

Disclosing Errors to Patients: An Interprofessional Approach

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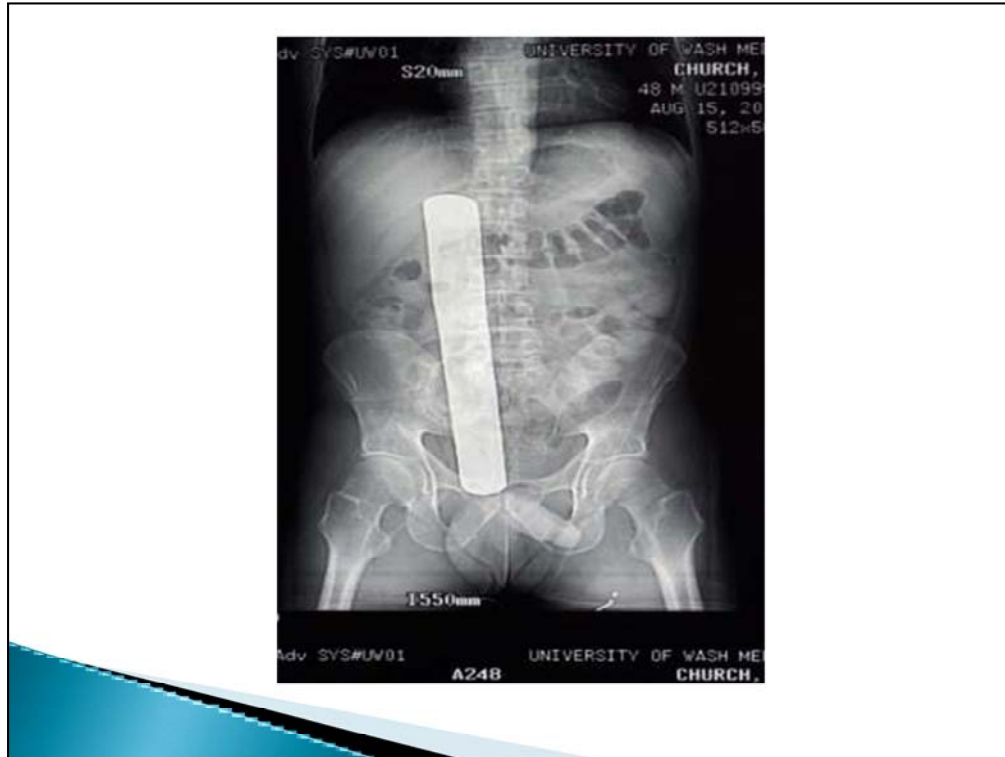
it is exciting to see all of you here because when I look back on my time in medical education and look at practice now, I think this area of how we communicate with patients when something is going wrong in one area that's undergoing the most dramatic change, and its happening right as you're going through the process of education. Its really an exciting opportunity to sort of learn some new skills and think about a new paradigm. It used to be that sort of the recommendations were that when there were problems in healthcare, it basically was not to say anything to the patient. You didn't really say anything to one another on the healthcare team, we definitely did not say much to the patient, and in part we were concerned that if we told the patient we made a mistake they would sue us. The times really are changing, part of what we're learning is that to really do this well, we need to work with professional colleagues from other disciplines. People used to think that disclosure was just that the doctor talks with the patient, we're learning that its much more than that, and that's why all of you are together today to really learn about "so how do you work together as a team when something has gone wrong" and benefit from the knowledge and experience of folks from the different professions. We're also learning that like every other skill in medicine, this is something where you need to practice, and the practice is as important-it's a little scary, I remember as a medical student one of the things that made me the most bummed out, I sort of knew that mistakes were inevitable, but the notion of having to go tell the patient that we made a mistake was really upsetting and intimidating, and its something where learning some basic skills that we're going to outline today, and giving yourself the opportunity to practice really is invaluable.

Accelerating Interest in Disclosure

- ▶ Growing experimentation with disclosure approaches
 - Healthcare organizations
 - Malpractice insurers
- ▶ New standards–NQF and others
- ▶ State laws re disclosure, apology
- ▶ Increased emphasis on transparency in healthcare generally

