DOWNLOAD PDF HOW PHYSICIANS CAN AVOID SURRENDER AND LEAD CHANGE

Chapter 1 : Healthcare's evolution changing the role of hospitals and their leaders - Modern Healthcare

*How physicians can avoid surrender and lead change: Gaining real influence in your own health care organization before it's too late [Elizabeth M Gallup, Elizabeth Gallup] on www.nxgvision.com *FREE* shipping on qualifying offers.*

Improving patient safety and reducing risks The physician voice: Physicians are advocates for their patients and for healthcare improvements, but this dimension of medical care can be challenging if the role of physician advocacy is not well understood. Numerous definitions and various interpretations of the term can make it difficult for doctors to determine what advocacy approaches will be effective and considered appropriate. A deep tradition Advocacy has a long and deep tradition in medicine. Rudolf Virchow, one of the most prominent physicians of the 19th century and known as the father of modern pathology, said physicians were "natural attorneys of the poor. Advocacy is imbedded in many aspects of the medical profession, and as a result, medical associations or organizations have identified programs, policies, and statements that define the role of physicians in advocacy. The Canadian Medical Association states doctors "must be able to freely advocate when necessary on behalf of their patients and should do so in a way that respects the views of others and is likely to bring about meaningful change that will benefit their patients and the healthcare system. As well, many Colleges have indicated it is generally appropriate for doctors to advocate responsibly, and advocacy should not interrupt the safe provision of care. Jurisdictions such as Alberta have developed detailed resources to support physicians in their advocacy work. Ambiguity about what is the appropriate level of advocacy and the general approaches can lead to misunderstandings or conflicts between physicians, or between physicians and other individuals or groups. This uncertainty can also lead to accusations of overstepping bounds, irresponsibility, or inappropriate behaviours and actions. Failure to successfully influence change through advocacy can lead to frustration, cynicism, and complacency. Healthcare advocacy by physicians can occur at many levels and can take different forms. For example, doctors often advocate for individual patients by requesting timely diagnostic tests, access to certain treatments, or referral to a specialist. Physicians may advocate at the regional level or for groups of patients, for example by supporting an expanded community health centre or by seeking funding for a health provider to join a hospital. Advocacy can also be global, for instance, when physicians support health-related environmental protection. Advocacy strategies can vary from one-on-one discussions with those in authority, to letter writing and social media campaigns. Physicians will want to consider the appropriateness of the campaign, and their role within it. Prior to engaging in any public advocacy activity, physicians should consider whether it is necessary or appropriate to discuss the planned activity with parties who may be affected e. While it is generally a courtesy for physicians working in hospitals to notify the hospital administration in advance, some hospitals may require that express permission be obtained before a physician embarks on activities that could be interpreted as directly involving the hospital. Hospitals, institutions, and health authorities may have policies or guidelines on the role of physicians in advocacy activities, including media or social media campaigns. When speaking publicly, physicians should be clear when their comments are made in a personal capacity or on behalf of a third party. The CMPA recognizes there may sometimes be ambiguity regarding what constitutes appropriate advocacy. The Association believes physicians should remain engaged in healthcare decision-making and advocate in a professional manner for the interests of patients and the healthcare system. For example, many physicians strongly support health promotion initiatives such as influenza vaccines, while others avoid doing so. Some doctors may back patients in their quest for new healthcare programs, or encourage new disease treatment options, or promote innovation at the point of care. All of these activities are appropriate as long as physicians act professionally, provide an informed perspective, and offer constructive input and recommendations to the appropriate groups or individuals. Learning about advocacy Medical students and doctors may be attracted to medicine because of the impact that medical care, including advocacy, can have on individuals and society. Trainees and new physicians are increasingly exposed to a wide spectrum of patients

