Restoring Honesty, Trust and Safety in Healthcare: Educating the Next Generation of Caregivers

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UIC Institute for Patient Safety Excellence

US Department of Education
FIPSE grants
"You should've seen the look on our faces when we realized that we'd been looking at the x-rays backward for the first hour of surgery."
Definition of Professionalism

AAMC & NBME:
- Altruism
- Honor and Integrity
- Caring and Compassion
- Respect
- Responsibility
- Accountability
- Excellence and Scholarship
- Leadership
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The ultimate purpose of a curriculum in medical education is to address problems that affect the health of the public.

Why introduce patient safety into the health sciences curriculum?

Experience gained in other safety critical industries has shown that if healthcare is to truly change its culture to one of safety and optimal quality care outcomes, education and experiential application “should be introduced early in healthcare training –
Why introduce patient safety into the health sciences curriculum?

- specifically at the student level as this is the period of acculturation into the profession. Health science schools must invest in curriculum development to address these safety issues at the earliest stages of training”.

Musson DM, Helmreich RL.
Patient Safety Curricular Needs Assessment

Decisions had to be made on:
• What material should be taught?
• How should it be taught?
• Who should teach it?
• How will it be assessed?
Annual Roundtable on: “Designing Patient Safety and Quality Outcomes Health Sciences Curricula”
Telluride, CO

Supported by UIC IPSE; SIU COM
Sixth Annual Roundtable on: “Open and Honest Communication Skills in Healthcare”
July 12th – 16th, 2010
Telluride, CO

Supported by UIC IPSE & AHRQ
Telluride Invitational Roundtable

Deliberative Inquiry Participation:
• AMA, ANA, NBME, JC, ACGME, ISMP, LLI, ABMS, AAMC, NQF
• Deans, Educators, Simulation, Legal, IT, Patient Safety Leaders, Patient Advocates, Policy makers
• Medicine, Nursing, Public Health, Pharmacy, Law, Engineering, Business
• 18 health science and law students
SPECIAL ARTICLES

Designing a Patient Safety Undergraduate Medical Curriculum: The Telluride Interdisciplinary Roundtable Experience
Roundtable Consensus

- Education should be patient-centered
- Education should be interdisciplinary
- Education should compliment patient safety initiatives instituted at the bedside
- Learners need to witness correct role modeling that reinforces knowledge and skills
- Education should be longitudinal
- Assessment should be aligned to competencies
UIC Patient Safety Education

Patient Safety Workshops:
- Teamwork
- Communication skills
- Leadership
- Stress management/conflict resolution
- Mindfulness and Emotional Intelligence
- Disruptive Caregivers
- Transparency and Disclosure
Core philosophies of patient safety curriculum
1.) Patients help design/teach our curriculum
2.) Use real medical error cases
3.) Videos, movies and narratives
4.) Gaming, simulation (e.g. SP, HFS) and experiential learning focused on teamwork, leadership & communication skills
When Helen Haskell tells the story of her 15-year-old son to medical students at the University of Illinois Chicago campus, they weep. Her son, Lewis Blackman, bled to death, in excruciating pain, of a perforated ulcer that doctors at a South Carolina hospital failed to diagnose.

Lewis Blackman, 15, bled to death because doctors failed to diagnose a perforated ulcer.
The Faces of Medical Error… from tears to transparency: The Story of Lewis Blackman

www.transparentlearning.com
WALL OF SILENCE

The Untold Story of the Medical Mistakes That Kill and Injure Millions of Americans

ROSEMARY GIBSON AND JANARDAN PRASAD SINGH
Core elements in disclosure of medical errors

- What patients want to hear:
  - Honesty
  - Recognition: investigation
  - Regret: apology
  - Responsibility: accountability and prevention
  - Remedy
Linking honesty with patient safety and quality care improvements