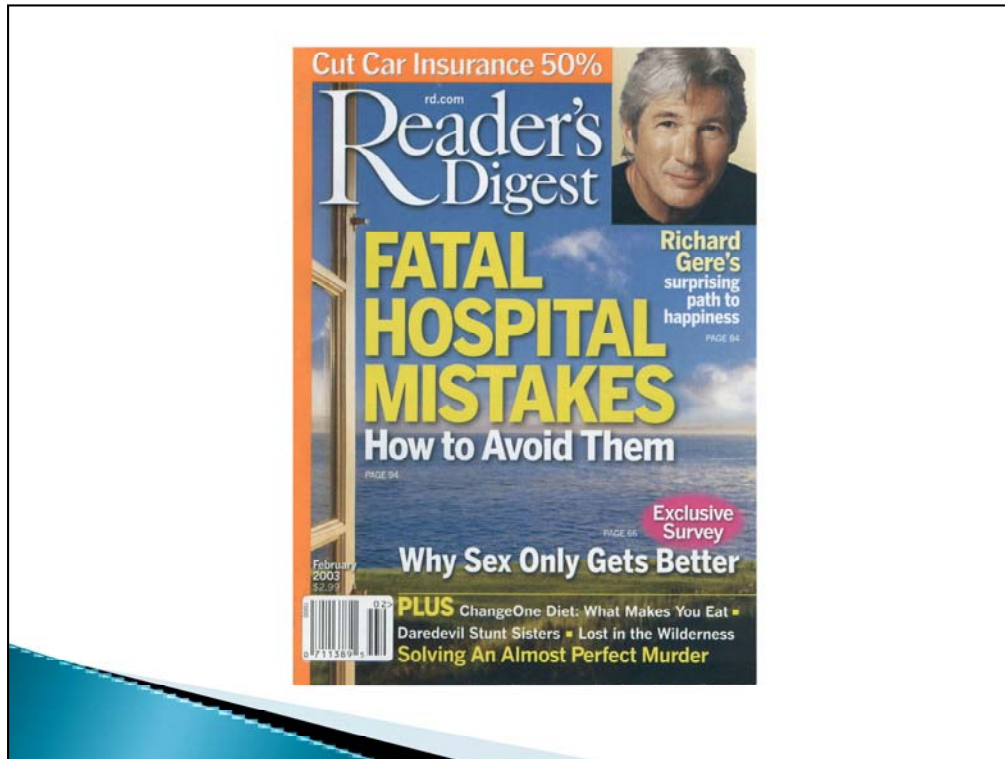
We're seeing all sorts of interest in this issue of disclosure on a number of fronts. We're seeing healthcare organizations experimenting with different approaches to it. One of the reasons that we know disclosure is sort of not a fad is that malpractice insurers, organizations traditionally have advised us to really be cautious, are now the ones that are out in front trying to teach new approaches for doing this effectively. We're seeing new standards and guidelines emerge in this area, there weren't any standards when I went through training about how to do this effectively. States are getting into the act; the state of Washington and many others are trying to promote disclosure and apology by providing some protections from what you say being used against you for, and it really has to do with an increasing emphasis on the importance of transparency in healthcare generally. This really is a paradigm shift, and we figure that when something goes wrong our natural instinct is to keep that to ourselves, we're looking at if that instinct is really wrong. We need to be open and talk with one another when there has been problems, but also to talk with the patient.

Should We Disclose Harmful Medical Errors? If So, How?



Things can go wrong in a pretty dramatic way. This was a patient (slide) who came to the UW Medical Center for routine abdominal surgery and no one realized that anything was amiss until they couldn't make it through the metal detector at SeaTac airport, and this is when this 12inch by 2 inch retractor was discovered in the patient's abdomen. You can imagine that if you were a patient and saw a picture like this, how scary it would be, sort of in terms of the safety of healthcare generally.

Should We Disclose Harmful Medical Errors? If So, How?



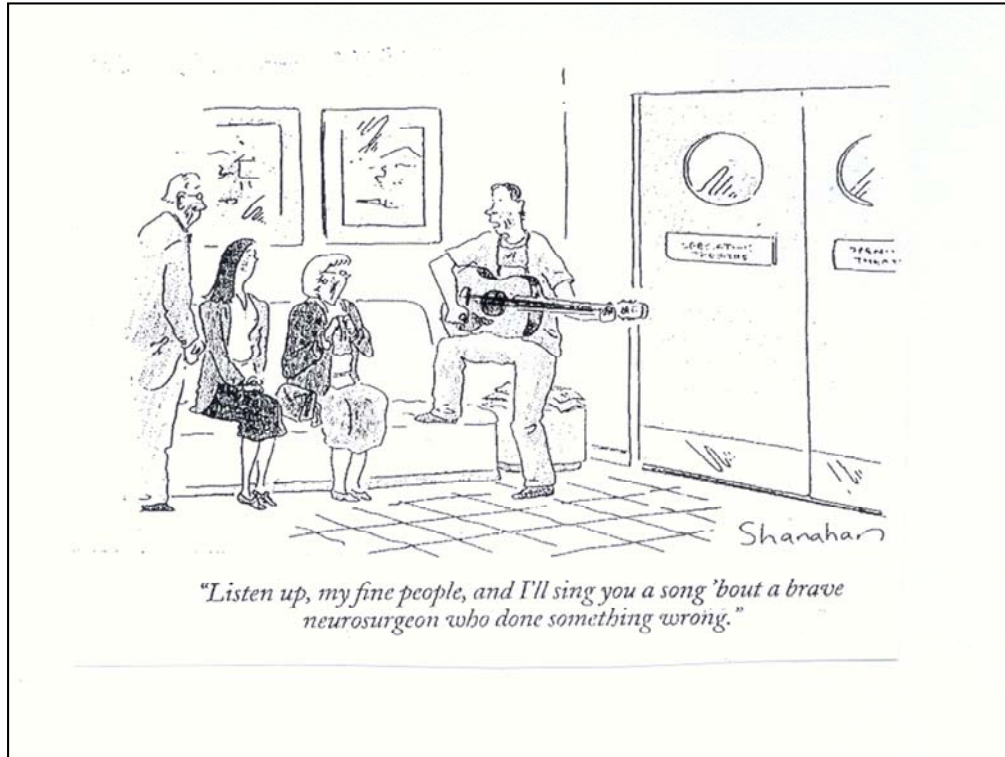
This issue also made it to the cover of Reader's Digest, it turns out it was about a womb infection, which turns out lots of which aren't preventable, but again dramatizes how this hits the public's consciousness.

