

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

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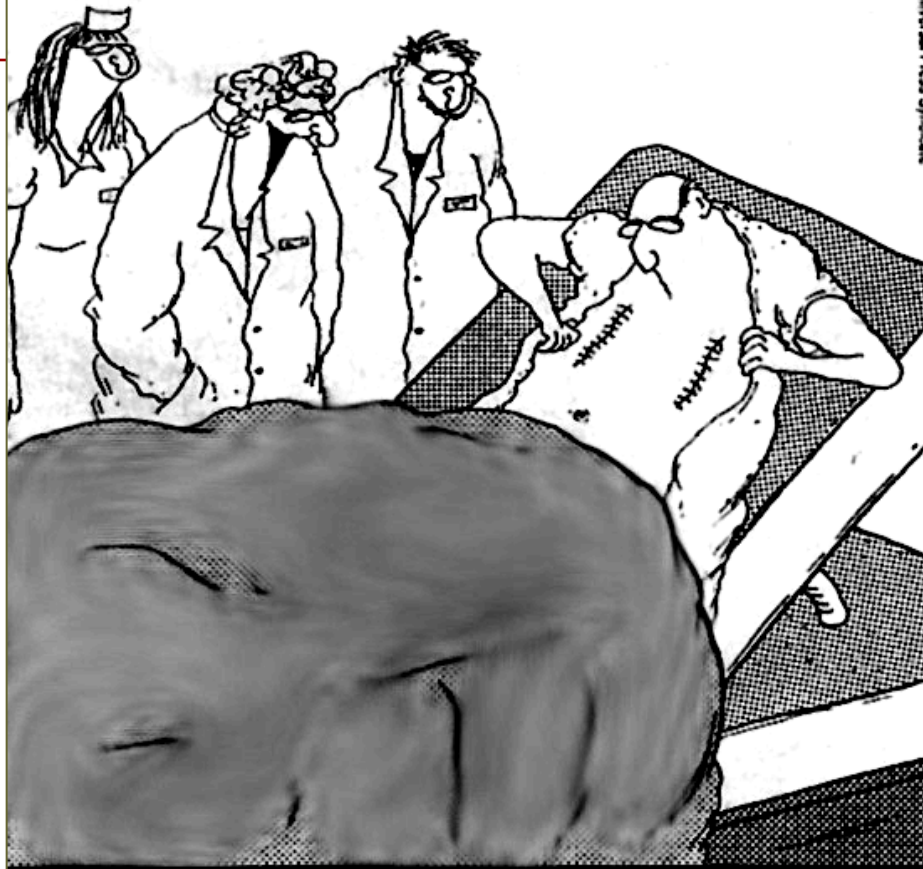
US Department of Education
FIPSE grants



5-14

McPHERSON

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"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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- Leadership

The ultimate purpose of a curriculum in medical education is to address problems that affect the health of the public.

Kern DE, Thomas PA, Howard DM, Bass EB. *Curriculum Development for Medical Education: A Six-Step Approach.*

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

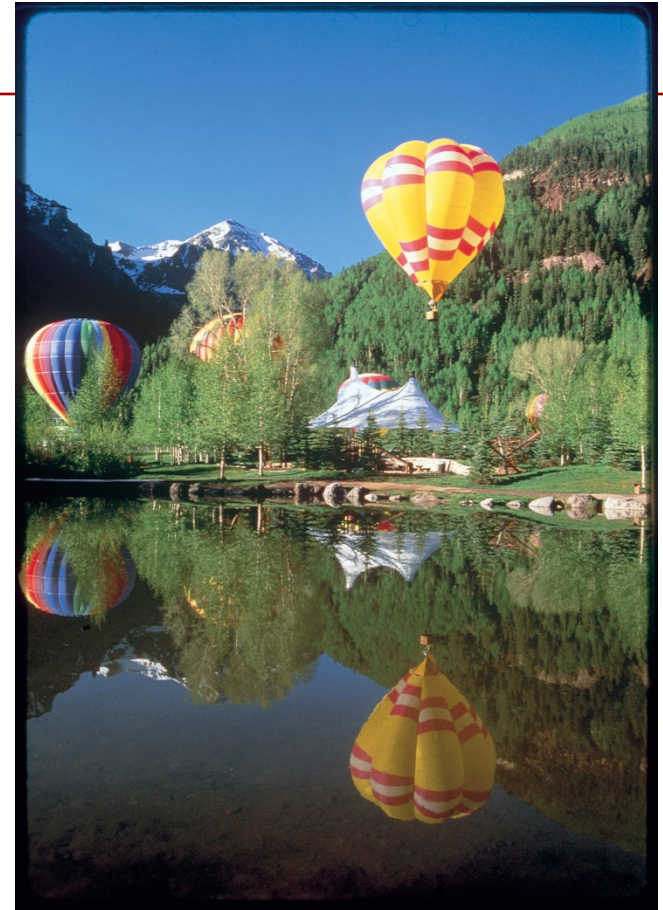
Decisions had to be made on:

- 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

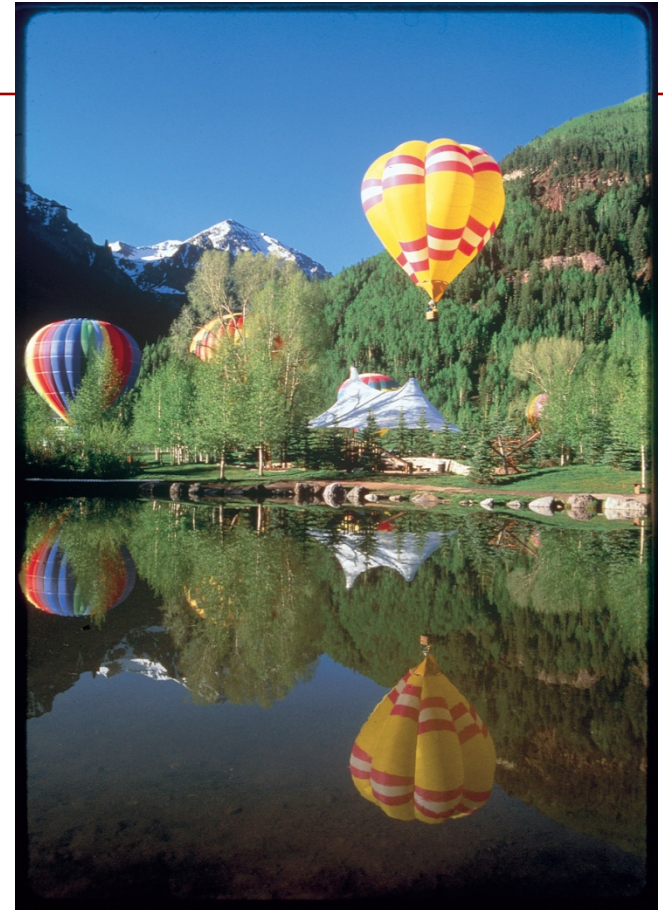


Sixth Annual Roundtable on:
***“Open and Honest
Communication Skills in
Healthcare”***

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

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DOI: 10.1080/10401330802574090

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

UIC Patient Safety Education

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

UIC Patient Safety Education

28

CHICAGO TRIBUNE • SECTION 1 • SUNDAY, AUGUST 19, 2007

Story so poignant med classes weep

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.

"This is a rare film that pulls at the heart and enters the soul, yet also calmly lays out a set of well-reasoned suggestions that flow individuals and institutions to respond to what they have seen, heard and felt."

- Michael L. Millenson
Health Care Consultant and Author
*Demanding Medical Excellence:
Doctors and Accountability in the Information Age*



The Faces of Medical Error...From Tears to Transparency: The Story of Lewis Blackman is the first in a series of educational videos that will address two important issues in health care today - prevention of medical errors and the need for a comprehensive, caring, and compassionate response when care has caused harm.

Lewis entered the hospital to have what was believed to be a low risk surgical procedure. Due to a number of avoidable tragic events over the course of his hospital stay, the outcome was much different than expected. *The Story of Lewis Blackman* is his family's commitment to see beyond their loss and give back to the health care community so we, as caregivers, can find ways to fix our systems and prevent similar harm from occurring to others.

Educational Program Includes:

- Full Length Feature Film (Runtime 57 minutes)
- Educational Support Materials
- Reference Materials
- National Quality Forum Safe Practices Applied to Lewis' Story

With an introduction by:



Dr. Lucian Leape
Harvard School of Public Health

Produced by:

Solid Line
Media

www.solidlinemedia.com

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TRANSPARENT HEALTH

THE FACES OF MEDICAL ERROR...
from tears to transparency

www.transparent-health.com

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The Faces of Medical Error... From Tears to Transparency: The Story of Lewis Blackman



TRANSPARENT HEALTH

THE FACES OF MEDICAL ERROR...
from tears to transparency

• THE STORY OF LEWIS BLACKMAN •



The Faces of Medical Error...*from tears to transparency.*
The Story of Lewis Blackman
www.transparentlearning.com

