

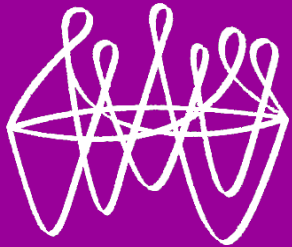


Living Through a Sentinel Event Crisis: Lessons Learned from the David Arndt, MD Case

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*6th Annual
NPSF Patient
Safety Congress*
*Let's Get On
With It!*

*May 3-7, 2004
Hynes Convention
Center
Boston, MA*



What Happened?

- ◆ On July 10, 2002, during complicated orthopedic spine surgery-with his patient fully anesthetized-a physician left the operating room and hospital to make a bank deposit
- ◆ He was absent for 35 minutes
- ◆ Upon his return, the surgery was completed without further incident
- ◆ The Hospital immediately suspended the physician, placed the patient under the care of another physician, and reported the incident to both the Board of Registration in Medicine and Department of Public Health
- ◆ As documented in the subsequent Department of Public Health investigation, the patient did not suffer medical harm as a consequence of the physician's lapse in professional judgment



The Aftermath

- ◆ Although a replacement physician had been appointed, the suspended physician continued to participate in the care of the patient
- ◆ The patient was not advised that his surgeon left the OR, was subsequently suspended or the assignment of a replacement physician until 26 days after the incident took place
- ◆ The patient then retained an attorney and contacted the media
- ◆ The combination of perceived patient abandonment together with the delay in disclosure created adverse national attention and exposure for everyone involved



Two Distinct Aspects to This Event

- ◆ Clinical, Policy and Procedural successes and failures
- ◆ Public Relations crisis

"When something goes wrong it is how the organization acts that redefines and reshapes the culture."



Clinical, Policy and Procedure: What Went Right?

- ◆ Red flags were raised about Dr Arndt before the incident
 - Late arrivals/ no show to the operating room
 - Physician counseling had begun by Chief of Surgery
- ◆ Poised OR staff in the room immediately notified supervisors and Chief of Surgery; judgement made that he was capable and competent to finish the case
- ◆ CEO immediately notified
- ◆ Once confirmed that Dr. Arndt had actually left the building, he was immediately suspended by Chief of Surgery
- ◆ Emergency Credentials Committee called 12 hours later and suspension upheld
- ◆ Chief assigned another Orthopedic Surgeon to care for the patient and patient recovered without incident; discharged to rehab hospital 4 days later



What Went Wrong?

Disclosure: “Why didn’t you tell the patient?”

- ◆ Patient was not told about the incident immediately
- ◆ Patient did not have the opportunity to choose an alternate physician (Patient rights violation)
- ◆ Physician did not fully understand the terms of the suspension and came in to see the patient and even wrote an order
- ◆ Poor communication among covering physicians and nursing staff about what procedures to follow when the attending physician is summarily suspended



Disclosure: System Repair

- ◆ A new policy was written outlining the specific actions required of all staff when a summary suspension occurs
- ◆ Senior leaders realized that there needed to be a systematic and organizational culture change that embraced disclosure of adverse, unexpected and untoward events
- ◆ In our case disclosure to the patient acknowledged:
 - An unusual event/ breach of policy occurred
 - Exactly what happened
 - An apology was given
 - A description of the analysis and corrective action taken

_____ **But it was too late.....**



Credentialing: “How did this physician get on to your staff?”

- ◆ Initial credentialing background (education, training, references) all ok
- ◆ Reappointment did not include review of misdemeanor conviction or any in-depth discussion of “red flag” issues
- ◆ Credentialing process did not include background checks
- ◆ Double standard existed: background checks mandatory for employees
- ◆ What we didn’t know about this physician really hurt us



Credentialing:

“How did this physician get on to your staff?”

- ◆ Serious flaws in the systems used by hospitals to credential
- ◆ Current system is a fragmented, hospital by hospital approach to licensing, credentialing and accountability - particularly as it relates to physician behavior - leaves all hospitals and their patients vulnerable to similar risks
- ◆ A “credentialing best practice” does not exist
- ◆ A single official comprehensive “look” at all relevant data for an individual physician does not currently exist



Current Physician Credentialing: System Limitations

- ◆ Each hospital requires a physician requesting privileges,
 - To interact directly or indirectly with multiple agencies that have overlapping but differing goals and accountabilities
 - State and Federal Regulatory Agencies
 - JCAHO
 - Harvard Risk Management Foundation
 - Complete separate non-uniform application forms containing a variety of disparate informational requirements



