CENTER FOR HEALTH SCIENCES INTERPROFESSIONAL EDUCATION, RESEARCH & PRACTICE
UNIVERSITY of WASHINGTON

Faculty Guide

All Health Professions Learning Day

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AGENDA for Learning Event

OPTIONAL TRAINING SESSIONS FOR FACULTY		
Time	**What**	**Where**
11:00–12:20 pm	*New* faculty training	**HSB T-553**
12:30-1:20 pm	Lunch and meet teaching partner Review of purpose for returning faculty	**South Campus Center Room 316**

GENERAL SESSION – Hogness Auditorium HSB A420		
Time	**Speaker**	**Activity**
2:30–3:20 pm	Dr. Tom Gallagher Internal Medicine	Keynote on basics of error disclosure with turn-to-your-neighbor skills practice and videos
3:20–3:30	Travel time to small groups	

SMALL GROUP BREAKOUT SESSIONS – Health Sciences Building & South Campus Center		
Time	**Activity**	**Supporting Materials**
3:30-3:45 (15 min)	Nametags as learners arrive Brief introductions Facilitator faculty describe learning activity to group Learners read case	Nametags in packet Short Icebreaker in Faculty Guide Instructions in Faculty guide Case in packet – **by professional group**
3:45-3:50 (10 min)	Learners discuss error and plan for disclosure as large group	Facilitator Faculty assists group [Content Faculty is outside room]
3:55-4:00 (5 min)	Divide into 3 Interprofessional teams Short discussion within each team to plan disclosure roles	Balance SoM, SoN, and SoPharm students as much as possible
4:00–4:15 (15 min)	**First** team discloses error to "family member" 5 minute debrief with first team	*"Error Disclosure: Learning Pearls"* in faculty guide
4:15–4:30 (15 min)	**Second** team discloses error to "family member" 5 minute debrief with second team	*"Error Disclosure: Learning Pearls"* in faculty guide
4:30–4:45 (15 min)	**Third** team discloses error to "family member" 5 minute debrief with third team	*"Error Disclosure: Learning Pearls"* in faculty guide
4:45-5:15 (30 min)	Debrief as large group about team practice and communication	*"Interprofessional Team Practice and Communication: Learning Pearls"* in faculty guide
5:15–5:20	Student Evaluations !	In Faculty packet

SMALL GROUP SESSION: OVERVIEW

LEARNING OBJECTIVES:

1. Practice discussing a medical error in a blame-free way as an interprofessional team.
2. Practice planning for disclosure of a medical error as an interprofessional team.
3. Practice disclosing a medical error to a patient or family member as an interprofessional team with honesty, compassion and demonstrating respect for team members.

WHAT: Groups of two faculty and 12 interprofessional students will practice error disclosure in teams using one case.

FACULTY ROLES:

- Facilitator Faculty Role: This person is familiar with how to facilitate a team communication with a "family member". He/she will facilitate the learners' communication with each other, with the "family member" and guide the debrief.
- Content Faculty Role: This person will play the role of the family member of a patient who had an error occur in his care. The team will disclose an error to this faculty member. This person's key role is to be a realistic family member for the learners to practice communication skills with. At the end of the session, this faculty member will provide feedback in the debrief.

COMPOSITION OF GROUPS:

6	2nd year medical students
3-4	senior BSN or accelerated BSN nursing students
2-3	pharmacy students
1	Facilitator Faculty
1	Content Faculty (sit to side or outside room and join group for disclosure)

BASIC CASE: The case is a missed medication allergy to penicillin (patient from nursing home receives Zosyn in ED). It involves all members of the health care team. The group of students will break into THREE interprofessional teams. Each team will talk with the patient's adult son/daughter (your faculty colleague). The students have learned about discussing errors, planning for the disclosure, and then disclosing errors to patients/families as an interprofessional team in the large group session.

MATERIALS FOR STUDENTS:

1. Nametags: Critical! Ask students to write name AND PROFESSION (ie, MD, RN, Pharm).
2. Pocket Guide: quick reference for basics of team error disclosure
3. Case: three different versions – physician, nurse, pharmacist.
   Please distribute the correct version to learners – they differ slightly.
4. Course Evaluation: One-page evaluation with return envelope. Please collect evaluations in envelope and return via campus mail. Thank you!