including refugees, the homeless, and other disadvantaged patient groups. Doctors are well-positioned to identify areas for health system change and to recommend improvements. While many physicians are very skilled advocates, these abilities are not necessarily natural for all doctors. Most often, advocacy is a learned skill. Advocacy plays a larger role in the new edition of the CanMEDS Framework, which will be used to guide both residency training and education for practising physicians. They work with those they serve to determine and understand needs, speak on behalf of others when required, and support the mobilization of resources to effect change. The Canadian Medical Association offers an advocacy skills training program that includes tips for meeting members of parliament, an overview of how government works, media training, and communicating key messages. For example, the College of Physicians and Surgeons of Alberta signaled its intention to help physicians understand how, when, and under what circumstances they can advocate effectively. In Ontario, the College has a policy on Physician Behaviour in the Professional Environment that recognizes advocacy as an important component of the doctor-patient relationship. The Code indicates that a "physician must collaborate with other physicians in maintaining and improving the availability and quality of the medical services to which a clientele or population must have access. Meanwhile, physicians working in healthcare institutions may face more complexity. Hospitals or health regions may have guidelines on how to advocate for improvements. There may be organizational bylaws or policies that outline how to advocate on behalf of patients or health system issues. In some instances, this has led to disagreements between individual doctors and hospitals or health authorities. As healthcare providers and leaders, physicians can help improve and sustain the health system. This may include being involved in structural changes, priority setting, resource allocation decisions, quality improvement projects, or initiatives to improve patient safety, among other matters. All who advocate within the system must demonstrate recognition of competing demands. Physician advocacy should be accompanied by evidence of that awareness. Approach the issue with transparency, professionalism, and integrity. Work within approved channels of communication. Discuss concerns, suggestions, and recommendations calmly. Provide an informed perspective, and seek the perspectives of patients and other healthcare professionals. Use evidence to help persuade others. Remain open to alternative suggestions or solutions, and try to build on areas of consensus. Be cognizant that not all good ideas can happen at once; be patient. As a result, patients will continue to look to their doctor as a trusted source for healthcare information and support. Consequently, it is likely advocacy will only increase in importance. While the definition of appropriate advocacy in healthcare is evolving, physicians can show leadership by remaining engaged and seeking to advance their viewpoints in a professional and appropriate manner. Members with questions or concerns about advocacy should contact the CMPA to discuss these with a physician advisor. Advocacy as Medical Responsibility. Canadian Medical Association [Internet]. Where Do We Stand? Physician Behaviour in the Professional Environment. Policy number [cited Apr 28]. Code of ethics of physicians. Jugglers, tightrope walkers, and ringmasters: Priority setting, allocation, and reducing moral burden. Healthcare Management Forum summer The information contained in this learning material is for general educational purposes only and is not intended to provide specific professional medical or legal advice, nor to constitute a "standard of care" for Canadian healthcare professionals.

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Chapter 2 : How can prescription drug misuse be prevented? | National Institute on Drug Abuse (NIDA)

A ROADMAP FOR PHYSICIANS flags" that could lead to potential liability in criminal, civil, and administrative enforcement actions. or surrender of a license.

Misuse of Prescription Drugs How can prescription drug misuse be prevented? Clinicians, Patients, and Pharmacists Physicians, their patients, and pharmacists all can play a role in identifying and preventing nonmedical use of prescription drugs. By asking about all drugs, physicians can help their patients recognize that a problem exists, provide or refer them to appropriate treatment, and set recovery goals. Evidence-based screening tools for nonmedical use of prescription drugs can be incorporated into routine medical visits see the NIDAMED webpage for resources for medical and health professionals. Doctors should also take note of rapid increases in the amount of medication needed or frequent, unscheduled refill requests. Doctors should be alert to the fact that those misusing prescription drugs may engage in "doctor shopping"â€”moving from provider to providerâ€”in an effort to obtain multiple prescriptions for their drug s of choice. Prescription drug monitoring programs PDMPs , state-run electronic databases used to track the prescribing and dispensing of controlled prescription drugs to patients, are also important tools for preventing and identifying prescription drug misuse. While research regarding the impact of these programs is currently mixed, the use of PDMPs in some states has been associated with lower rates of opioid prescribing and overdose 53â€”56 , though issues of best practices, ease of use, and interoperability remain to be resolved. In , the federal government launched an initiative directed toward reducing opioid misuse and overdose, in part by promoting more cautious and responsible prescribing of opioid medications. However, certain patients can benefit from prescription stimulants, sedatives, or opioid pain relievers. Therefore, physicians should balance the legitimate medical needs of patients with the potential risk for misuse and related harms. Patients can take steps to ensure that they use prescription medications appropriately by: Drug Enforcement Administration collection sites. Pharmacists can help patients understand instructions for taking their medications. In addition, by being watchful for prescription falsifications or alterations, pharmacists can serve as the first line of defense in recognizing problematic patterns in prescription drug use. Some pharmacies have developed hotlines to alert other pharmacies in the region when they detect a fraudulent prescription. Along with physicians, pharmacists can use PDMPs to help track opioid-prescribing patterns in patients. Medication Formulation and Regulation Manufacturers of prescription drugs continue to work on new formulations of opioid medications, known as abuse-deterrent formulations ADF , which include technologies designed to prevent people from misusing them by snorting or injection. Approaches currently being used or studied for use include: In , the Drug Enforcement Administration moved hydrocodone products from schedule III to the more restrictive schedule II, which resulted in a decrease in hydrocodone prescribing that did not result in any attendant increases in the prescribing of other opioids. A growing number of older adults and an increasing number of injured military service members add to the urgency of finding new treatments. This page was last updated January Contents.

Chapter 3 : Patient-Physician Communication: Why and How | The Journal of the American Osteopathic As

This means health systems must stay engaged with physicians throughout any change process. They need to understand and address concerns at each stage, then move forward. Once you lock in one new standard or process well, you can proceed to the next one.