Event

Investigation, Full Disclosure, Apology, Remedy, Prevention and Accountability

Becomes the Trojan Horse for Cultural Transformation
The non-principled approach

The beginning circa 2000
- The K.C. case, COO of sister hospital
- Preoperative testing prior to plastic surgical procedure
- Evening before surgery - lab tests done
- WBC <1,000 (normal value 4-12,000)
- Only Hgb & Hct checked on day of surgery
- Repeated CBC (complete blood count) postop
- WBC <600
- Called as critical result to the unit – reported to “Mary, RN”
- Never found out who “Mary, RN” was
The non-principled approach

- Patient discharged from hospital on post-op day 3
- Died 6 weeks later from leukemia
- Physician colleagues/friends reported death to Risk Management
- Legal Counsel & Claims Office were approached with a plan for “making it right”
- All attempts to disclose, apologize, or provide remedy were rejected by University
What about a “Principled Approach”

- Barriers
- Benefits
A “Principled Approach”

**Barriers**
- Money
- Reputation
- “Shame and blame”
- Loss of control
- Loss of license
- Resource intense
- Uncertainty

**Benefits**
- Maintain trust
- Learn from mistakes
- Improve patient safety
- Employee morale
- Psychological well-being
- Accountability
- Money
Condition Predicate to a “Principled Approach”
Condition Predicate to a “Principled Approach”

- Courage…… and Leadership
It Is a Mistake to Admit a Mistake

A n admission is a detrimental statement of a party in a lawsuit that is introduced in evidence against that party during the trial of a lawsuit by that party’s opponent. In Asher v. Straussberg, 2 a defendant physician’s statement that, as far as it was concerned, he may have been at fault and that he had an insurance policy of $100,000 for malpractice, was held to constitute an admission. An admission is one of the most powerful pieces of evidence that can be introduced during the trial of a lawsuit.

A physician’s statement to a patient that either directly or inferentially suggests faulty treatment may be an admission. However, a trial judge makes the determination of what is an admission. For example, if a physician tells a patient, “I am sorry that I removed your perfectly good leg instead of your badly damaged leg,” that statement is most likely going to be admitted into evidence by the trial judge. If a physician tells a patient, “I am sorry things could have happened better,” that statement might be admitted into evidence by the trial judge. On the other hand, if a physician tells a patient, “I am sorry for your loss,” that statement is less likely to be admitted into evidence by the trial judge.

Recently, a movement has taken place that encourages physicians to come forward and admit to a patient any mistake that the physician thinks he or she made while treating that patient. The theory behind this move is that, movement is that the physician’s admission of a mistake immediately after making that mistake will avoid a future lawsuit. In my opinion as a medical malpractice defense attorney, who for over 30 years has gone to verdict many times, admitting to a mistake in treatment by a physician is dangerous and should not be done. I do not believe that confessing to a mistake will eliminate a potential lawsuit. Rather, confessing to a mistake will encourage a potential lawsuit to occur and will also provide strong support for that lawsuit.

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2. 78 Ill. 2d 167, 227 N.E.2d 303 (1st Dist. 1966).
4. Id.
Non-principled approach

“The first thing we do…
let’s kill all the lawyers”

William Shakespeare
Implementing a principled approach to adverse events and unanticipated outcomes

Decide upon and adopt “full disclosure” principles

- We will provide effective and honest communication to patients and families following adverse events and unanticipated outcomes
- We will apologize and compensate quickly and fairly when inappropriate medical care causes harm
- We will defend medically appropriate care vigorously
- We will reduce medical errors, patient injuries and claims by learning from the past

Credit to Rick Boothman, CRO, University of Michigan
Responding to patient safety incidents: the “seven pillars”

T B McDonald,1,2 L A Helmchen,3,4 K M Smith,1,2 N Centomani,5 A Gunderson,1 D Mayer,1,2 W H Chamberlin5
The “Principled Approach” to Adverse Patient Events

Concern or unexpected event reported to Safety/Risk Management

Data Base

Patient Harm?

No

Patient Communication Consult Service

Yes

Event Investigation
Consider “Care for Care Provider” hold bills?

No

Unreasonable Care?

