Communication with Patients and Families in the Aftermath of Adverse Events and Medical Error

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Over the past two years, the Institute for Professionalism and Ethical Practice at Children's Hospital has partnered with CRICO/RMF to develop and produce a workshop devoted to supporting clinicians in their communication with patients and families in the aftermath of adverse events and medical error. While the workshop employs some of the same strategies used in simulation and team training, it incorporates some unique differences as well.

The "Coaching for Disclosure" workshop has been constructed around the National Quality Forum (NQF) standard on "Disclosure of Serious Unanticipated Outcomes," one of the 30 Safe Practice Guidelines[1] developed by this organization that form the metric for the pay-for-performance programs endorsed by the Leapfrog Group[2] and other payers. The model is premised on the assumption that it is simply not feasible to train all of the clinicians in a health care institution to be highly knowledgeable about and proficient in the disclosure of adverse events and medical error, but rather that hospitals should develop systems to assure the availability of "coaches" who can provide the necessary just-in-time training and support to clinicians on a 24/7 basis. The goal of our workshop, therefore, is to train a cohort of coaches to fill this role at each of the CRICO-insured institutions.[3]

The primary role of the coach is to guide the clinicians in the immediate aftermath of an adverse event, starting with the initial conversation or conversations that the clinical team has with the patient and family. These conversations are critical—data show that decisions to file lawsuits against clinicians and hospitals correlate poorly with whether the event was due to an error or even the seriousness of the error, but instead are driven largely by failures of the clinicians to treat patients and family members with honesty, openness, respect, and compassion. As Hillary Clinton and Barack Obama recently wrote in the *New England Journal of Medicine,* "Studies show that the most important factor in people's decisions to file lawsuits is not negligence, but ineffective communication between patients and providers."[4]

One section of the workshop is devoted to detailed exploration of a case scenario, using live enactments with workshop participants and professional actors portraying a middle-aged patient and her husband. The patient has just had abdominal surgery, and as a result of faulty communication between the surgical intern and the bedside nurse, receives a morphine infusion 10 times greater than the intended dose. She suffers a respiratory arrest, but is quickly resuscitated and restored to her baseline health without any evidence of lasting harm from the error.

Participants from the audience are selected to play the various roles in the event—the surgical attending, surgical intern, bedside nurse, nurse manager, social worker or chaplain, and the coach. With the goal of primarily emphasizing the coaching process, the enactment is performed in two parts. First, we simulate the team huddle that occurs between the coach and the clinicians to prepare for the conversation with the patient and her spouse; then we have the clinicians engage in the actual conversation with the patient and husband.

In the first conversation, the coach faces a complex set of tasks. In a short period of time, the coach needs to assess the emotional state of those who were involved in the event (Are any of the clinicians too angry or upset to participate? Are they capable of being "team players" in the meeting with the patient and family?). In addition to determining which of the clinicians will meet and speak with the family, the coach must help the team develop an agenda for the conversation and formulate a plan for what the family will be told (What are the facts that we can and should share with the family at this time? Are there areas of uncertainty where we should avoid conjecture and speculation? Is it appropriate to convey expressions of regret or, possibly, apology?). The coach needs to help the team anticipate difficult questions that might be raised by the patient or family member ("Who is going to pay for the extra costs associated with this event?" "What if I don't want that doctor to take care of me anymore?")

Once the coach and the team feel that they are adequately prepared for the conversation, there is a short break while the patient and her husband set the scene for the second conversation, which is now imagined to be the patient's bedside. The patient is in a hospital gown, attached to an IV, with her husband seated beside her. The clinicians then join them, and the initial disclosure conversation takes place. As facilitators, we have been impressed by how these conversations differ from one workshop to another—no two are alike. The response of our talented actors has been consistent and predictable—when they experience the clinicians as honest and caring, they tend to feel reassured and open to trusting the clinicians. When the actors feel the clinicians are "beating around the bush" or hiding what they know, they are likely to become irritable and demanding. In this way, our approach to learning differs markedly from the method employed with "standardized patients," where the actors typically respond within defined scripts. Our approach is more like improvisational theater, where the content of the conversation is created by and emerges naturally from the nature of the interaction itself.

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Following the coaching session and the conversation, we typically spend about 30 minutes debriefing the event. The purpose here is not to criticize or even to focus on how the interaction could have been improved, but instead to respect what we have just observed as simply one of the many ways that these conversations might actually happen. We reflect on the insights we have gained and on what they might teach us about how to be more effective coaches. The actors are part of the debriefing and play an essential and valued role, as they are perceived as authentic understudies for real patients and family members. They are frequently called upon to respond to questions from the participants such as "How did you feel when the attending said he was sorry about what happened?" or "What might have been said differently that would have increased your trust in the team?"

Attendance at a half-day workshop is a big commitment for clinical leaders, yet it is not enough time to fully teach all of the complicated skills that coaches require. Indeed, one of the most frequent comments we receive on our evaluations is that our participants feel this is an excellent *beginning*, but that additional and ongoing training will be necessary before they will feel comfortable taking on the coaching role. To date, we have conducted 12 workshops with more than 250 participants from the physician and nursing leadership of the hospitals; but we recognize that this is only a beginning to meeting the challenge from the NQF to make this model of just-in-time support through coaching a successful reality. ■

References

1 30 Safe Practices for Better Health Care http://www.ahrq.gov/qual/30safe.htm

2 www.leapfroggroup.org/

3 www.rmf.harvard.edu/company/harvard-medical-institutions.aspx

4 Clinton HR, Obama B. Making patient safety the centerpiece of medical liability reform. *NEJM*. 2008 354(21):2205–08.

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Getting Organized at STRATUS

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Before my first STRATUS session, I reviewed the management of hypotension and hypoxia, as well as ACLS (Advanced Cardiac Life Support) algorithms. I knew that the sessions were intended for us (medicine residents) to practice managing sick patients in code situations in the hospital. And, I knew that a patient mannequin would be the focus of the simulation. However, exactly how the session would work was unclear to me.

On the day of the session, prior to the simulation, one of the staff physicians introduced us to STRATUS. He explained that the mannequin could speak and answer our questions. The mannequin also has physical exam findings such as pulses, heart sounds, and lung sounds. A cardiac monitor would provide continuous data. An ECG, chest X-ray, and lab tests could be obtained by request. For treatment, there was oxygen, tools for intubation, materials to put in IVs (which could actually be performed on the patient), medications, and other items to perform a variety of procedures if needed. The session would begin with us being given the symptoms or abnormal vital signs that brought us, the medical team, to the bedside. It was then our job to evaluate and treat the patient. Afterwards we would discuss how things went.

"This is a 74-year-old man who was admitted two days ago with shortness of breath. He has been doing OK, but now his BP is 93/45 and his oxygen saturation is 84 percent on five liters of oxygen."

Upon entering the room the mannequin was moaning and saying, "I cannot breath." The six of us approached the patient somewhat timidly, not sure what to do first. Somebody talked to the patient and reviewed the chart. Someone else started to monitor his vital signs, but then got distracted by looking at the ECGs. And someone else examined him, but did not tell anyone else what he found. There was a lot of confusion and it was not always clear what we had determined and what needed to be done. We eventually arrived at the most likely diagnosis of flash pulmonary edema. We wanted to give Lasix, but there was no IV in place. Then, a staff member came into the room to discuss how things went.

The discussion was focused on not just the diagnosis and treatment, but also about how we managed the situation. Our approach had been disorganized. The staff physician recommended that we have a leader who stood at the end of the bed and kept the group organized. He or she would give jobs to