Disclosure Performance Gap Also Increasingly Evident

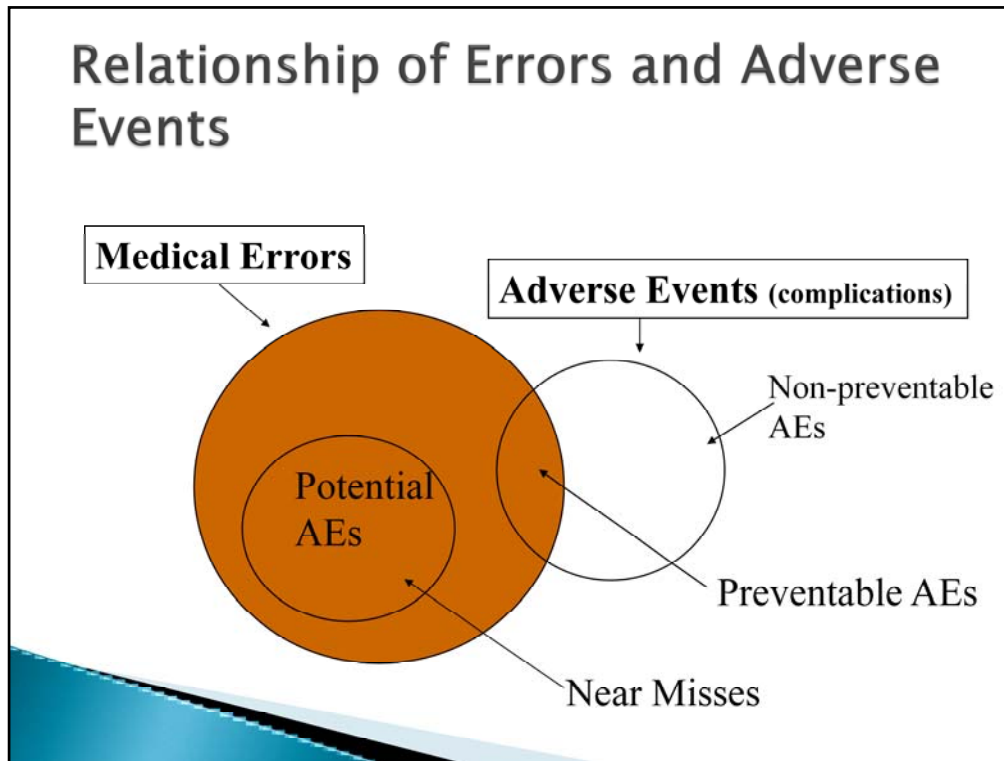
- ▶ Harmful errors often not disclosed
- ▶ When disclosure does take place, often falls short of meeting patient expectations
 - Failed disclosures have substantial impact for patient, healthcare workers, institution
- ▶ Little prospective evidence exists regarding what disclosure strategies are effective

So even though there's lots and lots of talk about the importance of disclosure, we recognize that we do a bad job of it. It turns out that most harmful errors aren't disclosed to patients, and when they are disclosed, often times, they fall short of meeting patient expectations in areas, and when disclosures don't go well, it really has substantial negative consequences not only for patients, but for healthcare workers. Imagine if you were a patient and you were expecting your workers to take good care of you and for things to go well, you'd be completely bummed out if an error happened. It would be like pouring salt in your wounds if no one would talk with you about what happened. We really need to learn how to do these conversations and do them well. Part of the challenge has been up until relatively recently, there is not a lot of evidence about how to do this and how to do this well, but that's starting to change and we are going to be sharing some of these strategies and evidence with you today...