Yes

Full Disclosure with Apology and Remedy

No

Process Improvements

Activation of Crisis Management Team

“Near misses”
“Full Disclosure” and Residency Education

Resident Learning Opportunities within the context of a Comprehensive Program for Responding to Adverse Patient Events

Timothy McDonald, MD, JD, Kelly M. Smith, PhD and David Mayer, MD

May, 2008
An Assessment of an Educational Intervention on Resident Physician Attitudes, Knowledge, and Skills Related to Adverse Event Reporting

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188 Journal of Graduate Medical Education, June 2010
The “Principled Approach” to Adverse Patient Events

Data Base

Patient Harm?

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Full Disclosure with
Apology and Remedy

Concern or unexpected
event reported to
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"Near misses"

Activation of
Crisis Management Team
Data to date: 42 months

- > 200 Patient Communication Consults
- 52 Preventable errors with apology
- 51 cases settled in under seven months
- Several cases [6] with $ added to waiver of bill
- Higher percent of funds going to patients/families
- Decrease of defense counsel costs
- No increase in payment to self-insurance fund or payment for excess coverage
- Increase in occurrence reports (1,500/yr – 7,000/yr)
- Increased AHRQ culture surveys
- Close to 200 process improvements
Hospitals Own Up to Errors
Some Find That Confronting Mistakes Reduces Litigation—and Future Mishaps
Retained instruments: a ‘never’ event
Scope of the Problem

- 1 in 1000 vs 1 in 5000 surgical cases
- Potentially catastrophic
- Res Ipsa Loquitur: “the thing speaks for itself”
- Media Nightmare
- JCAHO sentinel and CMS “never event”
A standard process for intraop instrument/sponge management

Count Before Incision

Surgery

Count before final closure

Correct Count?

Intraop X-ray

To PACU
Pitfalls associated with the “standard process” for managing intraoperative instruments/sponges

- Relies entirely on human counting processes
  - The human factor
- Lack of consistency in count vs. no need to count
- Inability to count: emergencies
- Count was correct or not done in most claims related to retained foreign objects
- Some procedural objects not routinely counted (OR towels etc)
Standard process for instrument/sponge management

1. Count Before Incision
2. Surgery
3. Count before final closure
4. Correct Count? (NO! To Intraop X-ray, YES To PACU)

Potential Points Of Failure
“Evidenced-based” medicine and retained objects

Risk Factors for Retained Instruments and Sponges after Surgery


Abstract
Risk factors for retained objects

- Emergency open cavity surgery
- Unexpected change in surgical procedure
- BMI > 35
- No count of sponges or instruments
- “Case-controlled analysis of medical malpractice claims may identify and quantify risk factors…”
UIC data for additional risk factors

- Extending beyond change of shift
- Greater than 6 hours in duration
- Multiple (>1) surgical services involved
Implementing a modified process

1. Count Before Incision
2. Surgery
3. Count before final closure
   - Correct Count?
     - Yes
     - No!
     - Other Indication?
       - Yes!
       - No: To PACU or ICU
       - Yes: Intraop X-ray
         - No!
         - Yes!
Lessons learned in past 40 months

9 objects identified in “correct count” cases

- 2 neck case
- 1 OB case
- 1 ortho case
- 1 chest
- 4 abdominal cavity
- No claims since implementation
A “near-miss” in OB

- 28 year old primigravid
- Worrisome FHR; scalp electrode placed
- 2 hours later emergent c-section
- ‘Unable to count’ indication for x-ray
- Intraop x-ray taken after closure of abdomen
- Patient taken to PACU
Intraoperative x-ray
Intraoperative x-ray
Gratified Patient

that a second operation was required to retrieve the device, and that her lawyers had recognized the error had been accidental. She rejected advice to call a lawyer, saying that she did not want to see her injuries treated that way.

Ms. Valdez said she was gratified that the hospital acknowledged its mistake, paid her, and put in place improved procedures for keeping track of electrodes. “I think they had the time to explain it to me,” she said. “I felt good that they were sorry.”

There also has been a cultural shift among plaintiffs who recognize the