Since a public healthcare district regained control of the safety net hospital when it split from Sutter Health in , Marin has looked to the community and other healthcare organizations to maintain its independence. Its leadership has formed an array of partnerships and joint ventures that have allowed it to control costs and improve outcomes during an era of consolidation across the healthcare industry, Marin CEO Lee Domanico said. Executives had to lead a cultural transformation emphasizing collaboration over competition as the largest hospital in Marin County, Calif. Marin partnered with 12 other providers in the Bay Area to form an accountable care organization called Canopy Health established by the University of California at San Francisco. It has joint ventures with local physicians for its surgery center and imaging centers. As hospitals, physician groups and health systems continue to consolidate , navigating a sustainable route to clinical and operational alignment is more complex. While systems search for ways to scale up, many organizations are finding that partnerships are an easier choice. Providers increasingly look to team up with other healthcare providers to streamline operations and minimize risk rather than trying to control each lever of the care continuum. As systems acquire more types of service lines and turn to , the hospital is becoming less of a focal point. Executives increasingly view their organizations as a clinic that operates hospitals, rather than a hospital-centered system. As a result, CEOs must focus on an overarching vision and clinical alignment as their organizations grow. Emulating models such as Cleveland Clinic and Mayo Clinic, more physicians are being tapped to lead that charge. Hospitals are being essentially disintermediated as technology and new economic incentives drive care to outpatient settings, said Dr. Hospitals will be cost centers instead of profit centers. From counting beds to calculating bytes While fee-for-service revenue and value-based reimbursement, health systems such as the integrated managed-care giant Kaiser Permanente are building technology around populations, rather than trying to bring patients into the hospital. The industry was built around the hospital, but today technology is the infrastructure needed to build care continuity, Kaiser Chairman and CEO Bernard Tyson said. Physicians to the fore More physicians are being tapped to lead health systems, as organizations look to work closely with doctors to limit unnecessary care and reduce variation. Demand is growing for strategists who can align physicians around a clinically integrated network and have the operational expertise to establish vertically integrated service lines, Hafner said. Physicians also respond better to leaders who share their background and expertise, experts said. Some see it as acknowledgment of the importance of clinical care. The patient-physician relationship drives the healthcare industry, said Dr. One of the most common issues brought up by AMGA members is changing the physician compensation culture when systems have a foot in both fee-for-service and value-based medicine, said Dr. Conversely, more needs to be done to better prepare physicians in how to lead. But there needs to be more leadership education and professional development. But providers are taking cues from companies outside of healthcare that have undergone successful transformations, said John Driscoll, CEO of CareCentrix, a post-acute care management company. Some of those strategies involve nutrition, transportation and behavioral support, he said.

Chapter 4 : CMPA - The physician voice: When advocacy leads to change

Failure to successfully influence change through advocacy can lead to frustration, cynicism, and complacency. Healthcare advocacy by physicians can occur at many levels and can take different forms. For example, doctors often advocate for individual patients by requesting timely diagnostic tests, access to certain treatments, or referral to a.

If you are still using antiquated one-way communication methods like fax, e-fax, or your EMR to file referrals away and not communicate with other providers in real time, its time to change by using ReferralMD â€" an online referral management platform. Facing the problems with patient referral networks is the first step towards solving those problems and making the entire system a more effective platform for medical staff, patients and physicians alike. To solve this problem, set the goals of this process with your patient before referring them to a specialist. The specialist will have feedback about the patient and the process, which is completely acceptable and important. This discussion about expectations must be set from the beginning to prevent any issues down the road. This is a huge problem for a referral network because the patient is the one who will quickly see the negative effects of guesswork when it comes to their well being. Too often do referrals get made to another physician without the proper paperwork, test results or any other notes about the patient. This is extremely cumbersome with patients that have an extensive medical history and need an accurate trail of information about them presented to each physician to properly prepare them. Both the Specialist and Primary Care Doctor Manage the Patient After Consult If there is a lack of understanding from the beginning of your relationship with other medical professionals in the referral network, then problems could arise at the expense of the patient. If one physician is telling a patient one piece of advice and another specialist is telling them something different, then this could be seriously frustrating for a patient during an already potentially difficult medical issue or procedure. Make sure the role of the final decision maker concerning administering medical advice is clarified in writing to avoid confusion, frustration or misinformation. By relying on guesswork or tunnel vision decision-making, it defeats the purpose of involving other members in a referral network. The unique skill sets and talents of each physician can help patients progress quicker, more effectively, with less pain and recovery in the long-term. To solve this problem and make the most of the physician referral network: It is easy for a doctor to unknowingly decide against a referral to avoid the embarrassment of passing a patient along. Some doctors have a fear of appearing unknowledgeable or are attempting to keep costs down but in-actuality they are causing longer delays for their patient in the long-term. Once the agreement is drafted, ensure that all members of the process agree to the terms stated in the documentation. Now implement this process in your existing referral program, and it will ideally save time for everyone involved, most importantly for your patients. One of the best ways to ensure your referral network remains efficient over time and provides a quick process for patients is to do inspections and audits of the process on a quarterly or annual basis. This way your organization can prove whether having an official process for referrals is improving and speeding up the process for your patients or if it is just for show. Not to mention, having your referral program online can help cut out unnecessary paperwork, communication, tracking and management that could also slow down the overall patient care process. How will you strive to improve your physician referral program and avoid these mistakes? Have these mistakes happened to you? What techniques have work to speed up the referral process for both your organization and patients? Please share your experience in the comments below!

Chapter 5 : Let Go of Control: How to Learn the Art of Surrender

title = "How physicians can change the future of health care", abstract = "Today's preoccupation with cost shifting and cost reduction undermines physicians and patients. Instead, health care reform must focus on improving health and health care value for patients.