Disclosing medical errors to patients: Recent developments and future directions

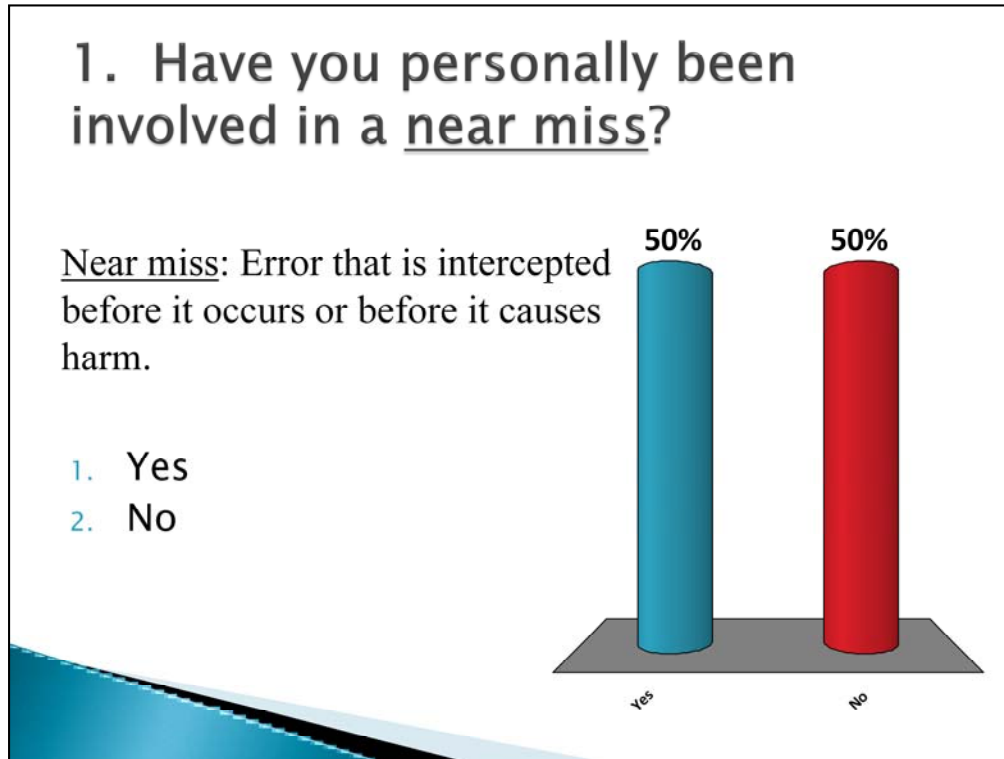


...but this (point to slide) is not one of them. Hopefully at the end of the session today you will have a clearer idea of specific skills other than the singing neurosurgeon to help you in this area.



I wanted to make one more point then I wanted to ask you some questions. It really is important that you differentiate between adverse events and medical errors. The formal definitions for adverse events and errors are long and not really helpful, the importance thing to recognize is that an adverse event is any time we harm the patient through the process of healthcare. Anytime we cause a patient harm through healthcare, rather than their underlying disease, is an adverse event. A patient has an allergic reaction to medication, that is an adverse event. We cut their bioduct (?) during surgery, that's an adverse event. Anytime we cause harm through healthcare, that's an adverse event. The vast majority of adverse events though are not associated with a medical error. They are not preventable. But there is this area of overlap where an adverse event has happened and its because of a medical error. That's what is going to be our area of focus today is what do you do when you have made a mistake and and the mistake has harmed somebody.