FACILITATOR FACULTY MATERIALS:

I. SET UP LEARNING ENVIRONMENT (10 minutes):

A. Introductions and icebreaker question:
Introduce yourself: Share your name, where you teach, and clinical specialty.
"Please tell us your name, where you are in clinical right now, and in what area you see yourself practicing after graduation."

II. DESCRIBE LEARNING ACTIVITY AND DISTRIBUTE CASE (5 min):

A. Describe learning activity:
- *"We are going to practice communication skills for disclosing an error to a patient or family member.*
- *"I'm going to give you a case that involved everyone on the team.*
- *"First we'll spend about 10 minutes as a group discussing how this error happened and planning how to disclose this error to the family member.*
- *"Then you will break into three interprofessional teams and you'll spend another minute in your subgroups finalizing your roles.*
- *"When you are ready to disclose the error, another faculty member will come in to be the patient's family member.*
- *"Each subgroup will have about 10 minutes to disclose the error and debrief a little about how it went.*
- *"After each group has had a turn, we'll spend about 20 minutes talking about team error disclosure "*

B. Distribute case (different versions for each professional group) and distribute Pocket Guide. Allow learners time to read case.

III. OPEN DISCUSSION OF ERROR and PLAN DISCLOSURE (15 min):

A. LEARNING GOALS:

- Relevant information and concerns about the error are raised in the group discussion through open, non-blaming conversation.
- Team avoids 'winging it'. Team thinks through the actual disclosure to anticipate handling patient emotion, patient blame, etc.

Team Discusses the Error	1. Acknowledges error 2. Conducts blame-free communication during team conversation 3. Demonstrates team-oriented communication 4. Negotiates differences of opinion collaboratively

Team Plans the Disclosure	1. Advocates for full disclosure 2. Plans roles for disclosure 3. Anticipate patient's questions and reactions 4. Plans responses to patient

B. IDEAS FOR FACILIATION:

Encourage acknowledgment of error: be curious and non-judgmental.
"How are allergy alerts recorded in the computer system?"
"In case the patient/family member asks, it might be helpful to understand the process of how medications are given. Could someone walk me through it step by step?"
"How would nursing usually double-check an allergy?"

Avoid blame and help learners take personal accountability: model blame-free communication.
Student says: "As a nurse, *I should have checked the medical record more carefully. If I had, I would have seen the drug allergy."* Reply: *"What other checks and cross-checks in this patient's care might have caught this allergy."*
Student says: *"I think pharmacy is supposed to record these allergies so that the information is available when the doc is trying to order meds."* Reply: *"That is one check but what are others?"*

Address emotion in colleagues: be respectful and supportive.
Student says: "I think I would feel awful about this." Reply: "I bet you aren't alone in that feeling. Are others feeling responsible for this error."

Explore differences among all team members: be respectful and encouraging.
"I'm wondering if everyone has had the chance to express their perspective. It would be helpful to hear your thoughts, particularly before we talk with the patient/family."

Advocate for full disclosure: support honesty
Student says: *"I'm not sure we should tell the patient/family member everything. This wasn't entirely our fault. The nursing home played a role."* Reply: *"These situations are often complex. What do others think? What would you want to be told if this had happened to your parent?"*

Anticipate family member's questions and reactions and plan responses:
"How do you think the patient/family member may react when you tell them about this? What if he/she gets really upset or cries?" What if he/she gets angry?"
"What should we do if the patient/family member blames one of us?"
"What if they have questions we cannot answer today?"

IV. BREAK INTO TEAMS AND PLAN ROLES FOR DISCLOSURE (5 minutes):

A. Break the large group into **three teams** (try to balance professions in each group)

B. Ask teams to talk together about roles in the disclosure:
"Think about who will begin the conversation. Is there specific information each of you would like to share with the family member?"

V. TEAM DISCLOSURE OF ERROR (10 min per team + short team debrief):

A. LEARNING GOALS:

- **Disclose error honestly, clearly and compassionately**

B. PROCESS

1. Ask for a team to volunteer to be first. Thank them!
2. Move them, if possible, to a circle of chairs with place for the family member.
3. Bring family member (content faculty) into the room, indicate his/her chair, and introduce to the team. Be formal in referring to the Content Faculty as the family member.
4. **Each team has 10 minutes (or less) for their disclosure to the family member.**
5. Debrief: short debrief for each team immediately after they practice:

NOTE:

- ✓ The rest of the group will listen. They will have their chance when they practice.
- ✓ Remember to allow each team member who just practiced to make a comment.
- ✓ The family member can either stay in the room (head down and not interacting) or can leave the room and re-enter for the next team.

