. Patients are also being advised to contact their health care provider should it be determined that they may be taking product from Lot number 9991052 or if they have any questions."

TMLT risk management representatives have visited practices without proper protocols in place for safe management of sample medications.

Guidelines for receiving, storing and distributing sample medications include the following.

- The Texas Administrative Code, section 169.7 requires all licensees, e.g., physicians, maintain a copy of each signed request form for sample dangerous drugs as required by the Prescription Drug Marketing Act of 1987, Public Law #100-293, 102 Statute 95 (21 US Code 503 [s]) for a period of two years from the date of acquisition. Dangerous drugs are defined as any medication that requires a prescription.
- Check sample medications for expiration dates on a routine basis and remove expired samples from your supply. While pharmaceutical representatives may agree to dispose of their out-of-date samples, please note that it is the physician's responsibility to ensure expired samples are not dispensed to patients. If practice protocols include disposal of expired samples, **do not place in the regular trash.** Place in a biohazard bag or open all packages and flush the medications.
- Avoid accepting medications you do not prescribe or are inappropriate for your practice.



- Store sample medications in an area inaccessible to patients to avoid the risk of theft. Do not keep in exam rooms.
- Always document in the patient record when samples are given. Include the same elements as if writing a prescription. Include name of medication, dose, route of administration, and frequency.
- With medication recall an ever-present possibility, an inventory log to record patient name, medication and **lot number** becomes an important risk management tool. Should recalls occur again, your practice can find the patients affected in a timely fashion.
- Have strict protocols in place regarding distribution to staff, family, etc. Do not engage in this practice unless you are the attending physician as you will be held accountable should there be an adverse outcome.



An ounce of prevention

TMLT's Risk Management Department has designed a **Practice Review** to assist you and your staff in determining your risk exposure. A practice review places a risk management professional in your office to:

- examine the office for physical safety concerns
- review practice policies and procedures
- evaluate medical record documentation
- provide follow-up with a confidential, written summary

Practice reviews are free to all policyholders, and can be completed without disrupting patient appointments. Physicians who complete the process may be eligible for a 3 percent premium discount after review recommendations are met.

To request a practice review, please call (800) 580-8658 or visit the web site at www.tmlt.org.



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Closed claim study: *failure to perform a physical assessment*

Clinical presentation

A 44-year-old female employee of the physician had complaints of a backache. The employee performed a dipstick urine for herself, noting an abnormal pH result.

Physician action

The physician gave the employee samples of Cipro 500mg. Two days later the employee developed a rash. The next day the physician ordered an injection of steroids and Benadryl. A total of three steroid injections were given, one of which was administered at the employee's home. The employee was later seen in the emergency room and treated with Vistaril, Tagamet, and Ventolin nebulizer treatments. She was admitted to the hospital and treated by other physicians who ordered additional steroid therapy. She was discharged 4 days later with the diagnoses of serum sickness related to an allergic reaction to Cipro, chemical diabetes mellitus and anxiety reaction.

Allegations

- Failure to perform a physical assessment
- Failure to document in the medical record

Legal Principle

Negligence, according to the Texas Medical Jurisprudence, is defined as "the lack of ordinary care. Ordinary care is that degree of care that a reasonably prudent physician would have exercised under the same or similar circumstances." The insured physician failed to perform a history and physical before administering the samples of Cipro. There was no record of any office visits, including the urinalysis and the administration of corticosteroid injections. Experts stated that, although the physician may have done nothing intrinsically wrong, acting in good faith treating the employee, the failure to document the treatments given was detrimental to the outcome.

Disposition

This case was settled in mediation on behalf of the policyholder for \$35,000. Contributions were also made from codefendant treating physicians. Experts were critical of the physician's lack of any documentation relating to the treatments given. The claimant continues to suffer from joint pain, insomnia, hot flashes, swelling of her face and neck, memory difficulties and various other complaints that she feels are

related to the large amount of steroids she received.

Preventative measures

- When providing medical care, always document your assessment and any care given including the rationale behind your decision.
- Establish a written policy in your practice for medical care provided by you to your employees.
- Whether a prescription, injection or medication sample is given, include in your documentation that the instructions, side effects and potential adverse reactions were discussed and understood.

Do you see the potential for these events to occur in your office? Do you have written protocols in your practice regarding care of employees? If you provide medical treatment to employees, is it documented? Food for thought and appropriate action! Think "best practice" and risk management in all aspects of your practice of medicine.

Reference

Texas Medical Jurisprudence, 12th Edition, 1998; Fulbright & Jaworski LLP