GIBSON
AND
SINGH

"A call to arms for families who have had loved ones disabled or die in the pursuit of medical treatment." —Former First Lady Rosalynn Carter

WALL OF SILENCE

THE UNTOLD STORY OF THE
MEDICAL MISTAKES THAT KILL AND
INJURE MILLIONS OF AMERICANS

LifeLine
Press



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



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



2008...Non-principled approach

CHICAGO HOSPITAL NEWS

OCT, 2008

LEGAL HEALTH UPDATE

It Is a Mistake to Admit a Mistake

An admission is a detrimental statement of a party to a lawsuit that is introduced in evidence against that party during the trial of a lawsuit by that party's opponent.¹ In *Asher v. Stronberg*,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



BY JOHN M. STALMACK

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.³ The theory behind this mea culpa movement is that the physician's admission of a mistake immediately after making that mistake will avoid a future lawsuit.⁴ In my opin-

ion 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.

John M. Stalmack, partner with the Chicago law firm of Bollinger, Ruberry & Carvey, can be reached at (312) 456-7248 or john.stalmack@brg-law.net.

1. *Litson v. Gulf, Mobil & Ohio Railroad Co.*, 42 Ill. 2d 193, 296 N.E.2d 269 (1969).

2. 70 Ill. App. 2d 267, 227 N.E.2d 303 (1st Dist. 1966).

3. Kevin Seck, *Doctors Say "I'm Sorry" Before "See You in Court"*, *The New York Times* (May 18, 2005).

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

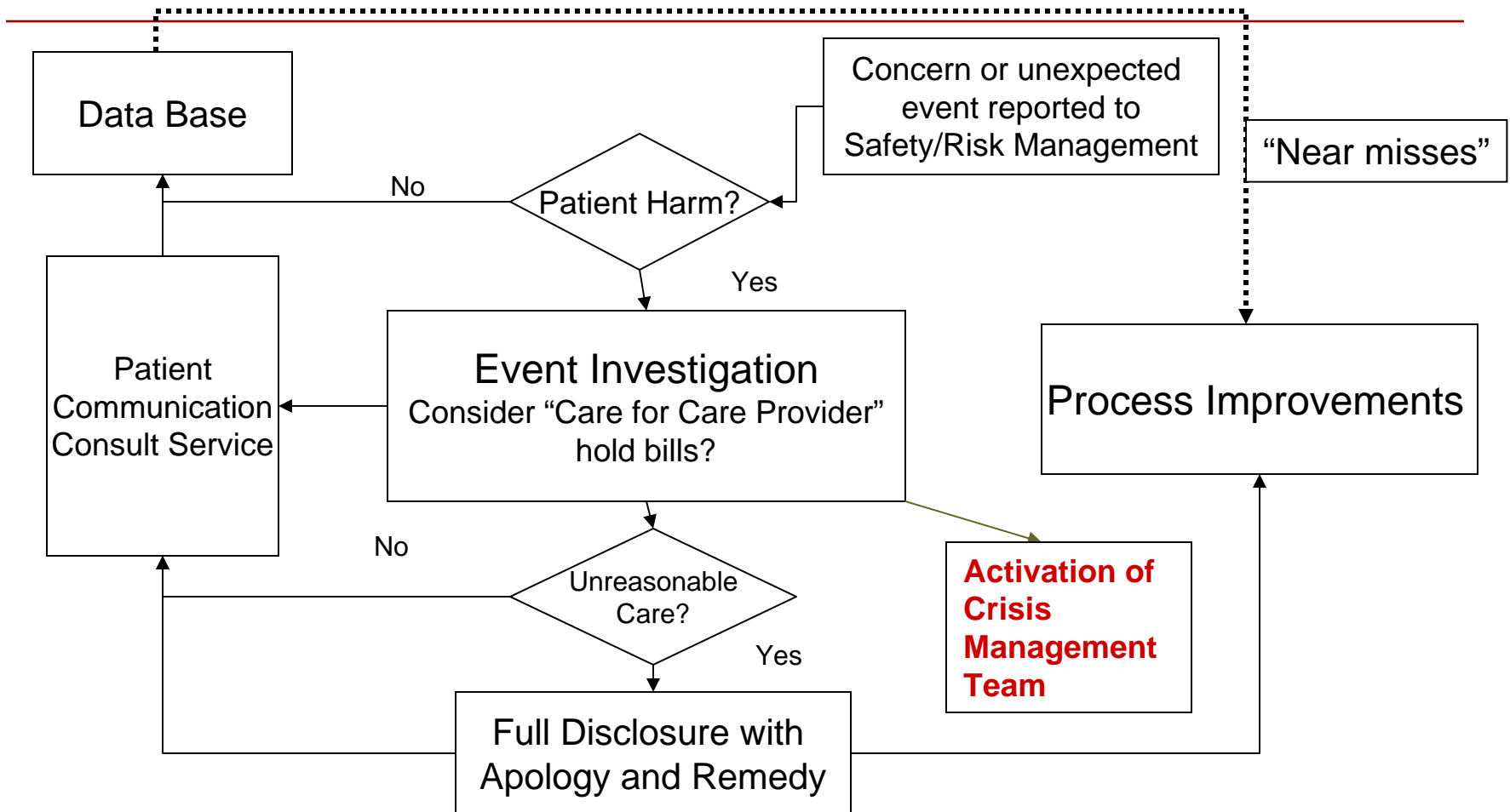
Downloaded from qshc.bmj.com on March 8, 2010 - Published by group.bmj.com

