Being Open with Patients and Families about Adverse Events

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Removing Insult from Injury
Case

65 year old woman transferred from Cardiac Intensive Care where she had been admitted for Acute Myocardial Infarction and Congestive Heart Failure
Rapidly progressive increasing dyspnea

Cardiac team returns, administers 100% $O_2$ via face mask

Cardiology fellow calls for 2 mg Morphine Sulfate “IV Push”
Or, directs Medical Student to “Push this”

Medical Student administers 10 mg of intravenous Morphine Sulfate
Respiratory Rates slows from 32 to 2
Respiratory rate slows from 32 to 2

Patient intubated

Returns to Cardiac Intensive Care
“I don’t think anyone else really needs to know about this”
Special Communication

Do House Officers Learn From Their Mistakes?

Albert W. Wu, MD, MPH; Susan Folkman, PhD; Stephen J. McPhee, MD; Bernard Lo, MD

The most fruitful lesson is the conquest of one's own error. Whoever refuses to admit error may be a great scholar but he is not a great learner. Whoever is ashamed of error will struggle against recognizing and admitting it, which means that he struggles against his greatest inward gain.

Goethe, Maxims and Reflections

Mistakes are inevitable in medicine. To learn how medical mistakes relate to subsequent changes in practice, we surveyed 254 internal medicine house officers. One hundred fourteen house officers (45%) completed an anonymous questionnaire describing their most significant mistake and their response to it. Mistakes included errors in diagnosis (33%), prescribing (29%), evaluation (21%), and communication (5%) and procedural complications (11%). Patients

Only 54% of house officers discussed the mistake with their attending and only 24% told the patients or families.

constructive changes in practice. Residents were less likely to make constructive changes if they attributed the mistake to job overload. They were more likely to report defensive changes if they felt the institution was judgmental. Decreasing the work load and closer supervision may help prevent mistakes. To promote learning, faculty should encourage house officers to accept responsibility and to discuss their mistakes.

(JAMA. 1991;265:2089-2094)
MEDICAL ERROR DISCLOSURE

Philosophy
The Johns Hopkins Hospital (JHH) strives for safety in patient care, teaching, and research.

Policy
- All health care professionals have an obligation to report medical errors as a means to improve patient care delivery and to help promote safety and quality in patient care.
- Since the majority of medical errors can be linked to environmental and systems-related issues that may affect the actions of health professionals, a systems improvement focus will be used in all error analysis.
- **Prompt reporting of a medical error in good faith will not result in punitive action** by the hospital against the involved individuals except as mandated by law or regulatory requirements. The principles concerning non-punitive reporting do not eliminate the hospital’s obligations to conduct ongoing and periodic performance review, where repeated errors or other issues may lead to personnel action.
- **It is the right of the patient to receive information about clinically relevant medical errors.** The JHH has an obligation to disclose information regarding these errors to the patient in a prompt, clear and honest manner. This is consistent with The Johns Hopkins Hospital Code of Ethics.

Definition
Medical Error: An act or omission with potential or actual negative consequences for a patient that, based on standard of care, is considered to be an incorrect course of action.
If you know how to do something, your threshold to do it goes down.

“Why didn’t you tell the patient?”

“I didn’t know what to say.”

If you don’t know how, you’ll avoid it.
Barriers to Disclosing

- Shame
- Ignorance
- Fear

A particularly distressing aspect is deciding whether and how to disclose the error to the patient or family.
Serious Adverse Events Have More than One Victim

- Ability to deal with patients can be impaired
- Caregivers need care too
- Denial may be harmful
Medical error: the second victim

The doctor who makes the mistake needs help too

When I was a house officer another resident failed to identify the electrocardiographic signs of the pericardial tamponade that would rush the patient to the operating room late that night. The news spread rapidly, the case tried repeatedly before an incredulous jury of peers, who returned a summary judgment of incompetence. I was dismayed by the lack of sympathy and wondered secretly if I could have made the same mistake—and, like the hapless resident, become the second victim of the error.

Improvements that could decrease errors. Many errors are built into existing routines and devices, setting up the unwitting physician and patient for disaster. And, although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims.

Virtually every practitioner knows the sickening realisation of making a bad mistake. You feel singled out and exposed—seized by the instinct to see if anyone has noticed. You agonise about what to do, whether to
A patient’s response to injury

- Fear, anxiety, depression, anger, isolation
- Humiliated, powerless, betrayed
- Failure to disclose adds insult to injury
A Golden Hour for Disclosure

- A preventable injury is also an injury to the patient’s trust, and to the relationship
- Every day that goes by without effective communication adds harm to the patient and family
Patient Centered Care

- Versus Physician-centered care
- Physicians often only communicate what they think others need to know
- Patient needs are clinical, emotional, informational
Disclosure is part of an ongoing dialog between patient and physician

- Who? The patient’s doctor
- When? In real time
- Where? Allow privacy
- What? As much as you know
What to Say?

- Treat it as an instance of ‘breaking bad news’
What to Say?

