RESPONDING TO ADVERSE EVENTS
RECENT DEVELOPMENTS AND NEW DIRECTIONS

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Objective

- List best practices for communicating with patients and families after adverse events
Michelle Malizzo-Ballog

-Timothy McDonald and AHRQ Medical Liability Communication and Optimal Resolution Project (CANDOR)
Story of Michelle Malizzo Ballog

• 39 year old presents for endoscopic GI procedure under heavy moderate sedation
  o Had failed stent placement two weeks prior due to discomfort despite large amounts of narcotics.
  o Repeat scheduled for 1 pm with anesthesia present
  o GI physician delayed. Arrives at 4pm, at which point anesthesia not available for elective case
  o Twice the dose of fentanyl, midazolam used

• Standard monitors for HR, BP, O2 Sat used
• Dark room, patient on side, unable to auscultate
• Physician asks monitoring nurse to get different stent. Nurse leaves room
Story of Michelle Malizzo Ballog

- Upon return, patient found to be in respiratory distress
- Code called
- No response to reversal agents
- Team assumes allergic reaction to medication as etiology of arrest
- Michelle resuscitated but brain dead
Why we do this – a safety moment
Following Harm: Not Always Transparent, Not Always Learning

Health Affairs

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Survey Shows That At Least Some Physicians Are Not Always Open Or Honest With Patients

Lisa I. Iezzoni1,4, Sowmya R. Rao2, Catherine M. DesRoches3, Christine Vogeli4 and Eric C. Campbell5

Relationship of Errors and Adverse Events

Medical Errors

Potential AEs

Adverse Events (complications)

Near Misses

Preventable AEs

Non-preventable AEs
“Listen up, my fine people, and I'll sing you a song 'bout a brave neurosurgeon who done something wrong.”
Quality of Actual Disclosures?

- COPIC’s 3Rs: Disclosure and Compensation Program
- 2007 – 2009
  - 837 events
  - 445 patient surveys
  - 705 physician surveys
Quality of Disclosure
CAN A SINCERE "I'M SORRY" MAKE UP FOR MEDICAL MALPRACTICE?

During her operation, Celia Barbour's surgeon made an almost fatal error, one with long-term consequences on her health. He apologized for it profusely—should that be enough?

So now I've got a clot, just like I did the first day I walked into Dr. P's office. My right arm often gets achy and swollen when I use it, because the clot blocks the blood from draining effectively. In addition, my upper arm is numb because nerves were cut during surgery. The scars in my chest wall hurt when I take a deep breath. A surgery to remove this clot isn't an option, I've been told, so I inject myself with blood thinners each night, which leaves my stomach mottled with bruises. I face the possibility of lifelong damage from the blood thinners, and who knows what from the blood transfusions. And I have less money in the bank to cover it all.

-Michelle Mello
## Benefits of CRP Response

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<tr>
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<th>Traditional Response</th>
<th>CRP Response</th>
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<tr>
<td>Incident reporting by</td>
<td>Delayed, often absent</td>
<td>Immediate</td>
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<td>clinicians</td>
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<td>Communication with</td>
<td>Deny/defend</td>
<td>Transparent, ongoing</td>
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<td>patient, family</td>
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<tr>
<td>Event analysis</td>
<td>Physician, nurse are root cause</td>
<td>Focus on Just Culture, system, human factors</td>
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<td>Quality improvement</td>
<td>Provider training</td>
<td>Drive value through system solutions, disseminated learning</td>
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<td>Financial resolution</td>
<td>Only if family prevails on a malpractice claim</td>
<td>Proactively address patient/family needs</td>
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<td>Care for the caregivers</td>
<td>None</td>
<td>Offered immediately</td>
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<td>Patient, family</td>
<td>Little to none</td>
<td>Extensive and ongoing</td>
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<td>involvement</td>
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Benefits of CRP

