



**MEDICAL PROTECTION SOCIETY**

**A TEAM APPROACH TO  
IDENTIFYING AND REDUCING  
CLINICAL RISK IN YOUR  
PRACTICE.**

**Rotorua, June 11<sup>th</sup> – 13<sup>th</sup> 2009**

# Introduction:



MEDICAL PROTECTION SOCIETY

## Participants:

- MPS Medico-legal Consultants:

Drs Peter Robinson, **Aine McCoy**,  
Tim Cookson, **Denys Court**,  
**Brendon Gray**, Alan Doris.

- Barrister, Quay Chambers, Auckland:

**Catherine Garvey**;

# What MPS does for its members:



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- **Provides**
  - information: eg Casebook / Website
  - medico-legal advice: “prophylactic > therapeutic”; 6 medico-legal consultants
  - lawyers when required
  - Educational services (MPS Education)

# What MPS can & can't do for you:



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- We cannot provide you with the skills or protection which will allow you to cruise right through your career without any complaints (unless you retire at graduation)
- We can provide you with skills and provide our skills to:
  - Reduce the likelihood of complaint
  - Increase the chance of earlier and “lower-level” resolution of complaint
- If you and we succeed in these, you are more likely to have a more satisfying career!

# Why are you here?



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*To:*

*“Learn from the mistakes of others, you haven’t  
got time to make them all yourself”*

Eleanor Roosevelt

# Introduction:



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## Programme:

- Case presentations: managing risk
- Factors that lead to complaint
- How to respond to a complaint:
- HDC cases: how we can help:
- What MPS does for its members.
- Q&A

# The paradox:



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Most mistakes do not lead to complaint

Most complaints do not arise from mistakes

*Why?*

*Patients can only assess competence indirectly.*

# Communication and complaint



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Communication and breakdown are directly related

*Why?*

*Because it is subjective, and patients  
can and do assess it*



# Remember:



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There are usually a chain of factors which precipitate complaint;

...if we can identify the precursors to complaint, we may be able to predict and prevent it.

# The precursor chain...



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...is usually a complex of:

**Mis-communication**

*followed by*

**Unmet expectation**

*followed by*

**Adverse outcome**

**(from the patient's perspective!)**

# The precursor chain...



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...so, in assessing your risk, ask yourself:

**Have I been understood?** (Mis-communication)

*followed by*

**Can I meet these expectations?** (Unmet expectation)

*followed by*

**Is the patient satisfied by the outcome?** (Adverse outcome)

**( from the patient's perspective!)**

# What are your patients expectations?



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- Pleasant surroundings
- “Timely” access to care
- Humanity (you and your staff)
- Time spent
- Information
- Affordability
- Other? **ASK!!**

# So:



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- If you perceive increased risk;
  - ask yourself: what is the appropriate strategy
- If you need advice:
  - ask for it; colleague or MPS
- If you cannot determine expectations;
  - ask the patient.

# Put another way:



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*Your patient will not become a complainant if they continue to value the professional relationship more than their right to complain.*

So; Where you perceive increased risk; ask yourself:

**“What does this patient value in; and expect from; the relationship”**

If you don't know, ask!!

# All one team; in it together!



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- How does the “front desk” greet patients?
- What initial advice do they provide?
- When did you last ask them whether they had a good day? They might have perceived some risks!
- How do they handle patient dissatisfaction to care you have just provided?
- Do your staff feel safe to critique or correct? Have you checked that?

# Steps toward complaint prevention



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- Maintain constructive communication at all times, (especially after adverse outcomes)
- Remember systems competence, not just your own!
- Assess whether expectations are reasonable
- Be alert to “situational” risk.
- Take advice when you need it.
- Don’t drive a Porsche.



# The TEAM approach



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- T:** Triage your risk
- E:** Employees are your antennae
- A:** Act appropriately for risk
- M:** MPS is here to help

# Case 1:



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- New IMG GP consulted by male, mid 30's, patient of one of her partners:
- Requests codeine prescription-
  - Already on 30mg 2 qid for 'leg pain';
  - Declined to explain why he needed codeine
  - Wanted to take more than prescribed dose;
- Angry and abusive when questioned about pain

# Case 1:



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- GP excused herself and left the room-
  - Approached reception; whispered pt possibly drug seeker and was angry with her;
- He was behind her, heard this and yelled out to the waiting room that the GP was accusing him of being a drug seeker.

# Case 1: Assessing the risks.



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- When you have a difficult and threatening patient:
  - What are the risks?
  - Can these be anticipated? If so:
  - Could they have been handled differently?

# Case 1: Risks



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- Personal safety
- Complying with demand under threat/duress
- Notification? Discretion vs obligation.
- Adequacy of documentation
- Complaint
- Others?