General Information Disciplinary Action Disclosure: When renewing, each licensee must disclose whether they have had any license disciplined by a government agency or other disciplinary body, or, have been convicted of any crime in any state, the USA and its territories, military court or a foreign country. License includes permits, registrations and certificates. Conviction includes a plea of no contest and any conviction that has been set aside or deferred pursuant to sections or Discipline includes, but is not limited to, suspension, revocation, voluntary surrender, probation, or any other restriction. You may not be able to renew your license if you have been identified to have outstanding tax obligations or family support issues. Please allow weeks for processing. If a renewal notice is not received, the license must still be renewed before the expiration date on the license. If you have not submitted your renewal notice within two weeks of the expiration date, you may submit it to the address below or renew online by clicking the "BreEZe Online Services" button. Forms, information about current renewal fees, and requirements may be obtained by contacting: Practicing medicine without a valid license may lead to disciplinary action against a physician. There is no grace period; if a license has not been renewed within 30 days following the expiration date, the Licensing Program will notify the physician by certified mail. The date a license expires, the status is changed to "delinquent" if the renewal application and fees due are not received. The renewal of an expired license is retroactive to the expiration date if it is renewed within six months of the expiration date. After a license has been in "delinquent" status for five years, the license is automatically canceled. A canceled license may not be reactivated by simply paying delinquent fees and penalties. The physician must apply for a new license and meet the current licensure requirements. When can I expect to receive my renewal application? Renewal applications are sent by U. If you do not receive a renewal application two months prior to your license expiration date, contact the Board at or to request a duplicate renewal application. To ensure timely receipt of renewal applications, always keep the Board informed of any address changes. It is the responsibility of the licensee to renew his or her license whether a notice has been received or not. Do I have to pay the delinquent fee? Yes, if you did not renew prior to the due date the fees are imposed. A licensee required by law to notify the Medical Board in writing within 30 days of a change of address. Why do I have to pay? California law requires that to maintain an active, current license, each licensee, including out-of-state licensees, must pay the full biennial renewal fee at the time of license renewal. Can I pay my renewal fee ahead of time? The renewal must be paid within the 90 days prior to the expiration of the license. What is required to renew a license? The renewed license is valid for two years. The Physician Loan Repayment Program encourages recently licensed physicians to practice in underserved locations in California by authorizing a plan of repayment of their medical school loans in exchange for their service in a designated medically underserved area for a minimum of three years. Access to this information assists health care professionals in identifying possible prescription drug abuse. If the mandatory fees are not received prior to the expiration date, the license will be placed in a delinquent status and a pocket license will not be issued. The Board will need to determine the correct renewal, delinquent, and penalty fees. Please contact the Board at to obtain the current amount you will need to pay. In accordance with Section of the California Business and Professions Code, a physician whose California license expired five or more years ago must apply for a new license and meet the current licensing requirements in effect at the time of application.

Chapter 6 : Antibiotic Resistance Questions and Answers | Community | Antibiotic Use | CDC

Abandonment is a problem when a physician terminates a relationship with an individual patient, but can also be a problem when a physician closes a practice, thereby terminating all relationships with all patients. Abandonment is a particular problem if a physician abruptly closes a medical practice without prior notice to patients, or fails to.

Questions about Antibiotic Resistance Q: What is antibiotic resistance? Antibiotic resistance occurs when bacteria develop the ability to defeat the drugs designed to kill them. When bacteria become resistant, antibiotics cannot fight them, and the bacteria multiply. Learn more about antibiotic resistance. Why should I care about antibiotic resistance? Antibiotic resistant bacteria can cause illnesses that were once easily treatable with antibiotics to become untreatable, leading to dangerous infections. Antibiotic-resistant bacteria are often more difficult to kill and more expensive to treat. In some cases, the antibiotic-resistant infections can lead to serious disability or even death. Why are bacteria becoming resistant to antibiotics? Overuse and misuse of antibiotics allows the development of antibiotic-resistant bacteria. Every time a person takes antibiotics, sensitive bacteria bacteria that antibiotics can still attack are killed, but resistant bacteria are left to grow and multiply. This is how repeated use of antibiotics can increase the number of drug-resistant bacteria. Antibiotics are not effective against viral infections like the common cold, flu, most sore throats, bronchitis, and many sinus and ear infections. Widespread use of antibiotics for these illnesses is an example of how overuse of antibiotics can promote the spread of antibiotic resistance. Smart use of antibiotics is key to controlling the spread of resistance. How do bacteria become resistant to antibiotics? Bacteria can become resistant to antibiotics through several ways. Others have learned how to pump an antibiotic back outside of the bacteria before it can do any harm. Some bacteria can change their outer structure so the antibiotic has no way to attach to the bacteria it is designed to kill. After being exposed to antibiotics, sometimes one of the bacteria can survive because it found a way to resist the antibiotic. If even one bacterium becomes resistant to antibiotics, it can then multiply and replace all the bacteria that were killed off. That means that exposure to antibiotics provides selective pressure making the surviving bacteria more likely to be resistant. Bacteria can also become resistant through mutation of their genetic material. How should I use antibiotics to protect myself and my community from antibiotic resistance? Here is what you can do to help prevent antibiotic resistance: Dispose of Unused Medicines See helpful tips on how to safely throw away unused medications Tell your healthcare professional you are concerned about antibiotic resistance. Ask your healthcare professional if there are steps you can take to feel better and get symptomatic relief without using antibiotics. Take the prescribed antibiotic exactly as your healthcare professional tells you. Safely throw away leftover medication. Ask your healthcare professional about vaccines recommended for you and your family to prevent infections that may require an antibiotic. Never take an antibiotic for a viral infection like a cold or the flu. Never pressure your healthcare professional to prescribe an antibiotic. Never save antibiotics for the next time you get sick. Never take antibiotics prescribed for someone else. How can healthcare professionals help prevent the spread of antibiotic resistance? Healthcare professional can prevent the spread of antibiotic resistance by: Prescribing an antibiotic only when it is likely to benefit the patient. Encouraging patients to use the antibiotic as instructed. Collaborating with each other, office staff, and patients to promote appropriate antibiotic use. Is it healthier to use antimicrobial-containing products soaps, household cleaners than regular products? To date, studies have shown that there is no added health benefit for consumers this does not include professionals in the healthcare setting using soaps containing antibacterial ingredients compared with using plain soap. As a result, FDA released a proposed rule in December to require manufacturers to submit data supporting the efficacy and safety of antibacterial soaps and body washes. This proposed rule does not affect hand sanitizers, wipes, or antibacterial products used in healthcare settings. For more information, please see the CDC handwashing web page. Can antibiotic resistance develop from using acne medication? Antibiotic use, appropriate or not, contributes to the development of antibiotic resistance. This is true for acne