- Preserve trust and meet expectations of patients and families
- Reduce distress of clinicians
- Reduce likelihood of litigation
- Promote learning within and across institutions
- Strengthen institutional culture/climate
- Lower likelihood of disciplinary action by regulators
- Increase public trust in healthcare

There’s no easy way I can tell you this – so I’m sending you to somebody who can…
Communication after unexpected harm
Rationale for Communicating Following Harmful Events

- Extension of informed consent
- Error disclosure as truth telling
- Supports a learning environment
- Regulatory requirements
  - Joint Commission, hospital policy, State laws
- Need to meet patient expectations
- Reduction in legal liability
Real and Imagined Barriers to Disclosure

• Fear of litigation
• Misunderstanding of patient preferences
  o Does not know/would not want to know
  o It would harm patient to know
• Low confidence in communication skills
• Mixed messages from institution
• Specialty-specific challenges
  ▪ Radiology, pathology, birth injury, delayed diagnosis
• Shame/embarrassment
Case Study

• An internist at your hospital admitted a patient yesterday afternoon with a chronic obstructive pulmonary disease exacerbation. The doctor wrote the patient’s admitting orders while she was in a hurry to get home for the evening. The sloppily written “10U” order for 10 units of insulin was read by the nurse as 100 units of insulin, 10 times the patient’s normal dose. The patient received 100 units of insulin last night and was found three hours later unresponsive with a blood sugar of 35. The patient was successfully resuscitated and transferred to the intensive care unit. This morning he is feeling well and is transferred back to the floor.
Video Debrief
Disclosure 101

• Patients need –
  o Truthful, accurate information
  o Emotional support, including apology
  o Follow-up, potentially compensation

• Health care workers need
  o Communication coaching
  o Emotional support

• Process, not an event
  o Initial conversation
  o Event analysis
  o Follow up conversation
Communication – Skillset and Art

Form

- Certain principles are essential to effective communication conversations
- Content is not enough – genuine empathy, caring, and concern are essential; active listening is also essential
  - And patients can tell if you’re faking it!
- Few feel prepared for these conversations
  - 9 percent of physicians had training
  - 87 percent indicated a desire for training
Key Disclosure Planning Skills

- Most common failure – lack of planning
- Solicit team members’ views
- Plan roles for discussion
- Advocate for full disclosure
- Anticipate patient questions
- Avoid jargon, blame
Preparation: Advice for Clinicians

• Get help!!!
  o Most failed disclosures caused by lack of preparation
• Attend to the patient’s medical needs
• Have initial discussion within a few hours of the event
• Who will be in the room?
  o Clinicians with prior relationship (not coach)
  o Make sure everyone is emotionally capable
  o Careful planning around roles during discussion
• Attending usually leads the conversation
Emotion Handling – What Does the Provider Feel?

• Fear
• Self-doubt
• Disappointment
• Shame
What Does the Patient Want?

Empathy

• They want to be heard. They won’t listen until they are heard. Clear the emotion first.

Curiosity

• What skill accomplishes that?
• Reflective listening is not intuitive – Why?
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…”
- “I know how you feel”
- Quote from surgeon: "I know, I know for you this is unpleasant, awful...but believe me. For me, it's shattering."
“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.
  o “The lab always does this…”
• Be careful of apologies that include “buts”
  o “I’m sorry, but if the nurse had only called me…”
Additional Tips

- Be yourself – it is possible to be too careful in choosing your words
- Periods of silence are ok
- Families need to hear a plausible story that makes sense, even when facts are incomplete
- Anticipate potential reactions: quiet anger, loud anger, sarcasm
- Be prepared not to be forgiven
Follow-up Conversations

- Many organizations do reasonable initial disclosure but fall down on followup
- Second discussion usually required
  - Present results of event analysis
  - Discuss prevention plans
  - Respond to patient questions
  - Address compensation
- Minimize time between initial and followup discussions
Relationship Between Errors and Adverse Events

WHAT DO PATIENTS WANT: communication following all adverse harm events

Medical Errors

Potential AEs

Near Misses

Adverse Events (complications)

Non-preventable AEs

Preventable AEs
Should You Disclose? Why?