# Case 1: Managing the risks:



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- Manager ushered him to another room,
  - calmed him down;
  - arranged later meeting between him and GP
- Meeting took place with GP + support person;
  - GP explained her actions and apologised for any distress caused
  - pointed out that he had abused her;
  - all seemed settled
- Complained to HDC.
- We helped her to prepare her response; matter not investigated further.

# Case 2: HDC complaint:



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- Woman, 40yrs, saw midwife at 21wks gestation. Detected L breast lump; advised “See GP”.
- 1st consultation: woman & partner: no info from MW, patient could not recall MW’s name
- GP recalled taking full history regarding the breast lump, including:
  - Family history
  - Nipple discharge (nil)
  - Whether present at first antenatal examination (patient thought not)

# Case 2: Diagnosis:



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- O/E of breast (4 quadrants, axillary tail, areola and nipple, supraclavicular region axilla
  - Inflamed area of hardening;
  - Skin red and warm; areola also inflamed
  - Marked tenderness.
- Diagnosed “acute infection involving the breast tissue and overlying skin — cellulitis”.
  - A ten-day course of Floxapen prescribed.
  - Explained to Ms A that her symptoms could possibly be due to cancer.





- Discussed treatment plan including:
  - Antibiotics;
  - Review 7d and completion of Rx
  - That FNA, U/S and surgical referral at that time if not resolved
- Stated mammogram contra-indicated until >28w. *(Patient stated he said “no tests can be done”).*
- Said to return earlier if condition not improving. *(Denied by patient).*
- GP felt partner interrupted frequently; very “controlling”.

# Second consultation:



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- Lump remained, but not as sore, swelling less, had been taking antibiotics
- Dr stated that O/E of Ms A's breast, infection settling & area of induration smaller.
- Satisfied no abscess and advised her to continue with the antibiotics.
- Patient denied exam had occurred, record ambiguous as to whether exam findings or patient description documented.

# Subsequently...



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- Suggested apptmt in 5d.
- Patient refused stating “under care of MW, wanted to enjoy her pregnancy” and would return if did not improve or after birth.
- Recall entered for EDD
- Reiterated need to review after Rx to determine need for referral.
- Appointment made for 5d later. DNA. Practice mgr phoned twice. No reply.

# Contd...



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- Patient told MW GP “not concerned”
- Moved; new MW concerned, immediate surgical referral; carcinoma on biopsy
- Mastectomy etc
- Metastatic disease, dead within 6 months.

# Case 2: Assessing the risks.



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- What risks are evident from this scenario as it unfolds
- How could these risks have been mitigated?
- For situations where you believe there may be compliance (adherence with advice) or recall problems, how can you reduce your (and the patient's) risks?

# Risks:



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- No MW-GP-MW continuum of care
- How to react to indications of non-compliance.
- Does your assessment of risk affect your referral threshold?
- Diagnostic challenges
- Was the husband a “risk indicator”?
- Documentation: “detail vs usual custom”

# MCNZ: Ethical Guidelines: How to protect yourself



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1. Tell the patient the ideal position, i.e. how “ideally” they should be treated.
2. Advise them of other treatment options such as going private. Care options should also be raised, such as different types of prostheses.
3. Record that you have given this advice in your notes - for example:
  - OC + TD☐ (optimal care and timing discussed)
  - OC + TD☐ (optimal care and timing discussed at length)



4. Where appropriate, share the onus of communication with others caring for the patient. A statement in your referral such as “I have suggested [patient] discuss treatment options with you” documents your taking of steps to meet your duties.
5. Set up a system so that you have a prompt to act if treatment is delayed.
6. From time to time ensure resource issues are discussed and minuted at meetings you attend. Write letters recording concerns.



# Case 3:



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Surely I should help!

- GP practice 45min from you is about to close. Is it your worry?
- Public meeting held; some concern & anger expressed
- Block-bookings attempt made at your practice by an individual with a distinct accent
- Receptionist thinks it is the angry woman from the meeting
- What to do?



# GROPL

*I write to inform you that the professional relationship has broken down and can not be restored. I therefore cease to be your General Practitioner effective from the date of this letter. Please ring reception on \*\*\*\*\* and inform me as to where a copy of your records are to be sent.*

# Complaint lifespans:



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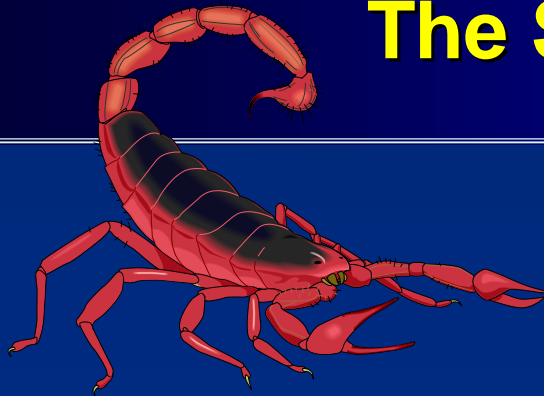
Longest period from:

- Consultation to complaint:
  - 50yrs: a dentist
  - Whew!
- Complaint to resolution:
  - 9yrs: a GP

# The Scorpion Effect



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**Delays between incident & reporting dates  
% of claims reported in each year following  
year of incident in New Zealand**

<b>Year</b>	<b><u>0</u></b>	<b><u>1</u></b>	<b><u>2</u></b>	<b><u>3</u></b>	<b><u>4</u></b>	<b><u>5</u></b>	<b><u>6</u></b>	<b><u>7</u></b>
<b>%</b>	<b>42</b>	<b>40</b>	<b>4</b>	<b>5</b>	<b>4</b>	<b>2</b>	<b>1</b>	<b>1</b>
<b>Cumulative</b>	<b>42</b>	<b>82</b>	<b>86</b>	<b>91</b>	<b>95</b>	<b>97</b>	<b>98</b>	<b>99</b>



**The typical NZ Doctor?**



**When you are in deep trouble,  
say nothing, and try to look inconspicuous.**

# HDC Letter



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Health and Disability Commissioner  
*Te Toihau Hauora, Hauātanga*

Delivered To You By New Zealand Post

Wellington MAIL SERVICE CENTRE

5 pm 03 OCT 05

150 Years of Stamps  
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New Zealand

Mr Adam Lewis  
Harbour Chambers  
P O Box 10-242  
WELLINGTON

P O Box 12 299, Wellington  
Level 13, Vogel Building, Aitken St  
Wellington, New Zealand  
[www.hdc.org.nz](http://www.hdc.org.nz)



# REACTION



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- DO YOU:
- Get sweaty and tachycardic
- Open it straight away
- Open it last
- Hide it in case anyone else sees it
- Toss it in the bin/Ignore it?



# How Do I Respond to a Complaint?



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- DO NOT:
- Ignore or 'Bin' the letter
- Respond in anger
- Resign
- Believe that you are alone
- Forget MPS

# How Do I Respond to a Complaint?



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- DO:
- Call MPS 0800 225 5677 EARLY
- Note the response date
- Be aware of your responsibilities to respond to the complaint under the H&D Act
- Keep your response professional

# Crafting a letter:



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1. Write report as if the addressee is a respected and learned colleague, focusing on the clinical/technical aspects of consultation complained about.
2. Edit letter as if the addressee is a lay person of average intelligence who has no knowledge of medical practice, i.e. simplify the language and define the terms: “why x is done, what x is, how x is done”.
3. Edit the letter thinking about protecting yourself from cross-examination and judicial interrogation. How could the words be used against you?

# Crafting a letter--contd



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4. Edit the letter as if the addressee is neurotic. What odd, distorted interpretation could they make of the letter?
5. Read the letter out to make sure it still feels like your letter.
6. Consult with others for their input.

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# What you can do to improve the medico-legal climate:



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- Refrain from making critical comments to patients about other health professionals.
- Decline to comment on a patient's complaint until you have the full set of facts.
- Be careful not to give the appearance of agreeing with criticisms by silence.

# CONSTRUCTION SITE

**DANGER**

**DEEP EXCAVATION  
DEMOLITION IN PROGRESS  
WORKERS OVERHEAD  
EXPLOSIVE POWERED TOOL IN USE**



**AUTHORISED  
PERSONNEL ONLY**



**FORKLIFT  
IN USE**



**NAILING TOOL  
IN USE  
KEEP CLEAR**



**WELDING IN  
PROGRESS**



**BEWARE OF  
CRANE**

**SAFETY INDUCTION MUST BE  
OBTAINED PRIOR TO ENTERING SITE**

**IF THERE'S A  
HUGE FUCK-UP  
CALL TODD  
6751 1827**

**GET SERIOUS ABOUT WORKPLACE HEALTH & SAFETY**



**SAFETY  
FOOTWEAR**



**SAFETY  
HELMETS**



**EAR & EYE  
PROTECTION**



**SAFETY HARNESS  
MUST BE WORN**



**FALL ARREST EQUIPMENT  
MUST BE USED**

ALL SUBCONTRACTORS  
ARE TO PRESENT  
ELECTRICAL TOOLS  
AND EQUIPMENT TO  
SITE FOREMAN BEFORE  
COMMENCEMENT

**NO ALCOHOL  
PERMITTED  
ON THIS SITE**

**MUST BE WORN ON THIS SITE WHERE REQUIRED**

**CAUTION BOBCAT & HEAVY MACHINERY OPERATING**

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