

Do Me a Favor

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The Case

A 26-year-old gravida 4 para 1 woman reported that her last menstrual period was 5 weeks prior, and she had a positive home pregnancy test. With a history of one ectopic pregnancy, one normal vaginal delivery, and one spontaneous abortion (miscarriage) at 6 weeks, she was concerned about a repeat ectopic pregnancy. The patient was a nurse who worked at the hospital and was friends with one of the obstetrics/gynecology residents. She asked the resident to perform a transvaginal ultrasound to check for an intrauterine pregnancy and rule out an ectopic pregnancy.

The resident brought the patient into the antenatal testing room without notifying the nursing staff or registering the patient. A transvaginal ultrasound was done, which did find an intrauterine pregnancy; neither the findings nor the patient's condition was documented in the medical record. The vaginal probe was not cleaned appropriately after the procedure.

The charge nurse on the floor noticed that the bed in the antenatal testing room had been used. On inquiry, she could not find a patient who had been admitted to that room. Ultimately, she asked the resident, who revealed that he had scanned his friend.

The Commentary

This case describes a common scenario among health care professionals. At some point, most of us have been asked to help a colleague, friend, or family member with a medical concern, or ourselves asked a colleague for advice about our own health or that of a family member. No doubt, some will read this case, scratch their heads, and wonder what the problem is, exactly. Is this just a case of an overzealous charge nurse upset with two colleagues who violated "protocol" and failed to clean up after themselves? Aside from that, what patient safety lessons are embedded in this case?

Although informal caregiving among health care providers is likely common, a literature search revealed no published reports on such informal care. However, some literature touches on the related issue of physicians caring for family members. A 1991 survey found that 99% (n=461) of physicians reported being

asked to provide medical advice, diagnosis, or treatment to family members, with up to 83% doing so.(1) Another survey, focused on physicians treating their own children, found that nearly three in four reported providing treatment for afebrile illnesses.(2) Finally, another study found that 85% of medical and family practice residents had written a prescription for someone who was not their patient; virtually none were aware of federal and state regulations prohibiting the practice.(3)

Informal polling of front-line staff at an academic medical center about requests for advice/treatment by colleagues suggests that scenarios similar to this case study are commonplace. Among the many personal anecdotes: nurses revealed that physicians often ask them for analgesics, antibiotics, or other medications to get them through busy shifts when they are feeling ill. In turn, physicians tell of frequent requests for prescriptions by non-patient colleagues. Both doctors and nurses recounted professional requests for health care "favors" include taking blood pressures, checking blood glucose levels, performing phlebotomy, administering intravenous infusions, and performing electrocardiographs, to name a few. Justifications for such requests include long work hours, difficulty accessing care when off-duty, distrust of or distaste for the "bureaucratic" system (providers frequently confessed that they did not have a primary physician and preferred to be treated by someone they know), reluctance to seek care through formal channels for minor problems, and efficiency/convenience. Since no apparent difficulties usually arise, the provider culture has come to "normalize" these informal practices.(4-6) The effect of this is to remove any possible professional stigma from seeking or providing care in this underground system, and to render any errors that do occur relatively invisible.

The American Medical Association Code of Ethics suggests that, in general, physicians should avoid treating themselves or members of their immediate families, with the exception of routine care for minor short-term problems.(7) The American College of Physicians Ethics Manual also suggests that physicians exercise caution if they choose to treat themselves, family members, close friends, or closely associated employees.(8,9) These sources focus on issues related to autonomy, confidentiality, and liability, but do not fully address safety risks inherent in informal caregiving among colleagues (Table).(7,9-11)

Why might informal care be potentially unsafe? There are several reasons. Informal care may bypass standard routines, safety checks, and supervision. In this case, the resident may not have been fully competent to perform the exam (resulting in injury or misdiagnosis), but reluctant to reveal this to his colleague. He was unsupervised and unchaperoned, which is problematic given the intimate nature of the procedure.(12) The exam may have provided the patient with a false sense of security. She was not afforded the usual pre- and post-procedure routines, such as education, resulting in potential delays in seeking follow-up treatment or future worries (eg, if the patient miscarried this pregnancy, she might mistakenly attribute it to the exam). The vaginal probe may not have been properly cleaned prior to use, exposing the patient to potential infection risks.