QHC Online First, published on 1 March 2010 as 10.1136/qshc.2008.031633

Responding to patient safety incidents: the “seven pillars”

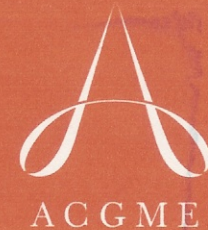
T B McDonald,^{1,2} L A Helmchen,^{3,4} K M Smith,^{1,2} N Centomani,⁵ A Gunderson,¹
D Mayer,^{1,2} W H Chamberlin⁵

The “Principled Approach” to Adverse Patient Events



Change and Improvement in the Learning Environment | May 2008

ACGME Bulletin



Acc

“Full Disclosure” and Residency Education

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

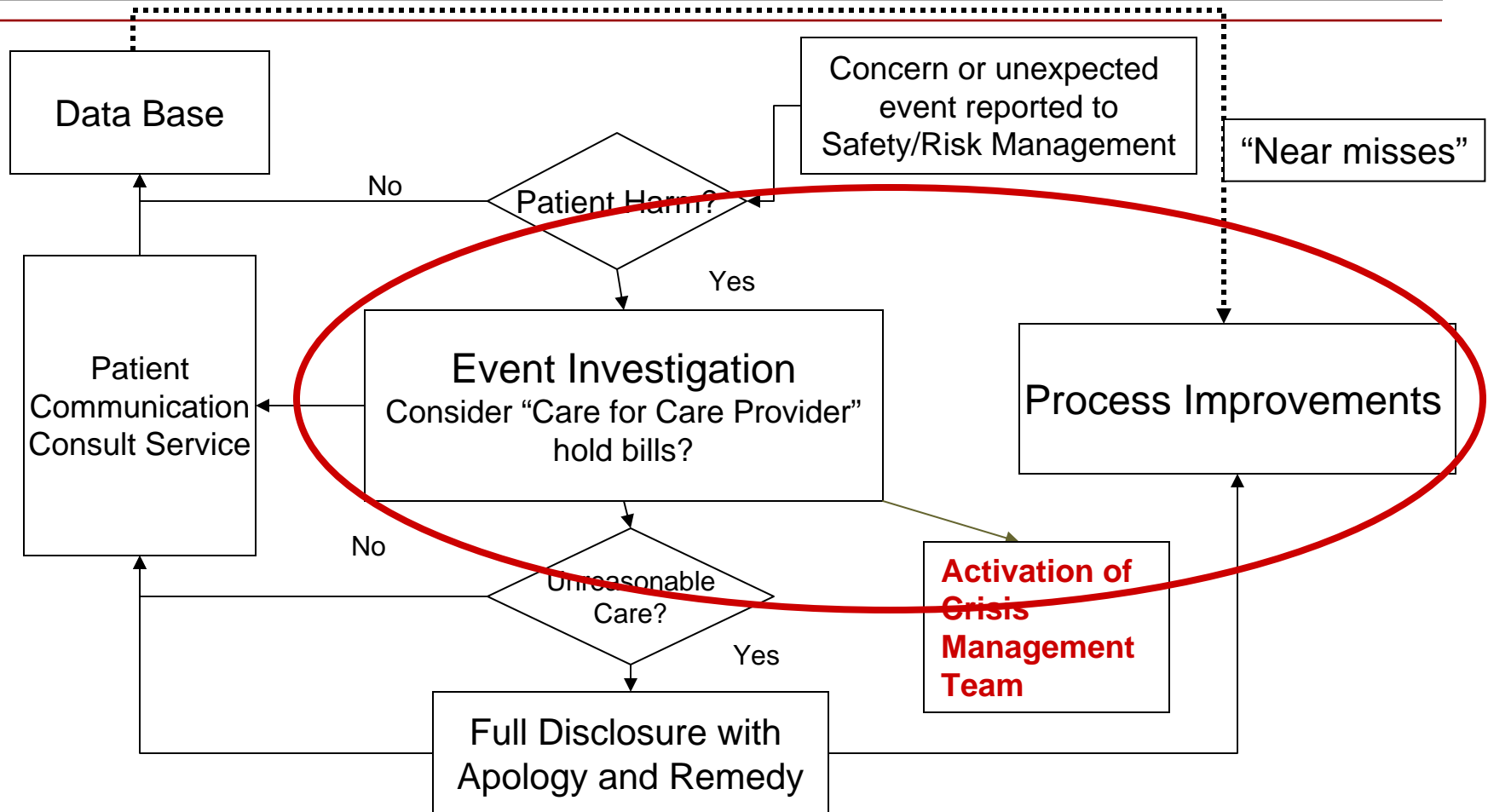
*Timothy McDonald, MD, JD, Kelly M. Smith, PhD and
David Mayer, MD*