Current Physician Credentialing: System Limitations

- ◆ A universally accepted definition of unacceptable physician conduct does not currently exist
- ◆ Specific peer review protections exist which prohibit healthcare organizations from sharing information
- ◆ Organizations do not have data systems able to continuously update credentialing decisions (e.g., for supervision or monitoring of a given individual physician)
- ◆ The willingness of hospitals and other providers to include legal protections and confidentiality clauses in termination agreements



Current Physician Credentialing: System Limitations

- ◆ Letters of recommendation often do not contain specific or frank behavioral assessment; even when “red flags” have obviously been present for long periods of time
- ◆ Pertinent behavioral issues at other hospitals or in the community are not typically available to other hospitals;
 - in part because of past confidentiality agreements
 - in part a consequence of peer review protections of other healthcare organizations
 - in part because of fear of liability caused by alleged defamation or restraint of trade



Current Physician Credentialing: System Limitations

- ◆ Physician hospital applications typically pass sequentially through:
 - Division Chief
 - Chairman of the Department
 - Clinical Services Committee
 - Credentials Committee
 - Medical Executive Committee
 - Board of Trustees
- ◆ Multiple layers have the potential to create more opaqueness than effective check and balance
- ◆ *Diffuse accountability may have the effect of no accountability at all*
- ◆ Physician re-credentialing is not typically approached with the same discipline and care as initial credentialing



Current Physician Credentialing: System Limitations

- ◆ Physicians responsible for the credentialing system don't have available:
 - Formal training in the definition and management of appropriate work place standards of behavior
 - Clear organizational definitions of appropriate physician behavior
 - An organizational methodology for monitoring the effectiveness of behavioral intervention
 - A formal process against which the actions of responsible professionals (e.g., chairperson) can be judged



Current Physician Credentialing: System Limitations

Given these very real limitations inherent in the current physician credentialing systems,

it is possible for inadvertent professional inexperience, bias or other organizational factors to create gaps in fulfilling institutional credentialing accountability



Credentialing Best Practice

- ◆ Adoption of one community-wide, standardized application form to be used by all licensing, credentialing and healthcare organizations

***All relevant information collected
should date from
medical school onward***



Credentialing Best Practice

- ◆ The standardized physician application should contain uniform definitions of acceptable physician behavior
 - *Explicit* standards are necessary and should be part of the application process
 - Standards of behavior for physicians must be identical to those required of all hospital employees
 - Adherence should be expected and verified as a condition of both credentialing and re-credentialing
 - If unacceptable behavior is clearly defined, then it will be clear what information is relevant for the credentialing file and for inter-institutional sharing

***Patients have a right to know
that standards and guidelines for physician behavior
have been established and that
deviations from those standards are promptly addressed***



Credentialing Best Practice

- ◆ Any aberrant physician behavior that may interfere with the ability to deliver safe and quality medical care is relevant in terms of medical credentialing
 - In addition to quality of medical care and outcome data, criteria for physician reappointment should include feedback and comment concerning physician behavior and interactions from:
 - Peers
 - Other caregivers
 - Employees
 - Patients



Credentialing Best Practice

- ◆ Any aberrant physician behavior that may interfere with the ability to deliver safe and quality medical care is relevant in terms of medical credentialing
 - Reporting of complications and aberrant behavior is a way to improve quality of care and is therefore highly desired
 - The prevailing ethic should be one of *disclosure, not concealment*, in order that in every transaction each party recognizes it has an obligation is to disclose information



Credentialing Best Practice

- ◆ Physician credentialing should include OIG and CORI checks
 - Background, current and ongoing screening of physicians should utilize the same standards that apply to all professionals dealing with *vulnerable populations* as well as those that apply to pilots and other high risk industry professionals



Credentialing Best Practice

- ◆ No physician has a “fundamental right” to be on the medical staff of any hospital
 - When applying for staff privileges, the only legitimate physician right is to be reviewed in the same manner as any other applicant and not have special requirements applied to him/her that others do not
 - In-depth inquiry into a physician’s past and present behavior as pertains to patient safety and the ability to deliver quality medical care is legitimate inquiry and should be applied uniformly to all applicants
 - In order to properly fulfill the critical community obligation of physician credentialing, Medical Staff Credentials Committees should include a non-physician member of the Board of Trustees



Credentialing Best Practice

- ◆ Unwillingness to provide full and complete disclosure of his/her relevant professional history should disqualify a physician from staff membership
 - Due process in this context should mean nothing more than equality and fairness in credential review
 - From the physician perspective, the following questions appear to be most pertinent:
 - a) Am I being judged fairly (like everyone else) by clear and explicit standards fairly applied (applied to everyone, not just to me)?
 - b) Am I informed of my deficiencies?
 - c) Am I given the opportunity and the means for improvement?
 - d) Are my rights being protected?