• A patient receives Lasix 20 mg twice daily for 2 days rather than once daily as prescribed. They experience increased urination but no other problems.

• A patient recently was diagnosed with breast cancer. The radiologist reviewing this year’s film notes a worrisome lesion was present last year but not identified.
Late Medication

• You are a nurse taking care of a 22-year old female with severe cellulitis, after starting your shift a few hours ago.

• At sign-out you were told that the her first dose of vancomycin had arrived from the pharmacy and was ready to be given. But then you got involved with a new patient, and you just gave it, 6 hours later. The patient didn’t say anything about the delay in treatment and seems to be doing fine.

  o Would you say anything about the late medication? If so, what would you say?
Afib case

• An 83-year-old longstanding patient of mine presented to clinic complaining of palpitations a few days ago. I wasn’t available, and neither was her regular cardiologist, so she was seen by a covering cardiologist.

• An electrocardiogram showed atrial fibrillation, presumed to be new, and the patient was scheduled for electrical cardioversion the following day without prior anticoagulation. The cardioversion was successful, and she went home feeling well. Eighteen hours after arriving home, the patient experienced a massive embolic stroke and was taken to a hospital, where she died.
Afib case continued…

• The patient’s spouse wrote me a letter, informing me of her death and thanking me for providing many years of excellent health care. The letter prompted me to review the old chart, where I found, as I suspected, an episode of atrial fibrillation documented by me 10 years previously in a progress note, but not in the problem list. Had the covering physician known about this episode, he may have anticoagulated the patient before cardioversion and avoided the stroke.

• What should I do? How should the institution handle this information?
Abnormal PAP

• I'm in clinic today, and I am about to see a 32-year-old woman in follow-up for an abnormal PAP result. Two weeks ago at her annual visit I performed a PAP smear and ordered an HPV test, which returned High grade dysplasia with a positive HPV. Before entering the room, I was skimming her record, and saw the result from the PAP smear I ordered at her routine visit last year, which was also abnormal. I don't know how this happened, but I am sure I never saw this result.

• Should I mention this result from last year when I see her now? If so, what should I say about it?
Fatal complication

• A 19-year-old presents to the emergency department with signs of meningitis and septic shock. The patient is intubated, receives a central line, and is resuscitated with fluid and pressors. Once stable on pressors, he is transported for a head computed tomography. The CT was completed, but moments after moving him back to the stretcher, he became hypotensive. Resuscitation is attempted, but he never responds and the code was called. As the team was preparing to take him back to the ED, they realized that his central venous line had become disconnected in the bed sheets and that none of his infusions or resuscitation meds had been administered. His CT scan showed massive cerebral edema and impending lethal tentorial herniation.
A patient was admitted to a community hospital’s rehab unit after a complex surgical procedure. The patient’s condition deteriorated, and the hospital elected to transfer the patient to their ICU. The patient’s condition continued to decline, and he was transferred to a larger hospital’s ICU where he subsequently died. The larger hospital sought an external expert’s review, which came back 3 months later and faulted the physician at the initial hospital for delayed recognition of the patient’s declining condition and transferring the patient too late. The larger hospital would like to disclose this information to the patient’s family.
The Way Forward

Goal: By 2022, High Functioning CRPs in Place at All Healthcare Organizations

- Incentives for high-functioning institutional CRP in Operation
  - CRP Institutional Certification
  - CRP Event Certification

- Tools to measure, improve CRP
  - CRP event certification
  - CRP metrics

- Best Practices Identified and Disseminated
  - National trainings
  - Institutional support
  - Case consultation

- Shared Learning Communities

- Trained CRP Workforce in Place
  - CRP Professional Certification

- Supportive State and Federal Policies

- National trainings
- Institutional support