May, 2008

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

BARBARA G. JERICO, MD
ROSALIE F. TASSONE, MD, MPH
NIKKI M. CENTOMANI, RN, BSN
JENNIFER CLARY, BA
CRESCENT TURNER, RN, MS
MICHAEL SIKORA, MD
DAVID MAYER, MD
TIMOTHY McDONALD, MD, JD

The “Principled Approach” to Adverse Patient Events



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

August 23, 2009



THE WALL STREET JOURNAL.

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Hospitals Own Up to Errors

Some Find That Confronting Mistakes Reduces Litigation—and Future Mishaps

Retained instruments: a 'never' event



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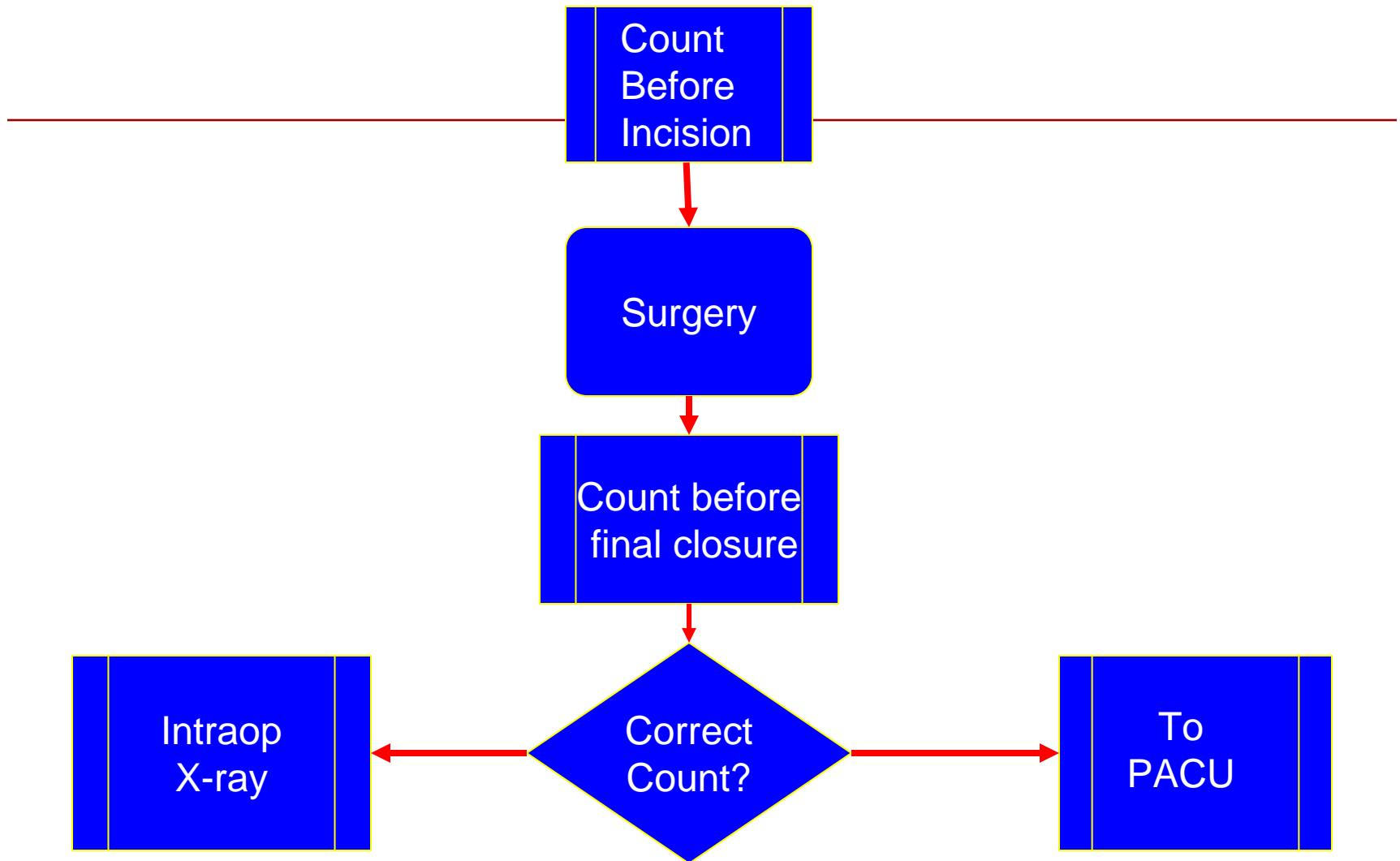