- Begin by stating you regret to say that there has been an adverse event
- Describe the course of events, using non-technical language
What to Say, cont...

- State the nature of the mistake, consequences and corrective action
- Express personal regret and apologize
- Elicit questions or concerns and address them
- Plan the next step and next contact
What NOT to Say

- “This happened for the best”
- “It’s God’s will”
- “At least you have another child”
- “This has never happened to me before”
The Apology

“*I’m sorry*” ≠ “*I am guilty*”

- Make an appropriate apology

- In the case of system failure or no obvious fault
  - “*I am so sorry that this happened*”

- In the case of personal responsibility
  - “*I am sorry that I did this*”
Almost Always Accept Responsibility

- Wrong patient
- Wrong procedure
- Wrong side or site
- Wrong drug or dose
- Wrong route
- Wrong administrative practice

Wu 2009
Medical Contrition
Doctors’ New Tool To Fight Lawsuits: Saying ‘I’m Sorry’
Malpractice Insurers Find Owning Up to Errors Soothes Patient Anger

“I found out he was a real person,” Ms. Kenney says. “He made an effort to seek me out and say he was sorry I suffered.” Moved by the doctor’s contrition, Ms. Kenney dropped her plans to sue.
Is Disclosure the Best Defense?

- Studdert, Health Affairs
- Lexington VA
- University of Michigan
- Johns Hopkins
Lexington VA 1997 – 2000
Financial Consequences
Workload
University of Michigan

- Modeled after Lexington – 2003
- Claims and suits down from 265 (2002) to 120 (2005) - Now at a 10-year low
- Average litigation and attorney fees down from $65,000 to $30,000/case*. 
- Time to completion from 1160 to 300 d
- Indemnity reserves $72 to $20 million

*$3.2 million/yr to < $1.5 million/year
East Baltimore Survey (N=200)

- Patient *perceptions* of what is said (full apology and acceptance of responsibility) more important than what is actually said.

Wu JGIM 2009
Taking Responsibility

- Responsibility for the error can be accepted on behalf of the health care team / institution as appropriate
- Others should not be personally named, blamed or criticized
Managing your own emotions

Avoid

- Anger
  Patient so angry – difficult to deal with
- Defensiveness
- Detachment
Vignette: Slow Response to Urgent Pages

- Timothy Brown is a one-year-old admitted to rule out intestinal obstruction
- Mother has remained at Timothy’s bedside
- On hospital day 2, the nurse notes a decrease in blood pressure and increased heart rate
- Nurse pages the attending surgeon Dr. Matthews 3 times but he does not come to check
• Dr. Matthews returns the third page but says “not to worry about it”
• An hour later Timothy codes, is resuscitated and rushed to emergency surgery
• An x-ray revealed free-air below the diaphragm
• Ms. Brown is in the waiting room expecting news of her son
- Trust?
- Refer?
- Sue?
Do Over
Disclosure

- Required component of quality care
- Central to the hospital mission
- Part of the doctor patient relationship
- Based on common sense expectations
- Should be done well
- Can be taught
- Plan but don’t script
Disclosure Not the Solution

- No matter how good the return policy, better products are better
- Good disclosure at best still bad outcome
- Good disclosure, bad follow through?
- Too narrowly focused
Being Open much better than ‘disclosure’
IOM - Patient Safety
Achieving New Standards of Care

All hospitals should establish comprehensive patient safety programs operated by trained personnel within a culture of safety.

Should invite the participation of patients and their families and be responsive to their inquiries.
Comprehensive

- Governance and leadership set expectations and culture
- Establish a policy & process
- Consistent message
- Treat disclosers fairly
- Training and supportive system
- Disclose to patients
- Learn from errors

Wu 2009
University of Illinois at Chicago’s
Comprehensive Approach to Adverse Patient Events

- Unexpected Event reported to Safety/Risk Management
- Patient Harm?
  - Yes
    - Consider “Second Victim” Error Investigation
    - hold bills?
    - Yes
      - Full Disclosure with Rapid Apology and Remedy
    - No
    - Preventable?
      - Yes
        - Process Improvement
      - No
        - Activation of Crisis Management Team

- “Near misses”
- Data Base
- Patient Communication Consult Service
Training and Education

- Risk Management seminars
- Orientation for house officers
  - Surgery + anesthesia + nursing
- Medical student education
- Patient safety grand rounds
- Patient safety courses
- Patient safety as scholarship
Closing the Loop

- All patients injured in the past year
- Disclosures
- Outcomes
  - Satisfaction
- Follow-up
- Measure improvement
Changing Culture

- Without information you can’t be just;
- Without facts you can’t create openness,
- Without personal example people won’t get it
The Agency for Healthcare Research and Quality
Josie's Story
A Mother's Inspiring Crusade to Make Medical Care Safe
Sorrel King

Includes a Resource Guide for Patients, Families, and Health Care Providers
For information on obtaining the video, go to:

www.jhsph.edu/removinginsultfrominjury