An effective credentialing system will be able to answer yes to all four questions.



Credentialing Best Practice

- ◆ The community of healthcare providers, patients, payers, insurers and regulators needs to develop a system for the *sharing* of all relevant background and pertinent ongoing information concerning physician behavior related to an individual's ability to provide safe, quality medical care.
- Any summary suspension of a physician, *once upheld*, should be immediately reported to all hospitals where the physician has active credentials, the Massachusetts Board of Registration in Medicine and the Harvard Risk Management Foundation



Credentialing Best Practice

- ◆ A “safe harbor system” that will allow hospitals, physician groups, medical schools, residency directors and others with legitimate professional interest to make available upon request all information relevant to professional and personal conduct including:
 - Disciplinary action
 - Non-renewal of privileges
 - Investigative findings
 - Patient and colleague complaints

The goal is to create a new norm or expectation that with a physician’s full knowledge, every hospital and healthcare entity has an **obligation** to share this information with all parties having a legitimate interest (i.e., hospital credentialing committees)

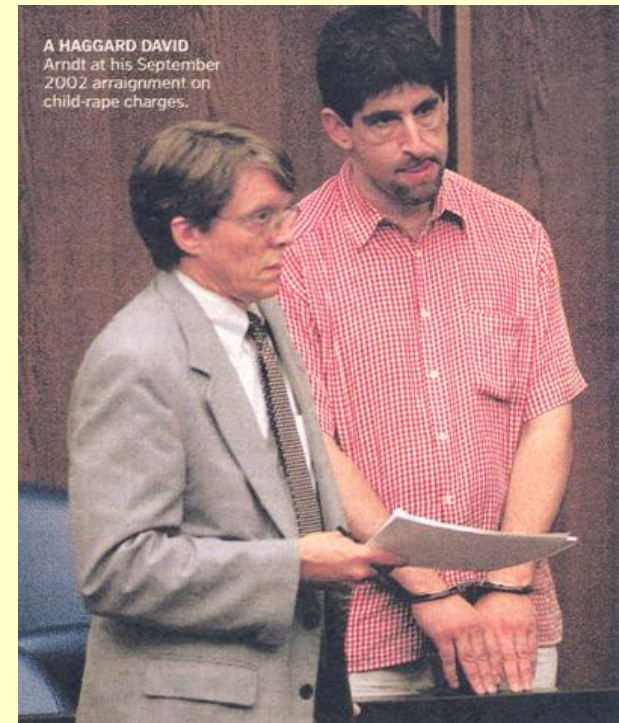


Dealing With the Public Relations Crisis

- ◆ Created serious breach of trust with the community
- ◆ Entire hospital community (trustees, donors, employees, loyal patients, physicians, volunteers and auxiliaries) embarrassed, hurt, confused, angry
- ◆ Severely damaged Mount Auburn's otherwise excellent reputation
- ◆ Unrelenting media coverage worldwide for days, weeks, months following
- ◆ TV, newspapers, internet - everywhere