DEBRIEF QUESTIONS:

a. *What went well when you talked with the patient's family?*
b. *What could have gone better?*
c. *What is one thing you would change the next time you disclose an error?*

C. Ideas for facilitation and debriefing: see "Error Disclosure Simulation: Potential Learning Pearls" (end of manual)

Team Discloses Error to a Patient	1. Conducts explicit disclosure of error to patient 2. Responds forthrightly to patient questions about event 3. Apologizes upfront and early in conversation 4. Exhibits general communication skill with patients 5. Conducts blame-free disclosure, acknowledges personal role 6. Offers plans to prevent future errors 7. Plans follow up with patient

VI. DEBRIEF AS LARGE GROUP (30 min):

A. LEARNING GOALS:

- Consider strengths and challenges of open disclosure of medical errors.
- Consider strengths and challenges of interprofessional teams around error disclosure.

B. IDEAS FOR FACILITATION:

See resources at end of guide including:

- Error Disclosure: Potential Learning Pearls
- Interprofessional Teams: Potential Learning Pearls
- Tips for Facilitating Interprofessional Learning Groups

C. EVALUATIONS:

Please distribute evaluations to learners and have them return to the self-addressed envelope. Please place envelope in campus mail.

Thank you!

CONTENT FACULTY MATERIALS:

I. OVERVIEW OF YOUR ROLE IN THE SIMULATION:

A. You will play the family member of an older man who lives in a nursing home in the Seattle area – likely your father (or grandfather or uncle?). You are the legal decision-maker for the patient.

B. Wait outside the room until the learners are ready to disclose the event to you (about 30 minutes).

C. There will be three "teams" who will disclose the same error to you. You will pretend to be hearing it for the first time with each group. The instructions provide three twists to assist you to change your response to each team to keep the experience fresh for the learners.

D. Each team will have 10 minutes to disclose the error to you. Help to keep them on time by bringing the conversation to a close by suggesting that you need time to think and would like to meet again later.

E. After each team's disclosure, the facilitator faculty will quickly debrief each team (5 min). During this time, it may be easiest to leave the room so that when you re-enter you can sit with the next team. If you do not leave the room, look down and try not to react to the team's comments. Do not engage with them at this point. Stay in character.

F. General debrief: After the last team's disclosure and quick debrief, the whole group will debrief the learning experience. Please participate!

G. Your comments to learners: What you say to the learners will make a lasting impression! Emphasize what learners did well when possible.
   - Tie specific things said to an increased understanding of the error
   - Don't tell them 'you should have said'—let them figure this out
   - Rather than say you didn't like what they said, tell them the effect on you as a family member—you were confused, you were irritated, you didn't understand, you wondered whether people were being truthful.

H. More ideas for comments: See "Error Disclosure: Potential Learning Pearls" and "Interprofessional Teams: Potential Learning Pearls"

II. CASE DESCRIPTION FAMILY MEMBER: Zosyn Case

Background: Your father, ALBERT JACKSON, is 92, and lives in a nearby nursing home because he has become progressively confused over the past five years. Albert still recognizes you but usually is confused about where he is, the date, etc. He needs help with showering, eating, dressing, etc. You worry about how quickly your father will continue to decline. You also wonder when the confusion and dependency will get to the point where your dad would not want life-sustaining treatment anymore. Albert has not been hospitalized for two years. However, about a year ago he had a minor infection that required antibiotics and he received penicillin pills in the nursing home. He developed hives, an itchy mouth and abdominal cramping indicating a drug allergy. He recovered without problems. Since then he has had an allergy alert for penicillin.

Last night you got a call from the nursing home that your father had a serious fever and the nursing home staff suspected pneumonia. You agreed to call an ambulance. Your dad was taken to the Emergency Room and then ended up in the ICU. You are worried that your father is so sick that he has required ICU care. You came to the hospital late last night and saw your dad in the ICU. Albert had a tube in his mouth that the nursing staff said was helping him breathe. It looked very uncomfortable. He barely opened his eyes when you were there and didn't seem to recognize you.

This morning you returned to the hospital. Albert is still in the ICU but the breathing tube is out of his mouth. He is on some oxygen with nasal prongs, has an IV and is getting antibiotics through the IV. Your dad looks better but he still does not recognize you.

