Conflicts of Interests Disclosure

- AAO Foundation – Hoskins Center for Quality and Safety
- American Board of Ophthalmology
- Centers for Disease Control and Prevention
- ARVO Foundation for Eye Research
- American Glaucoma Society
- American University Professors of Ophthalmology

- Consultant and Research funding
  - NIH
  - Kellogg Foundation

- University of Michigan
- Duke University
- Intellectual property
  - Statins for glaucoma
  - EMR decision support and data entry

- No Relevant Disclosures

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Breaking Bad: Empathetically Sharing Bad News with Patients (and Families)

Women in Ophthalmology
August 2017

Paul Lee, MD, JD
Kellogg Eye Center
University of Michigan
Themes of Presentation

• Why these discussions are important
  – Ethical
  – Practical
• How to improve discussions
  – Principles
  – Office / Surgical
• Importance of disclosure of error

Prototypes of Patient – Provider Relationships

High MD Control

Low Patient Control

• Paternalism
• Default

Low MD Control

High Patient Control

• Mutualism
• Consumerism
**Listening to Patients: Expectations**
Dawn & Lee, Archives, 2003

- Communication
  - honesty (1);
  - diagnosis and prognosis (2);
  - clear language (3);
  - listening and addressing concerns (6)
- Interpersonal manner
  - empathy (5);
  - personal connection (7)

**Addressing Patient Expectations**
Dawn & Lee, Archives, 2003

- Physician’s skills – experience / reputation (4)
- Logistics – waiting time (9)
- Other – time with physician (8)
**Depression Among Caregivers of Visually Impaired**

Kuriakose RK, Khan Z, Almeida DRP, Braich PS. Int Ophthalmol - online 29 July 2016

DOI 10.1007/s10792-016-0296-2

Goodman 19 – NYC
Bambara 23 – AL, USA
Braich 25 – Rural India
Braich 27 – NY, USA
Khan 26 – Kingston, ON, CA

Factors:
1) Hours of close supervision
2) Intensity of care
3) Child vs spouse
4) Lower income
Influence on Choice of MD’s
Kaiser/AHCPR 10/96

<table>
<thead>
<tr>
<th></th>
<th>A lot</th>
<th>Some</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications skills</td>
<td>84 %</td>
<td>12 %</td>
</tr>
<tr>
<td>Board-certified</td>
<td>71</td>
<td>20</td>
</tr>
<tr>
<td>On health insurance plan</td>
<td>49</td>
<td>31</td>
</tr>
<tr>
<td>Privileges at given hospital</td>
<td>38</td>
<td>36</td>
</tr>
<tr>
<td>Years in practice</td>
<td>35</td>
<td>41</td>
</tr>
<tr>
<td>Office close to patient</td>
<td>35</td>
<td>35</td>
</tr>
</tbody>
</table>

Cumulative Distribution of Physician Cohort Members and Unsolicited Complaints

Complaints and Risk Management
Hickson, et al, JAMA, 2002

Patient Communications

• PIAA experience with malpractice
  – $72 M paid for 768 telephone-related malpractice claims
  – Including delay in returning calls
• Will occur with emails
  – Multiple paths for input / explanation, yielding differences
• Patient access to EHR information
  – Determine what is posted and when
  – MD – critical to contact patient before concerning information is available to patient
• How manage patient sending information to MD

---

Table 2. Cohort Member Physicians With Selected Combinations of Risk Management File (RMF) Openings and Unsolicited Patient Complaints

<table>
<thead>
<tr>
<th>No. of RMF Openings</th>
<th>Unsolicited Patient Complaints, No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-1</td>
</tr>
<tr>
<td>0</td>
<td>223 (55)</td>
</tr>
<tr>
<td>1</td>
<td>38 (6)</td>
</tr>
<tr>
<td>2</td>
<td>9 (1)</td>
</tr>
<tr>
<td>≥3</td>
<td>5 (1)</td>
</tr>
<tr>
<td>Total</td>
<td>276 (43)</td>
</tr>
</tbody>
</table>

*χ²= 274; P<0.001.
National Academy of Medicine
Definition of Diagnostic Error

• “... the failure to
• (a) establish an accurate and timely explanation of the patient’s health problem(s) or
• (b) communicate that explanation to the patient

Why Discussions Are Important

• Professional ethics and morals
  – Respect for patient autonomy
  – Patient and family-centered care
  – Key to establishment of “safety culture”
• Patient and family satisfaction
• Personal and practice success and growth
• Avoid malpractice lawsuits – because we ARE going to make mistakes and have “bad outcomes”
Themes of Presentation

• Why these discussions are important
  – Ethical
  – Practical
• How to improve discussions
  – Principles
  – Surgery
• Importance of disclosure of error

Having Better Discussions

• Basic Principles

• Surgery
Physicians Often Have Different Views from Patients Regarding Care

Prior Literature Examples

• End-of-life care
• Tradeoffs for lifespan
• Desire for diagnostic testing
• Choice of therapies
• Adherence to medications
• Pain

Dietein TS, et al. Graefe’s, 2006

• German outpatient clinic with new glaucoma patient referrals – patient response vs. MD estimate of responses