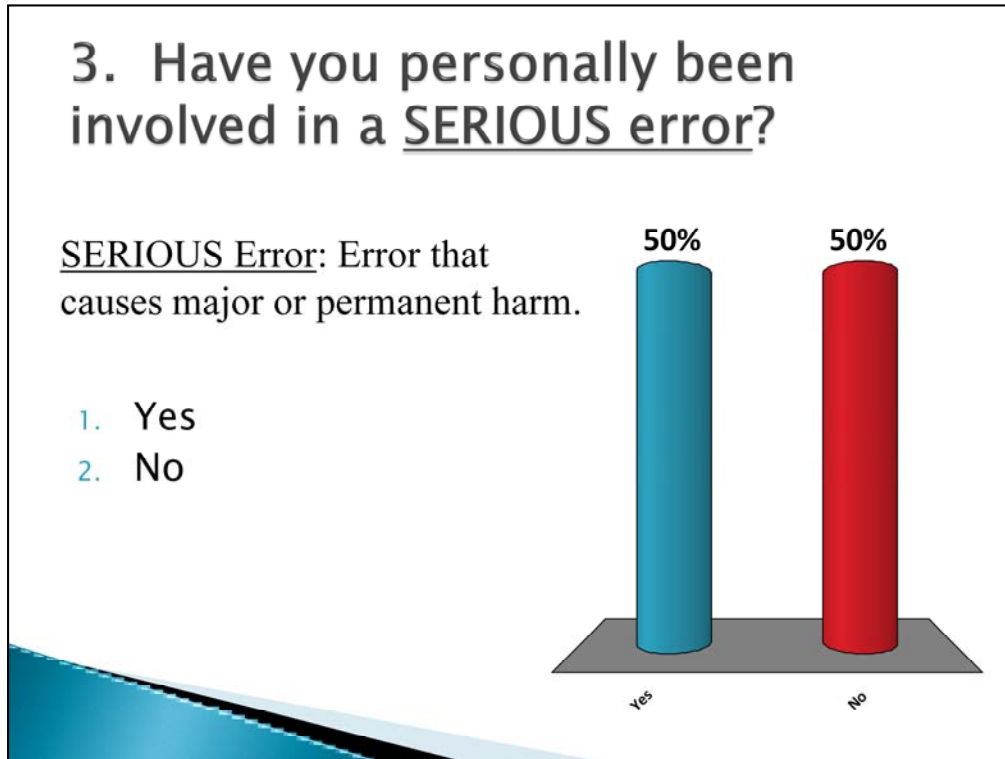
Obviously when something has gone wrong when there has been a harm from healthcare that wasn't a medical error we need to talk about that with the patient as well. We need to talk with them about their allergic reaction or injury to their bioduct. But those conversations are much more straightforward when we haven't done anything wrong than when we are trying to tell a patient about something wrong that we are responsible for. This slide also points out that there are lots and lots of errors in healthcare, very very common, that don't cause any harm. We'll talk later about what do you do if you have made a mistake and it hasn't harmed the patient, do you need to say anything



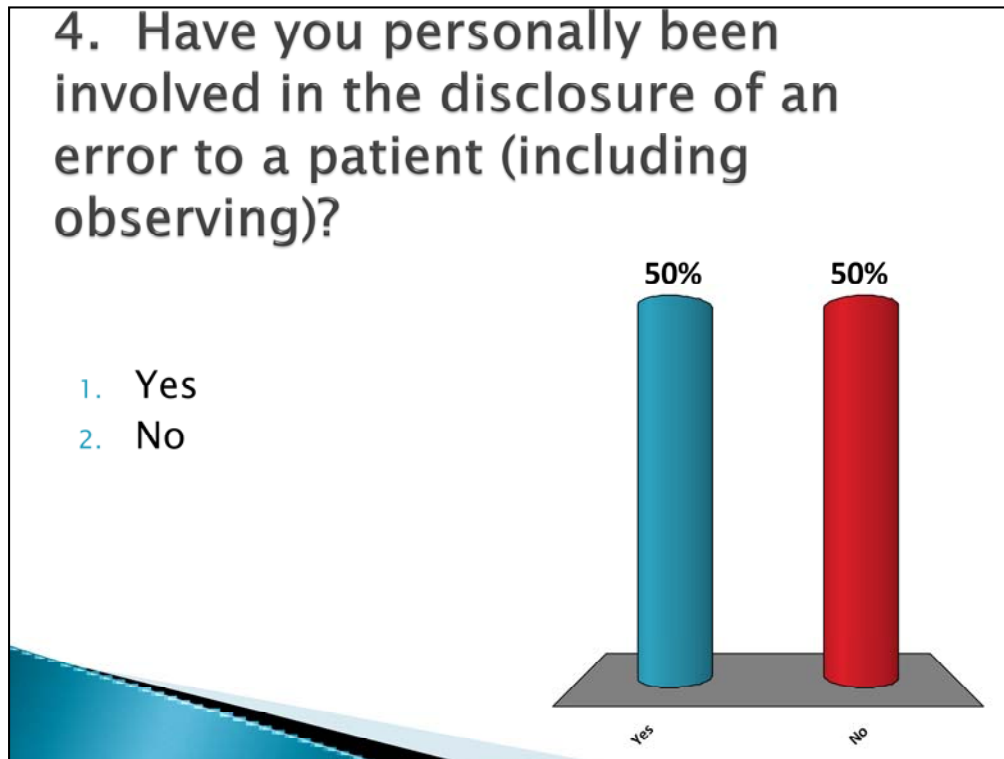
Lets start with some questions. Get out your clickers. First, have any of you been personally involved in a near miss? A near miss is an error that is intercepted before it occurs or before it causes harm. Answer (from audience): Lots of people involved in near misses.