Character background: You and your dad were close growing up. You grew up in north Seattle as an only child. After your mom passed away from breast cancer, you and your dad became even closer. Your dad lived alone for ten years until he started becoming increasingly forgetful and confused over about five years. You were relieved when your dad agreed to move into the nursing home because you had begun to fear for his safety. Your father has declined steadily and went from independent living to assisted living to the nursing home unit over three short years. Now Albert is increasingly frail and confused about where he is living and dates/times. However, he always recognizes you and appreciates your visits while you are there. The nursing home is close to you and you stop by several times a week.

III. INSTRUCTIONS EMOTION & CONTENT TRIGGERS: FAMILY MEMBER

1. Start: You will start the interaction worried and anxious for your father's health. [Your emotional level should be a 2 or 3 out of 10.] There are three variations for three possible teams:
   - First team: **Focus on your worry about why your dad does not recognize you**. Start with a statement such as, *"I am so relieved to talk with you! I've been worried about dad. I hope this wasn't a stroke. Has dad taken a turn for the worse?"*
   - Second team: **Focus on your irritation that you have been kept waiting so long to hear what really happened**. Start the interaction with a statement such as *"Finally! I have been here for an hour waiting to talk with all of you. I need to know what happened to my dad."*
   - Third team: **Share that an error happened in your mother's care also.** Start the interaction with a statement such as, *"I hope you aren't going to tell me something bad happened in my dad's care."* At some point you can share that an error happened when your mom was being treated for breast cancer. She received too much chemotherapy during one chemo sessions causing several weeks of nausea, fatigue and mucositis. Chemo was held before being resumed. The error was initially not disclosed to your family but eventually her oncologist told you what happened but not why or how.
2. Discovering the error: Keep asking questions about what happened to your dad, until you learn that it was an error that led to his ICU admission. EG: "*Why he is so sick that he is in the ICU? He's had pneumonia before and never ended up in the ICU?" "He didn't sound this sick when the nursing home called?"*
   - First team: **Started with worry about why your dad does not recognize you**. When find out was an error, you will be relieved that it is not something "permanent".
   - Second team: **Started with your irritation that you have been kept waiting so long to hear what really happened**. When find out was an error, you will share that you were suspicious it was something that wasn't supposed to happen by the way people kept telling you "the team would be by to talk with you".
   - Third team: **Started with statement about hoping nothing bad happened (error in mother's care).** When you find out it was an error, express disbelief this could have happened to your dad also.
3. Emotion with error: When you realize that an error occurred (and could have had even more serious effects), become **SAD**. Your emotional level should be 5 out of 10 – your greatest emotional reaction for the encounter. You might have a sharp intake of breath. Put your hand to your mouth. Cover your eyes in despair. Look away from the team. Perhaps even become a bit tearful.

4. Content of the disclosure: You should ask probing questions to try to find out what happened. If the team responds openly, disclosing details, answering questions directly, and appearing empathetic, you can continue to probe, but with an attitude of grudging acceptance, recognizing that these people are human beings, and that mistakes do sometimes happen. If the team, or a member of the team, appears to be evading answering the questions openly, are responding inappropriately to your emotional reaction, you can continue to probe, reacting with increasing frustration and anger and mistrust of the answers you are receiving. **Keep questions directed toward finding out what happened (in the past) and away from what will happen (in the future).**
5. SAD EMOTION FIRST: Stay SAD for a while to allow the team to respond to that emotion. If they acknowledge your emotion and stay present with it, allow yourself to become comforted. If they do not acknowledge your emotion, continue to be sad and detach from them by breaking eye contact.
6. ANGRY EMOTION SECOND: At some point in the interaction, evolve into becoming ANGRY. [Your emotional level should be a 4-5 out of 10 – anger is hard to handle so don't go overboard. Be frustrated/angry but not personally attacking, demeaning or sarcastic.] You might gradually begin to grow frustrated and say something like, *"This is awful! My dad could have died! Is that what I am understanding? He may just be an old man to you, but he's my dad. I can't believe this happened!"*
7. **(SECOND TEAM ONLY)** Blame Trigger: At some point, blame a member/s of the team for the error. Say something like, *"So you didn't*_____[physician: check for history of allergic reaction in the chart; nurse: read the armband carefully; pharmacist: have a better system for tracking allergies)." Don't be too harsh. Remember that the learners will be taking turns speaking so "who" you blame may shift as the learners respond. The goal is to allow the team to 'rescue' a member who is targeted. If the person you blame takes responsibility and apologizes, respond positively (ie, thank them). If other team members jump in and defend, or say something like "we are all at fault", consider saying something like, *"Well, isn't that a way to say no one is at fault?"*
8. **(THIRD TEAM ONLY)** Trust trigger: Toward the end of interaction, ask the team how you can trust them to take care of your dad. If they directly respond, thank them and tell them that you appreciate their honestly and will work to trust them again. Maybe tell them that you'll be paying close attention.
9. Try to help the team wrap up: In order to move the groups along, please help the learners get closure on the conversation after about 7-10 minutes by suggesting meeting again. Perhaps suggest you need time to think, consider questions or talk with other family.
10. End neutrally. With closure, resist urge to make the team feel good. But if the team has done well, okay to say something like*, "I appreciate your honesty. I'm not glad this happened but I think we just need to move forward from here and I trust you to tell me when things haven't gone right."* If team has really floundered, consider saying something like, *"I needed to know this even though I am not happy about it. I'm glad you told me."*