• Apply drops self 88% vs 78%
• Intolerance to meds 29% vs. 35%
• Discomfort after LTP 21% vs. 44%
• Enviro factors / stress affect IOP 31% vs. 55%

What are Potential Outcomes

Adapted from Lee P, J of Glauc, 1996; Vitale S, 2009

<table>
<thead>
<tr>
<th>“Organ”</th>
<th>System</th>
<th>Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician</td>
<td>IOP / RNFL</td>
<td>Va / VF</td>
</tr>
<tr>
<td>Person</td>
<td>Symptoms</td>
<td>Vision Function</td>
</tr>
<tr>
<td>Payor</td>
<td>Costs of care</td>
<td>Cost-effective</td>
</tr>
<tr>
<td>Society</td>
<td>Epidemiology</td>
<td>Utilities</td>
</tr>
</tbody>
</table>
Keys in Communications

- Treat patient as a person, not a disease
- Don’t assume, ask
- Use open-ended questions
- Listen and pay attention
- Acknowledge
- Understand lack of comprehension (feedback / repeat back)

Racial Differences in Perceptions of Health Care
Gender Differences - Communications

- Men prefer
  - solve problems
  - expect MD to solve

- Women prefer
  - discuss problems
  - consensual solution
  - get suggestions

Impact of Lower Literacy
Muir, et al, multiple publications

- Lower adherence to medications
  - Adults with glaucoma
  - Children with glaucoma (parental literacy)
- Providers educate about glaucoma meds
- Lower satisfaction with care
- Decreased follow-up care adherence

- Interventions with appropriate level materials help those with lower literacy

Figure 3 Preferred locations for learning about ophthalmology topics.

Notes: The survey question asked “Where do you prefer to learn about eye health and disease? Check all that apply.” Of the subset of respondents who rated a preference for this specific topic, the bars represent the percentage of respondents who preferred each location (home/eye center/primary care). For example, for cataracts, 72% of the respondents who rated an interest in cataracts also rated a preference for learning at home. 54% of respondents rated a preference for the eye center, and 19% rated a preference for the primary care location. The total percentage is greater than 100 because respondents could choose more than one. Overall, survey respondents preferred learning about ophthalmology topics at home and at the eye center. However, about 30% of respondents rated a preference for learning about ophthalmology topics at the primary care doctor’s office, particularly concerning the topics of low vision and laser vision correction, with one in three respondents noting the preference for primary care.

Having Better Discussions

• Basic Principles
• Surgery
Pre-operative Discussion is the MOST Important

• Minutes here saves hours of pain later
• Engage family and social support members
  – Helps patient understand
  – THEY are aware of potential issues and problems
  – Offer phone calls, including during patient visit so they can listen in
  – If too many family, ask them to decide
  – WE can understand social dynamics and available assistance for patient

Content of Pre-Operative Discussion

• WHY procedure is being done
• WHAT the “good” outcome will be from the surgery – especially for those not designed to improve vision such as glaucoma
• WHEN the procedure should be done AND expected post-operative visit frequency
• WHERE the procedure AND post-operative visits will occur
• WHO will be involved – co-management / trainees
Specific Suggestions

• Mention **ALL** alternatives
  – Cataract – IOL’s, techniques, suture
  – Glaucoma – medications, laser(s), types of incisional surgeries

• Recommendation for type of surgery and why
  • **Second opinions** are GOOD to offer

• Re-emphasize what goal of surgery is
  • Create **realistic expectations**

Discussion of Expected Post-op

• Likely rate of visual recovery (especially glaucoma)
• Likelihood of new refraction (if needed) and timing of such correction
• How many post-op visits and when (typical)
• Use of topical or other medications
• Caution that each person different and we personalize care to what each person needs
Discussion of Complications

• Risks of anesthesia – stroke, coma, death
• Risks of vision loss – bleeding, infection
• Risks of failure – short and long-term
• Possible need for additional surgery in future
• Cosmetic appearance / lids
• Surgery specific risks
  – Glaucoma - < 1% rate of visual loss w/o complications occurring

Key Considerations

• Don’t try to talk people into surgery, but should educate
  – Fear tactics may backfire – confirm belief of blindness as inevitable
  – Offer second opinion (very useful in general)
• Don’t skip important diagnostic testing
  – Reassurance that surgery needed (patient / family)
  – Particularly useful in the event of bad outcome
• Patients who don’t want to know risks
  – DOCUMENT clearly and talk to family if allowed
Communicating Bad Outcomes

- Maloccurrence not the same as malpractice
- **Draw upon prior informed consent and education**
- Honest communications of situation
  - Apology movement gaining momentum
  - People want to know what happened
- See the patient as often as needed
- Communicate with partners on call
- Second opinion / referral
- Careful co-management

**Influence of Knowing Informing MD on Perceptions of Communication of Bad News**

 Straus, et al, Peds 1995

- [Know well](#)
- [Didn't Know](#)

![Bar chart showing influence of informing MD on perceptions of communication of bad news.](chart)
Themes of Presentation

• Why these discussions are important
  – Ethical
  – Practical
• How to improve discussions
  – Principles
  – Surgery
• Importance of disclosure of error

The “Michigan Model”

We will compensate quickly and fairly when inappropriate medical care causes injury.