medications that contain antibiotics. Short- and long-term use of antibiotics for treatment or prevention of bacterial infections should be under the direction of a healthcare professional to ensure appropriate use and detection of resistance. Do probiotics have a role in helping to reduce antibiotic resistance? Probiotics are defined as microorganisms that when administered in sufficient quantities may improve health. There are a variety of probiotics that have been studied for various health benefits. Their role in preventing drug-resistant infections in humans has not been established. CDC is actively researching the subject. Although some studies have shown benefit, the data are not conclusive enough for CDC to issue specific recommendations at this time.

Chapter 7 : Change is not the problem - resistance to change is the problem

In the coming year, physicians and managers can anticipate even tighter reigns on future reimbursement, and may realize they will be expected to accomplish more with fewer resources. One of the things they can do is streamline their operational processes â€" however, that means change, which is not always welcomed.

Received May 3; Accepted Jan This is an open access article distributed under the terms of the Creative Commons Attribution License http: This article has been cited by other articles in PMC. Despite this, physicians practice behaviors that run counter to patient safety, including practicing defensive medicine, failing to report incidents, and hesitating to disclose incidents to patients. Methods We carried out an exploratory field study, consisting of 22 in-depth interviews with stakeholders in the malpractice litigation process: We analyzed the comments of the participants to find conditions that influence the relationship by developing codes and themes using a grounded approach. Conclusion In complex care settings procedures should be put in place for how incidents will be discussed, reported and disclosed. The lack of such procedures can lead to the shift and off-loading of responsibilities, and the failure to report and disclose incidents. Hospital managers and healthcare professionals should take these implications of complexity into account, to create a supportive and blame-free environment. Physicians need to know that they can rely on the hospital management after reporting an incident. To create realistic care expectations, patients and the general public also need to be better informed about the complexity and risks of providing health care. Physicians, Malpractice litigation risk, Patient safety Background Despite ongoing efforts during the last 10 years to increase patient safety in hospitals, the number of adverse events has not been reduced, nor have hospitals become safer [1 , 2]. A prerequisite for patient safety is that physicians behave in the interest of their patients. These behaviors include practicing defensive medicine [3 , 4], failing to report incidents [5 - 7], and hesitating to disclose incidents to patients [8 , 9]. Defensive medicine includes performing unnecessary medical procedures [10] and tests [11], deviating from guideline practices [12] and avoiding high-risk patients [3]. After an incident, patients may start legal action against health care workers to prevent similar incidents in the future, to find out how the incident happened and why, to receive financial compensation, or to hold staff or organizations accountable for their actions [13 , 14]. In this paper, we identify influences on the relationship between the risk of malpractice litigation and the unsafe behaviors of physicians. Prior research has offered many explanations for these patient unsafe behaviors. For example, physicians may practice defensive medicine to preserve the doctor-patient relationship [15]. Most harm occurs when incidents are not reported [16]. A lack of time, a scarcity of feedback on previously reported incidents, a rejection of bureaucracy, and associating reporting more with nursing discourage physicians from reporting incidents [5 , 16 , 17]. According to several studies, the risk of malpractice litigation leads to the practice of defensive medicine [3 , 4 , 10 - 12]. Worries about the financial burden and high cost of liability insurance premiums also seem to be positively linked to practicing defensive medicine [3]. A recent review study identified the fear of legal consequences and disciplinary actions to be an important barrier for reporting incidents [6]. Moreover, litigation risk discourages physicians from disclosing incidents to patients [8 , 9]. Healthcare workers may fail to provide patients with all requested information after an error, because of perceived inadequacies of legal protections from disclosure laws [20]. If physicians believe that disclosure makes patients less likely to sue, they are more likely to strongly endorse disclosure [21]. Our aim is to identify these additional conditions, which may increase our understanding of the underlying mechanisms of this relationship. This could help healthcare managers and professionals to create a supportive and blame-free environment, which reduces defensive medicine and encourages physicians to report incidents and disclose them to patients. We identified these conditions using an exploratory field study consisting of 22 in-depth interviews with stakeholders in the litigation process. Methods Qualitative interviews are a useful method for uncovering the meanings and understandings of the informants. They give an opportunity to explore how