IV. FAMILY MEMBER: QUICK SUMMARY OF TRIGGERS

	First Team	Second Team	Third Team
Start	**Focus on your worry about why your dad does not recognize you**. *"I am so relieved to talk with you! I've been worried about dad. I hope this wasn't a stroke. Has dad taken a turn for the worse?"*	**Focus on your irritation that you have been kept waiting so long to hear what really happened**. *"Finally! I have been here for an hour waiting to talk with all of you. I need to know what happened to my dad."*	**Share that an error happened in your mother's care also.** *"I hope you aren't going to tell me something bad happened in my dad's care."*
Discovering the error	Relieved that it is not something "permanent .	Suspicious it was something that wasn't supposed to happen by the way people kept telling you *"the team would be by to talk with you".*	Express disbelief this could have happened to your dad also (as mother experienced an error in her breast cancer care)
Sad emotion	**+++**		
Angry emotion			
Blame trigger		To physician: *"So you didn't check for history of allergic reaction in the chart?"* To nurse: *"You didn't read the armband carefully!?"* To pharmacist: *"You don't track patient allergies?"*	
Trust trigger			*"How can I trust that you all won't screw up again?"*
Wrap-up neutrally			

RESOURCES

I. Error Disclosure Simulations: Potential Learning Pearls

1. Remember the patient: The distress of making an error can cause clinicians to lose focus on the medical needs of the patient. What does the patient need right now? Also, remember the disclosure conversation is solely for the benefit of the patient and family.
2. What to tell? Treat patients and families the way you would want to be treated. Most people want to know what led to an error occurring and what will be done to ameliorate immediate and long term health consequences ("Am I okay? Am I going to be okay?"). There is no legal risk to disclosing the facts of the case as they are known at the moment, but avoid speculation. Initial impressions of how facts fit together can be wrong.
3. What else to say? In addition to understanding what happened, patients and families want to hear how similar errors will be prevented in the future. They also want to know if they will have another chance to ask additional questions. Offer that follow-up explicitly.
4. Apologize – authentically: Avoiding blame in an apology and taking an appropriate amount of responsibility is a skill. The basic formula is, "I apologize for my [action] that caused your [harm, inconvenience, worry, suffering]." Apologize early in the conversation and don't hesitate to apologize more than once.
5. Plan, prepare, practice, perform: Avoid "winging" these conversations to avoid being caught off guard by the patient's questions or reactions. When that happens, our responses can appear deceptive or uncaring. Think through who will lead the disclosure, what will be said, the need to apologize, possible patient reactions, who the patient might blame and how that will be handled, etc. Patients usually expect the attending physician to lead the discussion, but in some circumstances it may be the nurse.
6. We prefer "sad" to "mad" reactions: Sadness is perceived as an inner-directed emotion. Clinicians move towards sadness by wanting to rescue the other person and "fix" the sadness, potentially through minimizing. Anger feels outer-directed. Clinicians are likely to pull back, "catching" the anger and becoming irritated with the patient. For either emotional response, clinicians need to respond to patient emotion by acknowledging the emotion, communicating accountability, and apologizing for the error. *"I think if this had happened to my dad, I might feel pretty discouraged/angry/scared."*
7. Blame and trust: Patients or families may try to assign blame to a person. Teams need to think through how they will handle this to avoid abandoning that colleague (silence), having one person fall on the sword ("I'm the captain of the ship – it was my team, so my error"), or appearing to be the Keystone Cops ("We all screwed up"). Patients and families may also tell us that they have lost trust. Explicitly address statements about trust by saying, *"We hope to rebuild your trust"* or *"We would like the opportunity to earn back your trust".*
8. These conversations don't end "happy": Disclosures usually do not end with the patient thanking or forgiving us. Clinicians need to not expect support from the patient.
9. Get support from your colleagues or other resources: Making an error can be one of the most devastating experiences a clinician will face. Get (and offer) support from your team

members, colleagues, or other sources. Consider whether you or your colleague needs to go off-line for a period for patient safety.