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Scope of the Problem

- 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”

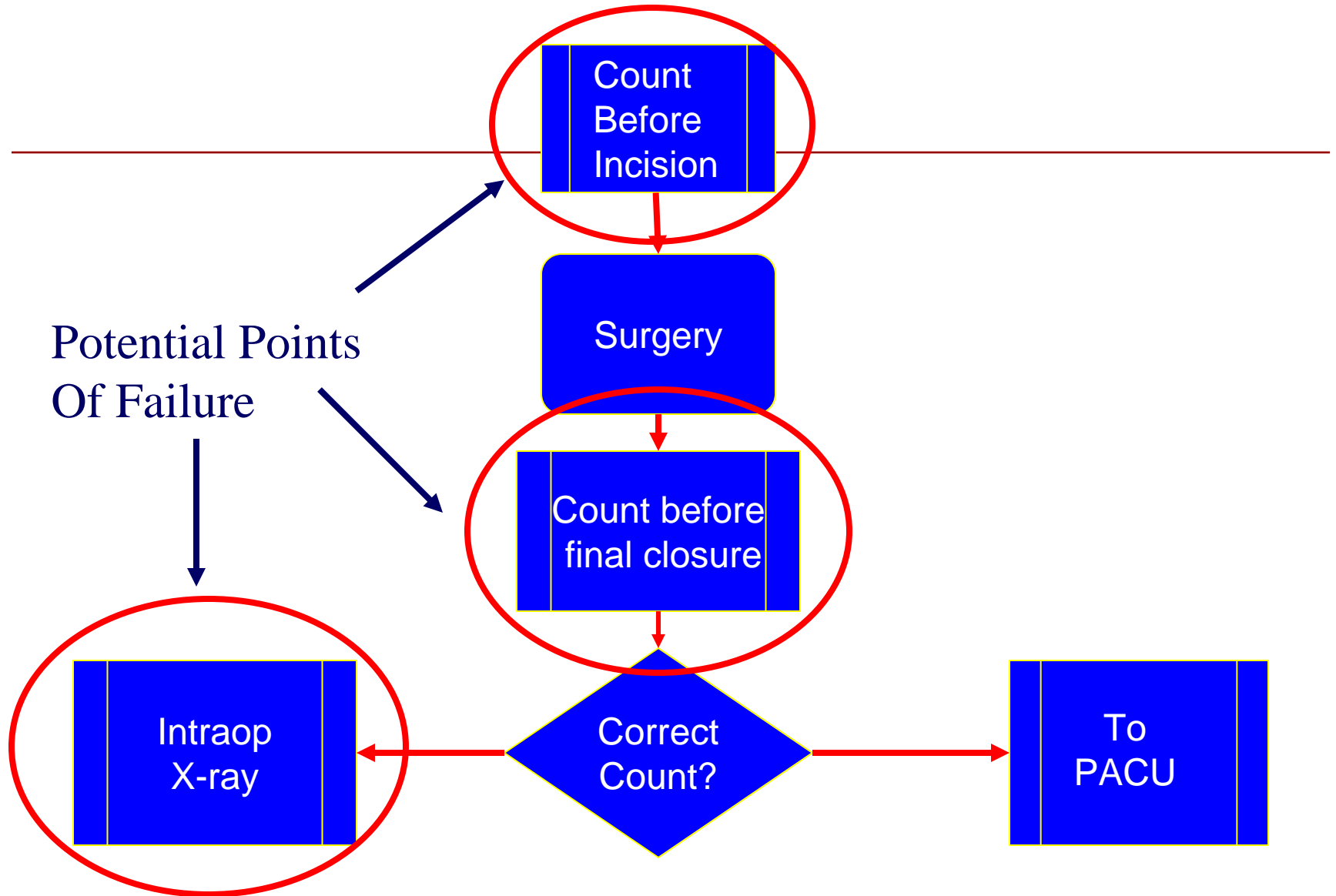
A standard process for intraop instrument/sponge management