informants describe experiences and practices that are the object of research [22]. From November until April , we conducted qualitative interviews to explore the conditional factors that affect the impact of the risk of malpractice litigation on behaviors that run counter to patient safety. To ascertain all potentially relevant factors, we consulted the potentially accused physicians and hospitals and other relevant stakeholders in the litigation process. None of the researchers occupies roles in any of the organizations that participate in the litigation process, or have a role in the litigation process itself. We focused on organizations that are involved in all stages of the litigation process. We included 20 organizations: Members of these organizations are in direct contact with physicians during different stages in the litigation process. We approached 22 members of these organizations in The Netherlands for a semi-structured interview, and obtained written informed consent from all study participants. We interviewed five physicians, two hospital board members, five patient safety staff members from hospitals, three representatives from governmental healthcare bodies, three healthcare law specialists, two managing directors from insurance companies, one representative from a patient organization, and one representative from a physician organization. The interview notes were analyzed using the qualitative analysis program NVivo version 9. Two team members ER and MB engaged in topic and analytical coding. However, to ensure rigor, all three authors contributed to the analysis through meetings where they discussed the codes. After having analyzed interviews with participants from all stakeholders in the litigation process, further data collection was considered not to yield any new insights and was terminated. We identified four conditions that influence the relationship, which we explore in the following section with example quotations to illustrate our findings and interpretation. Complexity of care refers to care with multiple and or interwoven problems and interventions [24]. One respondent referred to the difference in public opinion about routine-based errors and errors that arise from complex care: These errors are difficult to discuss with the patient. It is a public opinion that routine-based errors are not acceptable. On the contrary, very specialized care provides more space to make errors. Another respondent mentioned a different effect: Then, complexity does not mitigate the relationship between malpractice litigation risk and defensive medicine, but has the opposite effect. It strengthens this relationship or has a direct increasing effect on defensive medicine. The second conditional factor that we identified is whether physicians discuss incidents with colleagues: Some partnerships discuss errors or near accidents openly, and others do not. Within our partnership of gynecologists, a colleague is asked to support a physician when he is called to the disciplinary court. A complaint leads to practicing more defensively and can have a life-long impact. In our hospital, four physicians, with disciplinary litigation experience, have formed a help group to assist colleagues who are confronted with the Disciplinary Committee. A third influence on the relationship between malpractice litigation risk and physician behavior is personalized responsibility. According to literature from the field of organizational behavior and psychology, personalized responsibility implies that responsibility for a task belongs exclusively to an individual rather than being dispersed, shared, or undefined [25]. In practice, responsibilities are often dispersed: But, with complex patients treated by different physicians, it sometimes happens that a physician does not feel the responsibility to act because he has a different view of the treatment than the physician in charge. Next to being factual responsible, physicians generally have a strong feeling of responsibility towards their patients, but these quotes suggest this sense of responsibility varies. When something goes wrong physicians might even shift the blame towards colleagues, as mentioned in the second quote. One of our respondents mentioned a process that is being used to encourage the reporting of incidents: Reflection moments should be built-in when working in teams. If anything goes wrong, this can be discussed together and one can decide who on behalf of the team is going to report the adverse event; to prevent that reporting is experienced as betrayal. They want to protect their personnel. Only if the physician has behaved recklessly will the hospital not continue to assist the physician and provide a lawyer for the physician. The respondent mentioned that physicians consult the quality department for guidance when there has been an incident, for information about the practicalities and to find out what they should report. By responding in a non-punitive way, hospitals create a safe environment for incident reporting. How these factors influence this