In this case, an important quality of care and safety component was bypassed: the involvement of other appropriate team members. A transvaginal ultrasound is a relatively reliable and low-risk procedure at this stage of pregnancy; nevertheless, the risk for misdiagnosis exists (13,14) and appropriate senior resident or attending supervision would reduce this risk. Additionally, failing to include nursing in procedures exposes patients to risks of injury related to inadequate analgesia, inattention to other procedural details, and potential delays in emergency response, if complications arise. In addition, it deprives the patient of

concomitant social and psychological support.

When informal care occurs, another potential safety issue is the failure to document care or follow protocols. Patients undergoing procedures should be registered, and care should be documented for future reference. Breach of this common standard, as happened here, means that future providers will not have the benefit of the information gleaned from this exam. Appropriate protocols, including review of the case with another physician, were circumvented. Furthermore, failure to document care exposes the provider to legal liability.⁽¹⁵⁾

This case also illustrates a failure to return the system to "ready" status and to adhere to appropriate infection control principles. The colleagues left the vaginal probe and the room in a state of disarray, creating risks for future patients, including potential delays in treatment and/or infection. Maintaining equipment and supplies in "ready" status is critical for systems responsiveness.

Institutions need to create formal policies related to care of colleagues and family. While advice about routine problems, referrals, or simple prescriptions could be considered appropriate, policies should target intimate, invasive, or complex diagnostic work-ups, treatments, or procedures. An effective policy would not prohibit a care provider from facilitating the care of a colleague or family member, but rather would channel it through the formal systems, which have been carefully developed to provide safe and effective care. In this case, the resident could have done the procedure quickly, but should have had the patient formally registered, staffed by an attending, as well as chaperoned and assisted by nursing.

Systems approaches to prevent this type of error in the future center on the "safety culture."^(4,6) Open discussions about appropriate types of caregiving among colleagues in institutions is a good first step, followed by enforcement of agreed-upon standards. Additionally, educating all providers about the potential risks and liabilities of informal caregiving among colleagues might be helpful. One hopes that the charge nurse discovering this error capitalized on the opportunity to initiate dialogue about setting standards for such behavior in the future.

Key Considerations for Safe Caregiving Among Colleagues ^(9-11,15)

- Consider carefully the potential risks associated with informal treatment prior to making or responding to requests of colleagues for medical treatment. Assume that obtaining a complete history/exam may be difficult owing to privacy concerns of the colleague.
- Restrict treatment to advice for minor or routine concerns, as much as possible, avoid the use of institutional resources, intimate/invasive procedures, and complex decision-making.
- Assess carefully your level of knowledge, skill, and competency to manage the problem. Resist the temptation to practice outside your specialty or beyond your level of expertise.
- If you choose to treat a colleague, it is wise to document the encounter and provide the same level of care and consideration that you would for any patient. Why not offer to see the colleague in your clinic/office (and facilitate that)—instead of risking the hurried hallway encounter?
- Remember to consider the need for follow-up, education, and support. Communicate with other care providers, as appropriate, to ensure these needs are met.
- Organizations should consider developing explicit guidelines regarding informal caregiving among colleagues.

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Table

Table. Safety and Quality of Care Risks of Informal Caregiving Among Colleagues

Reluctance to obtain or provide a complete medical history

Reluctance to obtain or submit to a complete medical examination

Diagnosis and treatment beyond provider specialty knowledge, expertise, or competency

Loss of patient privacy and confidentiality

Lack of objectivity on the part of patient or provider

Under- or over-treatment related to "wishful thinking," hurried/informal nature of encounter, hypervigilance, or other factors

Circumvention of systems safety checks

Circumvention of beneficial education and/or procedural protocols

Impaired or inadequate patient education

Lack of documentation

Inadequate or absent follow-up

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