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 ect)

Standard process for instrument/sponge management



“Evidenced-based” medicine and retained objects



The NEW ENGLAND
JOURNAL of MEDICINE

Risk Factors for Retained Instruments and Sponges after Surgery

*Atul A. Gawande, M.D., M.P.H., David M. Studdert, LL.B., Sc.D., M.P.H., E. John Orav,
Ph.D., Troyen A. Brennan, M.D., J.D., M.P.H., and Michael J. Zinner, M.D.*

ABSTRACT

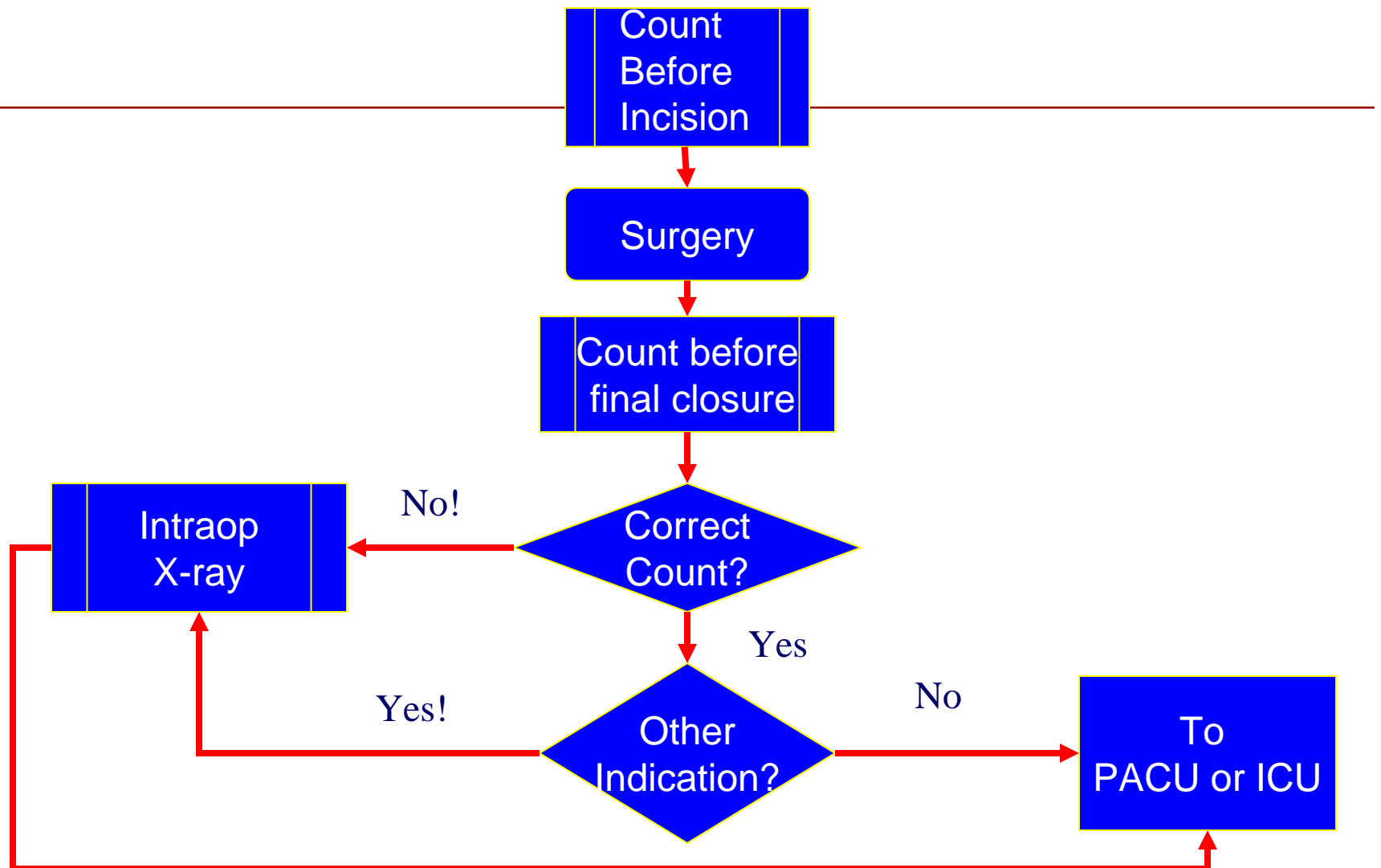
Risk factors for retained objects

- 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



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

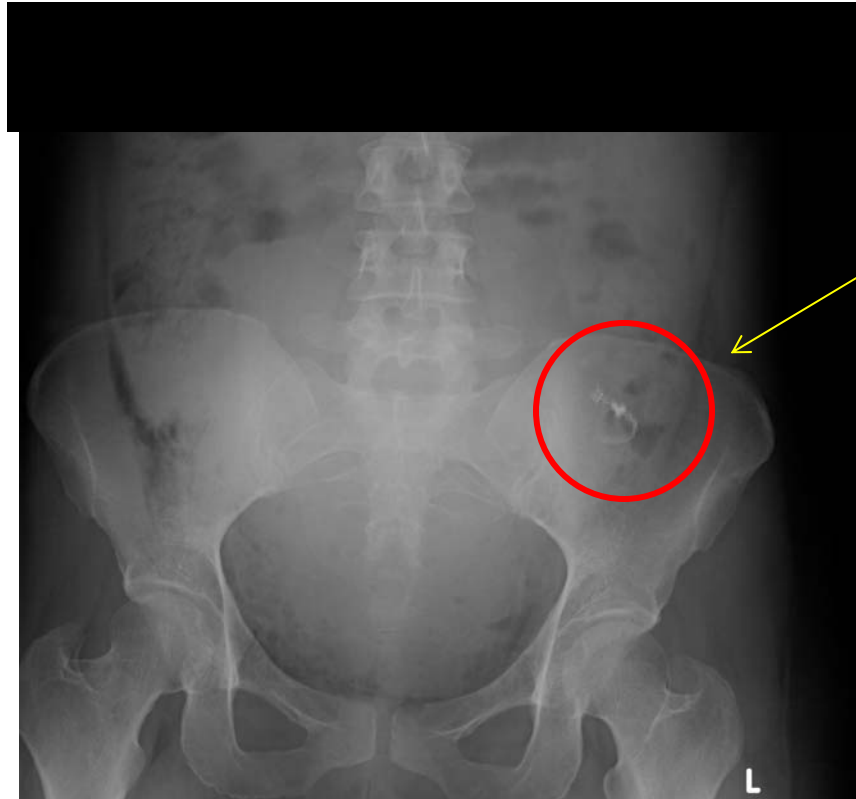
A “near-miss” in OB

- 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

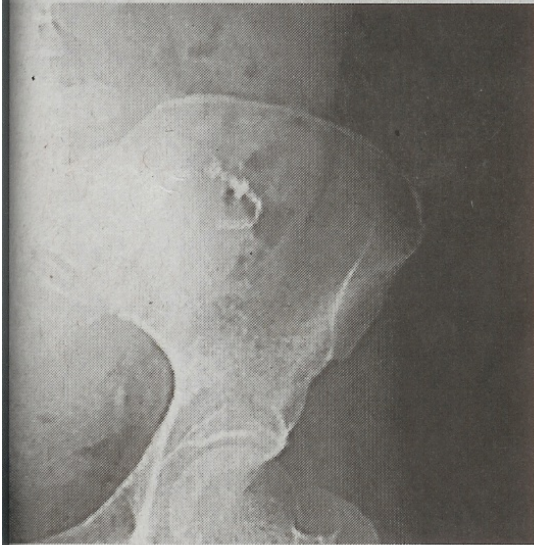


Gratified Patient

THE NEW YORK TIMES **NATIONAL** SUNDAY, MAY 18, 2008

□Y

ng to Say 'I'm Sorry' Long Before 'I'll See You in Court'



UNIVERSITY OF ILLINOIS MEDICAL CENTER



CARLOS JAVIER ORTIZ FOR THE NEW YORK TIMES

that a second operation required to retrieve the recognized the error had been accidental. She rejected his advice to call a lawyer that she did not want and that her injuries were that severe.

Ms. Valdez said she was satisfied that the hospital had acknowledged its mistake and that it had covered the cost of the procedure without charge and that it had provided procedures for tracking the location of the electrodes. "It was the time to explain it to me that they were sorry," she said. "I felt good that they were taking care of what they had done."

There also has been a gradual shift among plaintiffs' lawyers who recognize that



THANK
YOU!