relationship will be discussed in this section. If care for a patient becomes more complex, then the risk of an adverse event occurring increases [26]. Complex care also involves higher mortality rates, which increases calls for accountability [27]. Because of these aspects, complex care might increase the impact of litigation risk on physician behavior and lead to more defensive medicine. A study in which physicians stated that they avoid high-risk patients in response to the fear of malpractice litigation supports this hypothesis [3]. At the same time, if the public considers complex errors more acceptable, physicians may be encouraged to report or disclose incidents to patients. The exact effect of this condition requires further study. The literature reports that discussing medical errors with colleagues helps physicians to adapt their future behavior to prevent medical errors [29]. If discussing adverse events with colleagues has similar effects on their perceived malpractice litigation risk, then it might encourage incident reporting and disclosure of incidents to patients. This could be related to the complexity of care. Research shows that complexity is positively linked to the amount of information exchanged between health care team members [24]. Therefore, there could be a relationship between complexity and discussing incidents with colleagues, which might have a joint effect on the relationship between litigation risk and physician behavior. Personalized responsibility is also linked to complexity. Research shows that delivering complex services often involves more and different kinds of health care professionals see, for example, [24 , 31] , which makes it harder to pinpoint responsibilities [32]. We make a distinction between an internal response to incidents by the hospital organization and an external response by the legal system. Legal systems in most countries hold physicians individually accountable for errors. In some countries, the implementation of incident-reporting systems is accompanied by regulations that oblige the hospital management to create an atmosphere in which physicians do not have to fear that incident reporting will lead to punitive measures. According to some researchers, a non-punitive response to errors leads to an increase in the number of adverse events reported [33]. The effects of the conditional factors that we have identified may differ for different forms of behavior. Complex care could encourage reporting and disclosure if its risk is more accepted by the public, but at the same time, it could increase defensive medicine because of the impact of litigation risk. There are several limitations to our field study. The number of physicians was limited. We conducted this study in one country, The Netherlands. Malpractice litigation differs amongst countries. In the United States, the UK, The Netherlands and many other Western countries, medical malpractice claims are processed in a tort system. Patients need to prove that a physician was negligent and show that negligence caused their suffering. Some countries, such as New Zealand and the Nordic countries of Europe, use an administrative compensation system in which physicians are not exposed to financial litigation. The behavior of physicians in response to the risk of malpractice litigation may differ depending on how much physicians are exposed to the risk of litigation, and how they perceive this risk.

Chapter 8 : Overcoming the Barriers to Change in Healthcare System

It's always a good idea, in general, to avoid burning your bridges, especially if other family members are going to continue seeing me. Also, you never know: You may yet change your mind and want to come back.

Bruce Kestelman, March 17, Well Done! Especially like the connection with resistance and the organizational culture. The embedded PPT provides helpful reminders about what to avoid. Stefan Norrvall, March 22, There are also some strong arguments against this view of planning for resistance to change. Firstly, the use of change resistance model that is based on how individuals cope with bereavement and that has not been tested for use in organisational change. Furthermore, it is a model of personal emotions and does not take into account managing large-scale change with groups of people. It also projects a sense of victimisation of staff that have change done to them and there is nothing they can do about it. Organisational change and the loss of a loved one are not the same. Secondly, by assuming resistance to change in advance there is also the issue of creating the situation it predicts which further reinforces the need to address resistance to change. The issue is the confusion of cause and effect â€" resistance is not the cause of failure, it is the outcome of failure. Having worked in countless organisations I have not yet come across one where change was not desired. In some they spoke about change fatigue and what a hard job it would be to get them to change. It turned out to be the complete opposite â€" they were tired of all the initiatives that did not change anything. Milad Avaz, March 22, Great article Torben, However I fear that it is trending to consider resistance as a unilateral holistic thing when it is actually comprised of resistance to smaller things that the general change might be representing. Change Management theories are more and more trying to emulate science when the truth is that it is not. Thanks for a great blog! In that context this and other such publications provide useful learning and start points to our planning of change. In my experience this is rarely the case. Change will frequently impact on the personal aspirations of people with power and influence at some level. Only a part of this will be visible at the outset and the change leader must be vigilant to detect the direct and indirect signs as the change project proceeds. This does not necessarily mean they will resist change. Stefan Brian Chajewski, March 26, I enjoyed the article and the conversation that it has started. I agree that change needs to have a clearly communicated value statement and the endurance to see the training through. I have experienced massive organizational changes that were communicated well, money was spent to provide good training up front, and the employees felt like there was money being spent to train them. Then after the roll out, there was continual support and if need be, a person that has mastered the new process was flown to the site struggling for a week long of side-by-side mentoring. I have also experienced the massive change that has a lot of fan fare. A lot of up front training. Then the new system was unreliable and employees had to do a hybrid of old system and new system just to get through, which is not as efficient as doing either one. Also, the system was designed to identify if a service failure had occurred, but the procedures were never rewritten to account for this new data. This leaves the employees disillusioned about the information that can be provided by the change in systems. When an employee can adapt to the change in systems and see the information of how it is not a service failure, but still has to act like it is a service failure, it is very frustrating and leaves them asking what is the point of the change if the company will not let them use the information. Merkenhof, March 29, The subject is indeed key to successful change in any organization. People are not against change but against being changed. Force it upon them, and they all will find reasons not to collaborate. Change requires people to step out of their comfort zone; This induces fear. Discomfort and even more so, fear for the outcome, is the utmost important reason for resistance to change. It is about people and not machines. People think, feel and have emotions. The objective of all change: The last one will certainly increase internal competition, immediately jeopardizing personal safety. These and other personal interests and internal networks need to be understood, made visible and consequences in actions from the management need to be clear, integer and decisive. The inevitable questions need to be defined and answered upfront. Only then you can take the right decisions and implement the correct

measures to reduce R2C. People need to feel comfortable, every step of the change and you must obtain their buy-in check, check and check again. Trustworthiness only comes with clearness about the objectives and integer and consistent leadership. It will reduce the depth and length of the unavoidable depression in the resistance curve. Which is a symptom of our western culture. What I see is that we resist changing because we perceive stability as a security.