II. Interprofessional Team Practice and Communication: Potential Learning Pearls

1. All team members feel a fiduciary relationship to the patient: Health care professionals are devastated by errors made in their care. They often believe that an error was primarily their responsibility and are surprised when they learn that others on the team feel that same strong sense of responsibility. They may not have realized that they were not solely, or even primarily, responsible for the error.
2. Balancing personal responsibility, team responsibility, and system accountability: The concept of a "Just Culture" does not mean a blame-free culture but rather one where the individual acknowledges personal accountability and the team shared responsibility while the effect of the system on errors is recognized. Teams may want to avoid blaming each other by instead blaming "the system" or another institution. Recognizing how to accept (and share) responsibility without feeling blamed is critical. Teams need to be prepared to handle the patient or family member's attempts to fix blame on one person or group and to communicate shared responsibility.
3. Listening and speaking up are critical team skills: Listening is important but not enough for effective team communication. Good team skills require also speaking up. Team members need to contribute to discussions about patient care.
4. Providing support to each other helps teams provide better patient care: Making an error can be a devastating experience. Professionals may need to attend to the context of the error or adverse event and their emotional reaction to continue to provide safe and compassionate care to patients.
5. Role clarification: Understanding one's own role and the roles of those in other professions, and use this knowledge appropriately, can help to establish and achieve patient goals.
6. Patient/Family-Centered Care: Teams do best when they seek out, integrate and value, as a partner, the input and engagement of the patient or family in designing and implementing care services.
7. Team functioning: Teams understand the principles of team work dynamics and group/team processes to enable effective interprofessional collaboration. For example, open discussion of any differences of opinion around what to say in the error disclosure is critical to effective disclosure.
8. Collaborative leadership: Team understands and can apply leadership principles that support a collaborative practice model. In error disclosure conversations, formal and/or informal leadership is needed to insure effective communication.
9. Good patient communication requires good team communication: Interprofessional communication among members of the team from different professions needs to be collaborative, responsive and responsible. Patients want compassionate, honest, and consistent communication with their health care professionals. To have the whole picture,

teams need to communicate openly about errors and other adverse events before talking with the patient or family.

III. TIPS FOR FACILITATING INTERPROFESSIONAL LEARNING GROUPS

1. One student or group of students dominates the conversation:
    - Could be medical students who feel more confident with the learning format and know their peers
    - Could be nursing students who have had more clinical experience
    - Could be pharmacy students who feel that because the error involves a drug they should take the lead
    - If this occurs, encourage other students to speak up: "Any thoughts on this from the perspective of a nursing/medical/pharmacy student?"

2. Some learners are quiet or reluctant participants: Suggest they try something that they would like to experiment with, something that they have not tried before but would like to have "fun with". Continue in debrief to treat their effort as an "experiment" to make the learning environment safe.

3. Personal or war stories as distractions: Learners may want to use this opportunity to bring in other examples where interprofessional interactions did not go well or where they observed another professional not behaving well. Refocus group back to the learning activity for the day and *"how we can do this well"* or *"I know we each may have had individual experiences, but today, let's focus on this shared experience and then compare to our other experiences at the end if there is time."*

4. Challenging comment/s from a learner: Sometimes learners say something that separates them from the other learners ("I'm not sure we should disclose this error? Maybe it would be better to just not tell. The family wouldn't be able to find out if we didn't tell them.") If that happens, restate the comment as a feeling rather than a belief *("I bet there are others who are feeling that they might prefer to not disclose this error. This will be hard! What are the reasons we might feel that we have to be honest as clinicians?*"). The goal is to keep all learners as a part of the learning community by allowing them to reconsider their comments.

5. Getting sidetracked by discussions about "my profession": Learners are likely to be genuinely interested in each other's educational programs, normal clinical experiences, and the like. But they also may digress to avoid discussing the hard stuff – the error! Try to refocus general conversations back to the specifics of the case so learners have time for the simulation with the family member. They highly rate the opportunity for practice even though it makes them anxious.