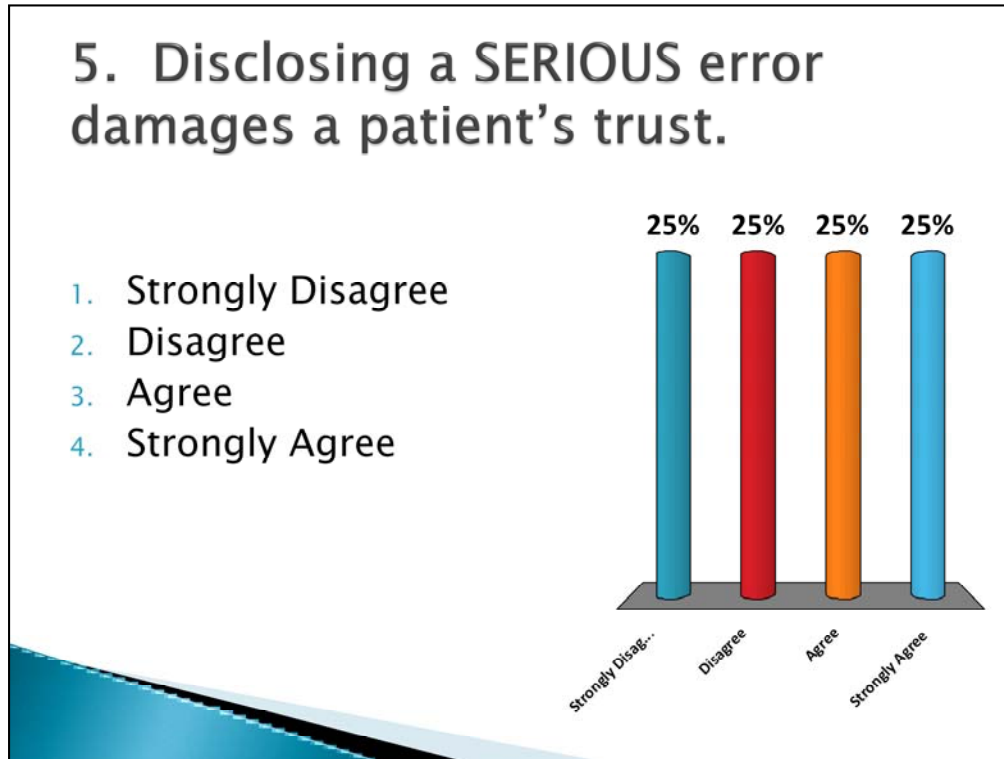
Next slide: Has anyone personally been involved in a minor error? An error that causes no harm or minor transient harm. Answer: half the class.



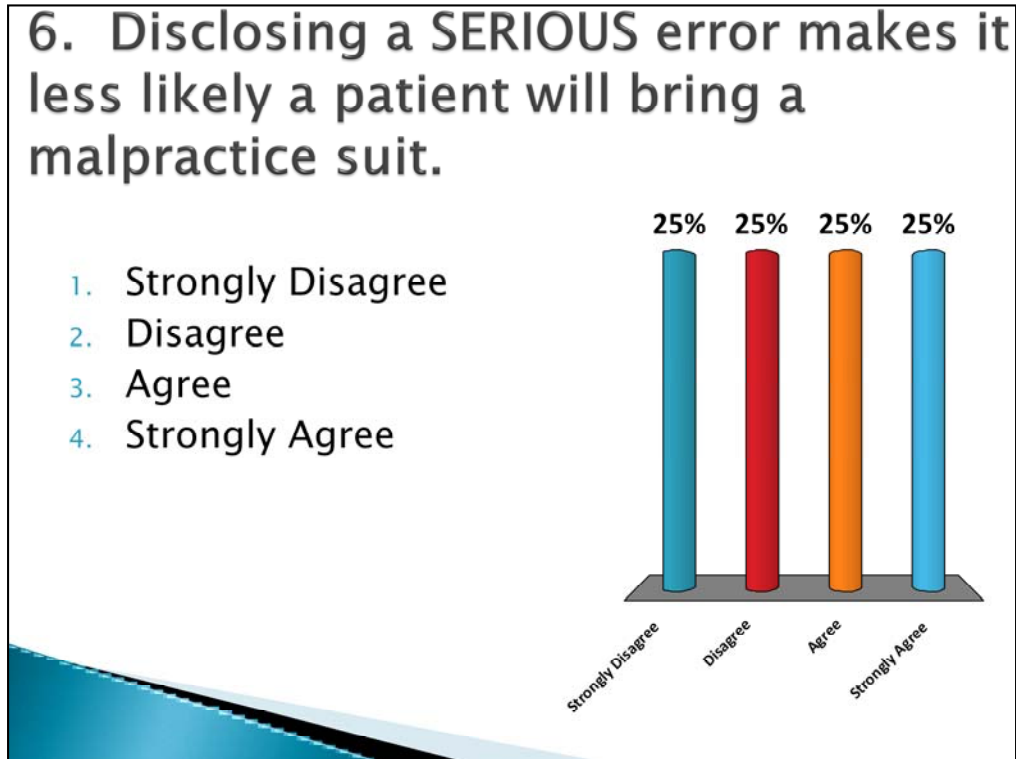
Next slide: How many have you been involved in serious errors? An error that either causes you major or permanent harm. Answer: fewer, but part of what you're seeing is that even for serious harm, at your level, involvement is not uncommon.