We will support our staff vigorously when the healthcare involved was reasonable.

We will reduce patient injuries (and claims) by learning from our patients’ experiences.
Why transparency?

• Because you can’t fix a problem if you don’t admit you have one
• Because the first disclosure is to ourselves when we admit we could have and should have done better
• Because the best risk management is not to hurt someone through medical error and the second best is not to do it again
• Because it reconnects you to the reason you entered Medicine
• Because only through a principled approach will we serve everyone’s interests and achieve lasting improvements in safety, quality and claims
UMHS RISK MANAGEMENT
INCIDENT TO DISPOSITION DATE

Results – Total Liability Costs

Total Liability Costs/Month per $1000 revenue

<table>
<thead>
<tr>
<th>Before</th>
<th>After</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>$18.91</td>
<td>$7.78</td>
<td>59%*</td>
</tr>
</tbody>
</table>

*Statistically significant
UMHS Medical Faculty Response

- Of more than 400 responses:
  - 87% said that the threat of litigation adversely impacted the satisfaction they derived from practice
  - 98% perceived a difference in approach post 2001
  - 98% approved of new approach
  - 55% said that the new approach was a “significant factor” in their decision to stay at UMHS
  - Only criticism was that they want more attention

Survey January, 2006

Communications and Care

- Discussions are important
  - Ethical
  - Practical – it’s important to patients and we aren’t good guessers
- We can improve discussions
  - “Golden rule”
  - Honesty and transparency
  - Patient understanding
- Critical to future care models
Plaintiff’s Attorneys’ Response

- 100% rated UMHS “the best” and “among the best” health systems for transparency
- 90% recognized a change since 2001
- 81% said they had changed their approach
- 81% said costs were less
- 71% said they had settled cases for less than had they litigated
- 86% said transparency allowed them to make better decisions about claims to pursue
- 57% admitted that they turned cases down they otherwise would have pursued

May, 2006
“It wasn’t done if it wasn’t documented ... “

• Note ALL phone calls
  – Who and what at a minimum
  – AND office response
  – AND file in patient’s chart

• Record all phone calls regarding lab results and advice in chart

Documenting Billing and Non-Care Related Disputes

• Do NOT put billing / financial or any non-clinical care disputes in medical chart

• When patients angry or hostile, document what happened without judgmental or emotional terms (use “appeared angry, shouted at staff” instead of “stupid”)

What We Do in Health Care:
Science and “Art”

- Human relationships
- Acquire data
- Interpret data
- Accurate diagnosis
- Appropriate therapy
- Patient use of care
- Communities / Networks
- Personal to patient and physician
- Instruments
- Algorithms
- Data integration / Analysis
- Point of care systems
- Leverage technology
- Relationships

Institute for Healthcare Improvement:
Elements of Safety Culture in Our Teams

- Leadership walk rounds for safety and quality issues
- Patient safety officer
- Reporting system
- Safety champion in every unit
- Adverse event response teams
- Involve patients
- Reporting system known to all in organization
- Re-enactment of real adverse events
- Safety reports with transitions of care
- Safety briefings
Characteristics of High-Performing Primary Care Practices (Peterson Foundation, 2015)

- “Always on” – easy to reach care team
- Adhere to quality guidelines and test wisely
- Actively solicit patient feedback
- In-source as much as can be safely done
- Stay close to trusted select group of specialists
- “Close the loop” with patients
- Maximize abilities of staff members
- Work in “bullpen” style environments to facilitate MD supervision / communication
- Balance compensation
- Invest in people over space, equipment and technology
- $300 billion in savings and higher quality of care

Benefits of “Just Culture”
Courtesy of Jim Bagian, MD

- Reduction in adverse events and near misses
- Higher employee engagement and satisfaction
- Higher patient satisfaction
- Better financial performance
- Improved quality and safety indicators
Communications and Care

• Discussions are important
  – Ethical
  – Practical – it’s important to patients and we aren’t good guessers

• We can improve discussions
  – “Golden rule”
  – Honesty and transparency
  – Patient understanding

• Critical to future care models

Fact vs Myth in Patient Care

• “Patients will talk forever”
  No more than 2.5 minutes
• “Takes too long to see a patient”
  Average of 17 minutes, 2/3 < 15 minutes
• “First complaint is the most important”
  Most patients have 3 complaints
• “I let the patient talk enough”
  Average of 16 seconds to interrupt
• “I can tell what’s bothering the patient”
  50 % of visits disagree on complaint
Real-World Assessment of Physical Activity in Glaucoma
Using an Accelerometer

Pradeep Y. Ramulu, Eugenio Maul, Chad Hochberg, Emilie S. Chan, Luigi Ferrucci, David S. Friedman


1) Severe Glaucoma
2) 5 db worse MD in better eye
3) Older age
4) Black
5) Lower education
6) Comorbidities
7) Depressive symptoms
8) BMI
9) Lower cognitive function

http://dx.doi.org/10.1016/j.ophtha.2012.01.013