Chapter 9 : Physicians - License Renewal | Medical Board of California

Physicians are in a position to help educate patients about the importance of healthy behavior change and to guide them to resources that may aid them in living healthier lives. Training in motivational interviewing is one useful tool that can aid clinicians to have productive conversations about behavior change with their patients.

By John Khoury, Pharm. How did burnout become such a sweeping epidemic? There are plenty of contributing factors. Policy changes, changing workflows, ICD, new payment models, general workload â€" all perfectly acceptable answers. Technology Clearly, technology advancements bring many benefits. But they also can have unintended consequences, particularly for physicians. Consider the example of EMRs. These tools digitize the health record and offer a new level of interconnectivity. However, EMRs were originally designed as billing systems â€" not as a clinical tool. This has often created numerous challenges for the physicians tasked with using them. Healthcare is changing constantly and for nearly every change, a new technology may be required to meet that change. In fact, physician burnout may as well be called change burnout. For instance, the shift to value-based care is currently transforming the industry. It affects payment, care delivery, and â€" no surprise â€" requires an unprecedented amount of technology integration. Given the stark state of physician burnout, it is easy to worry that the shift toward value-based care has the very real potential to make the problem even worse before it gets better. In fact, if done correctly, the shift to value-based care can actually reduce burnout. To achieve this goal, health systems must do the following. Then, the physician conducted an assessment, created a plan and moved on to the next patient. They documented everything in real time on a written chart, often finalizing each case before leaving the room. Injecting technology into the clinical practice changed everything. It has led to alterations in the workflow and additional documentation requirements â€" often meaning increased clerical work. It is not uncommon for physicians to take data entry work home with them, or hire additional staff to accomplish what was once completed during the visit. Often, this extra time includes entering redundant data into multiple systems. Physicians also complain that technology disrupts the time they spend with patients and often inhibits the building of a trusted advisor relationship with their patients. Many feel they already spend too little time with patients, and the time they do spend with their patients, they are often looking at a computer screen instead of the patient sitting across the room from them. When new initiatives disrupt the physician workflow, they increase frustration and lead to burnout. When possible, health systems should involve physicians in the solution, and integrate new technology and initiatives into workflows that enhance the physician-patient relationship and minimize disruption. Put Physician Engagement At The Forefront If you want physicians to adapt to a new initiative or technology, you need to invest as much if not more time in increasing physician engagement as in the technology itself. This is mission critical: One key to physician engagement is making incremental changes. For instance, the shift to value-based care requires physicians to adopt and use new processes and technologies to make data-driven decisions at both the point of care and when monitoring across populations. And, if you lose physician buy-in during the process, the whole effort could collapse. In this way, physician engagement is like pushing a large boulder up a hill. If you try to roll it all the way to the top at once, you risk it rolling back on you, and losing all your progress. So, you push the boulder up a bit, then put a stop behind it to keep it from rolling back. Once you see it hold, you repeat the process. This means health systems must stay engaged with physicians throughout any change process. They need to understand and address concerns at each stage, then move forward. Once you lock in one new standard or process well, you can proceed to the next one. Physician engagement also includes understanding what doctors really care about. Many if not most joined the field for altruistic reasons â€" namely to take care of patients. When possible, health systems should frame change around the clinical and financial goals that optimize patient and population care. For instance, maybe a new tool or initiative can remove administrative burden â€" freeing up additional time for each patient. Reignite the desire to help physicians deliver optimal care by making the right

thing to do, the easy thing to do â€" both clinically and financially â€" and fully aligning incentives across payer, system, provider and patient. Avoid Major Pitfalls When healthcare systems want to make major changes, from rolling out a new technology to embracing a new initiative, they often fall into a few key traps. Each can exacerbate physician burnout. One of the biggest mistakes is making too many changes all at once. Yes, the industry is changing rapidly, but change still takes time. If everything is important, nothing is important. Like the rock up the hill, change must be gradual to be effective. This also means avoiding information overload for physicians. Start with the most critical or familiar tools first, then slowly expand. Information overload also extends into the kind of data you give physicians. The healthcare field generates exabytes and exabytes of data each year, but how much of that is actionable? According to a report from the research firm IDC, the volume of healthcare data was exabytes in At current rates, that figure was estimated to increase to 2, exabytes in To keep physicians engaged, you should ensure they only get the actionable data they care about most â€" and it MUST be accurate. The final pitfall to watch out for is making decisions about processes or technology on knee-jerk reactions or without data. But when healthcare systems overreact, misinterpret a need or make a bad decision, they leave a trail of failed initiatives in their wake. By being aware of these common issues, health systems can avoid physician burnout and ensure the success of their new initiatives. Bringing It All Together The healthcare industry is going to keep changing. When making changes, health systems must create an environment that is engaging for both physicians and patients across the entire continuum of care. These changes should focus on achieving the triple aim plus one: With changes like value-based care looming, there are real opportunities to make healthcare better than ever before. But to make this a reality, physicians must be on board, engaged and not burnt out.