Next slide: have you been personally involved in the disclosure of the error to a patient? Including observing. Answer: this is consistent in what we have seen in other research. Half of trainees say they have some personal involvement either observing or being involved with disclosure, so this is not an uncommon situation even for trainees



Next slide: here is an attitudinal question: damage in disclosing a serious error, one that is causing permanent or transient life threatening harm, disclosing a serious error damages a patient's trust in you as a professional. How many of you disagree versus agree? Answer: So about split down the middle, and this is a real challenge. Lots of people worry "how am I going to disclose an error in a way that maintains a patient's trust"? It may be that disclosure has a different impact on different aspects of trust, they may have higher trust in your honesty and integrity, but lower trust in your clinical competence. So thinking through skills that help you maintain trust and drawing on your professional colleagues to help with that is important.



Next slide: Disclosing a serious error makes it less likely that a patient will bring a malpractice suit. Do you agree that if you disclose an error a patient is less likely? Answer: So lots of people agree, although I would say when you survey attendings, they are actually split down the middle. There is a little difference by specialty, so surgeons are less likely to agree with this than internal medicine doctors are. This is a little bit of a paradox, right? You would think that telling a patient about an error makes them more likely to sue, but it looks like the majority of you think it makes them less likely.

Disclosure 101

- ▶ Patients need
 - Truthful, accurate information
 - Emotional support, including apology
 - Follow-up, potentially compensation
- ▶ Healthcare workers need
 - Disclosure coaching
 - Emotional support
- ▶ Process, not an event
 - Initial conversation
 - Event analysis
 - Follow-up conversation

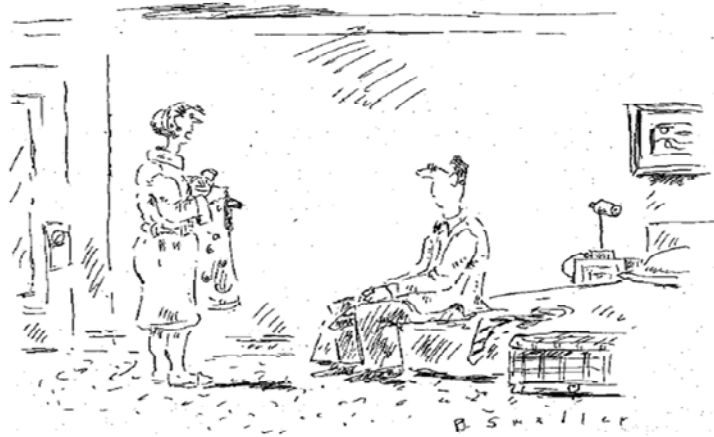
So let's just talk very quickly about disclosure skills. So patients need a couple of things: truthful and accurate information (information is sometimes harder than you think because sometimes it's not always clear exactly what happened), emotional support including an apology, and they need some sort of follow-up that is potentially including compensation. You have needs to. It turns out that healthcare workers need just in time sort of advice and coaching with disclosure. You'll learn more about how that works later. Healthcare workers also need emotional support. This is tremendously upsetting to be involved in an error like this. Some support for your upset emotions is an important part of really being able to meet the patient's needs. This is a process, not an event, so it is likely to involve several conversations with the patient about what happened over time.

Key Disclosure Skills

- ▶ Discuss error, plan disclosure, carry out disclosure
- ▶ Core disclosure content
 - Explicit statement that adverse event or error occurred
 - Implications for patient health
 - Why event happened
 - Plans for preventing recurrences
 - Discuss plans for follow-up, next steps
- ▶ Respond empathically to patient emotions
 - Early, explicit apology
- ▶ General communication skills
 - Avoid jargon
- ▶ Avoid blaming other team members
- ▶ Solicit and respond to patient questions