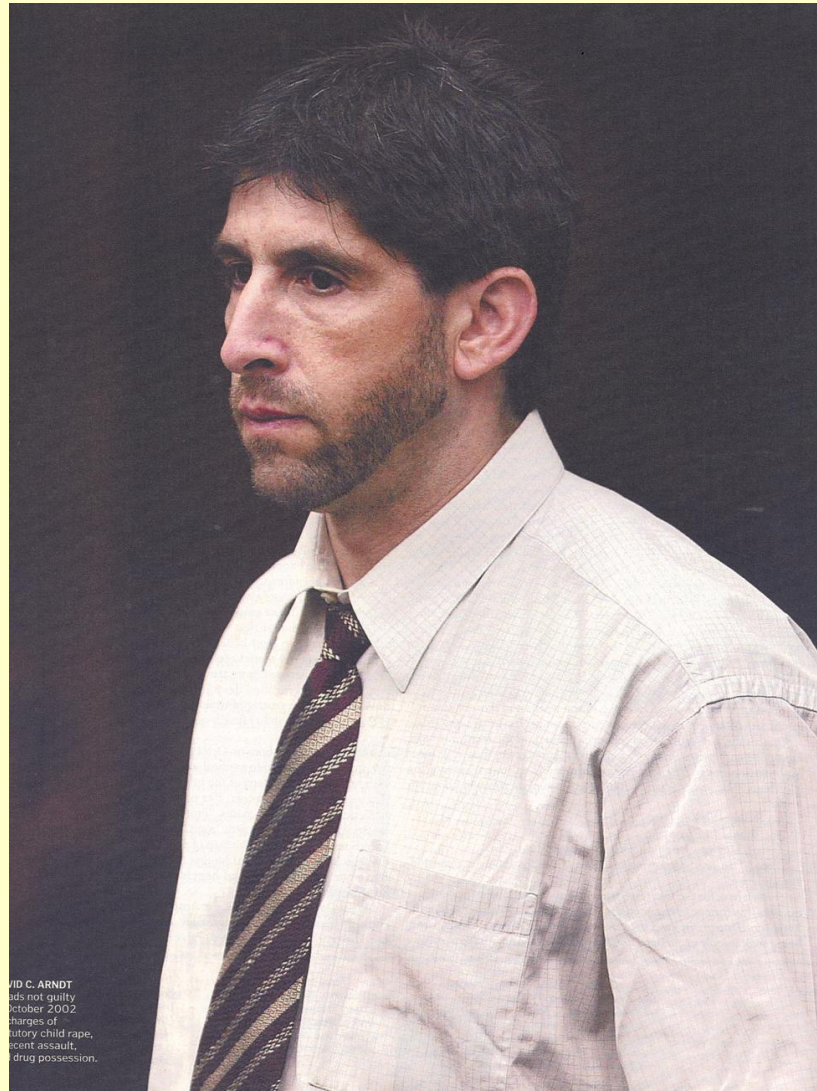
THE KID WAS BORN INTO MEDICINE. ■ He was on track to becoming one of Boston's next great spine surgeons, taking his place alongside his father among the city's medical elite. ■ But on this day in January, the 43-year-old sits on the dark bench in the dimly lit gallery of Middlesex Superior Court in Cambridge, watching the parade of career criminals take their familiar positions, wearing expressions of defiance or boredom. Look in *his* eyes, however, behind the boxy glasses, and you can see flashes of bewilderment. How did *I* get *here*? He watches as a paunchy guy charged with conspiring to kill a cop asks the court officer if he can give the large, weeping woman in the front row "a kiss and my lottery tickets" before being led away. And then the clerk calls out his number: "Case number 38 - David Arndt."



Dealing With the Public Relations Crisis

- ◆ Required carefully crafted strategy for public relations reponse and positioning
- ◆ Required continuos open communication to all constituents using all available means (letters, personal calls, internet, open letter in newspaper)
- ◆ Required carefully coordinated press statements and press releases
- ◆ Press conference called for CEO to meet face to face with the media





DAVID C. ARNDT
was found not guilty
in October 2002
on charges of
statutory child rape,
recent assault,
and drug possession.



Dealing With the Public Relations Crisis

- ◆ Trustees convened a “Blue Ribbon” panel of experts to review the course of events
- ◆ “Blue Ribbon” commission facilitated by nationally recognized physician expert
- ◆ Panel had access to all data regarding the incident and was able to offer expert insights and a final report that enabled greater change to occur
- ◆ Quality improvement executive team set a plan in place to oversee adopting the “Blue Ribbon” recommendations with regular reports to the Board of Trustees



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THE
BOSTON
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03.21.04 /// MAGAZINE

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POLITICS OF PROMOTING
(STRAIGHT) MARRIAGES

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THE LATE-NIGHT COMIC CRACKS
WISE ON HIS NEW KIDS' BOOK

OODLES OF NOODLES
SPICY PAN-ASIAN RECIPES
STIRRED UP AT HOME



Before he deserted a patient during surgery,
David Arndt was poised to become one of Boston's top doctors.
His shocking downfall is a story
of betrayal, arrogance, and wasted promise.
Will prison be the last chapter?

The Self-Destruction of an MD

BY NEIL SWIDEY

THE CLOTHES WE WEAR
Totes of the
Town
PAGE 10



**“Dig where you stumble;
that’s where the treasure is.”**

-Joseph Campbell