When we talk a lot about key disclosure skills, in your handout there is a little multi-colored page that lists some of these skills. You want to keep that in front of you as we go throughout the day today because this is what we are going to be learning. It includes a couple of different components. The first component is talking about the error, then planning the disclosure, and then carrying out the disclosure. I have listed the core disclosure content. What is the information that we need to tell patients? An explicit statement that an adverse event or error happened, what are the implications for the patient's health, why the event happened, how we are going to keep this from happening again, and how we are going to follow up. That is the information sharing part of things. The emotion handling is all about empathic communication. It's what you have been practicing and learning in your communication coursework throughout your education. But this really is a stress test. It is a hard test case for you really to respond empathically, because it's natural in these situations to think about your emotions, rather than empathic communication involves being focused to and attentive to the patient's emotions. A critical part of this is an early, explicit apology, and obviously you want to be using general, effective communications. We see healthcare workers hide behind kind of technical language when it is important to avoid jargon in these kinds of situations. It is also critical to avoid blaming other team members. When you bring multiple team members into this process, it is natural to want to figure out sometimes who is to blame and to share that information with the patient. That is completely counter-productive. A lot of what we are going to be talking about is how to talk through these events and talk with the patient about what happened in a way that does not involve blaming other team members.

“I’m sorry” ≠ “Apology”



“I don’t want your apology – I want you to be sorry.”

This is a cartoon that points out that there is a difference between saying “I’m sorry” and apologizing. Here she is saying “I don’t want your apology I want you to be sorry”. Part of what you are going to be thinking about and talking about is how you convey a sincere apology to a patient.

“I’m sorry” ≠ “Apology”

- ▶ “I’m sorry for what has happened to you” is always appropriate
- ▶ “I’m sorry for what I did to you” appropriate only when unanticipated outcome due to clear-cut error or system failure
- ▶ Do not blame “the system” or colleagues: “The lab always does this...”
- ▶ Be careful of apologies that include “buts”: “I’m sorry but if the nurse had only called me...”

So “I am sorry for what happened to you” is always appropriate, whether it was an adverse event due to an error, or “I am sorry for what I did to you” is typically appropriate when the adverse event was caused by an error or system failure. We talked about the importance of not blaming the system or colleagues. Apologies that include “buts” are not particularly productive. “I’m sorry but if the nurse had only called me...”, this is sort of an apology because an “I’m sorry” is in there, but you can see how the “but” makes that less helpful.

How apologies fail

- ▶ “I apologize for whatever happened...”
- ▶ “If there was an error...”
- ▶ “There was a mistake, but...”
- ▶ “These things happen to the best of people...”
- ▶ “The mistake certainly didn’t change the outcome...”
- ▶ Quote from surgeon: "I know, I know for you this is unpleasant, awful... but believe me, for me it's shattering"

Berlinger After Harm. Johns Hopkins, 2005

Lazare JAMA 2006; 296:1401

Apologies fail in a number of ways. “I apologize for whatever happened”- that’s not particularly effective. “If there was an error...”- people call this a conditional apology. This means “if we made a mistake, we’re sorry”. Right you can probably hear celebrity apologies that sound similar to these and are equally as ineffective. This is a situation where we often tend to minimize. “there was a mistake, but it is okay...it’s not so bad...we weren’t responsible... you’ll get over it...”: not particularly effective. There’s “These things have happened to the best of people”, patients don’t really want to hear that from you. “This mistake didn’t really change the outcome..”: also sort of minimizing, rationalizing, if you were a patient this would really just make you more mad. One surgeon said “I know, I know, for you this is unpleasant, awful...but believe me, for me it’s shattering”. Patients are really not so interested in the impact of the error on us, the focus really needs to be on making this a patient centered experience.

Skills Practice

- ▶ Backing out of your driveway this morning, you hit your neighbor's parked car. The car was unoccupied. There is damage to the headlight and front bumper.
- ▶ Your neighbor is unaware of the damage to his/her car.
- ▶ Turn to your neighbor and disclose what happened.

Role-play for your students.

More Skills Practice

- ▶ A patient is admitted with exacerbation of chronic obstructive pulmonary disease (COPD). The patient also has insulin dependent diabetes. Last night the physician ordered 8 units of regular insulin, the pt's usual dose. The physician hand-wrote the order:
 - ▶ "8U regular insulin"
- ▶ "U" for units is an unapproved abbreviation. The nurse read the order as "80 units". The nurse checked the order with another nurse who confirmed the dose of 80 units. Because the patient was sleeping, the nurse did not confirm the dose with the patient.
- ▶ Pharmacy also did not call the physician to clarify the order or catch the discrepancy with the patient's normal insulin dose.
- ▶ 80 units was administered to the patient. The nurse checked on the patient later noting signs of hypoglycemia. A blood sugar was checked, which was 32. Corrective action was promptly taken including administering glucose 50, oxygen, and transfer to the ICU for further monitoring. The incident should have no permanent effects.
- ▶ The patient is awake and alert. She/he is asking what happened. You are going to see the patient in her ICU room.
Turn to your neighbor and switch roles to disclose this event.

Role-play for your students.