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

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Patient Safety and Reducing Your Risk for Malpractice

Introductions

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  - Professor, Anesthesiology and Pediatrics
  - Chief Safety and Risk Officer for Health Affairs, UIC
  - Co-Executive Director, Institute for Patient Safety Excellence
- David Mayer, MD
  - Vice-chair Quality and Safety, Anesthesiology
  - Director, Cardiac Anesthesiology
  - Co-Executive Director, Institute for Patient Safety Excellence

Patient Safety

1. How do we make you safe physicians while lowering your risk of malpractice?
2. How do we protect our patients?

Institute of Medicine Report: "*To Err is Human: Building a Safer Health System*"

- 98,000 patients die each year from preventable medical errors

The non-principled approach when things went wrong circa 2000

- 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 when things went wrong circa 2000

- 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

Institute of Medicine Report: "*To Err is Human: Building a Safer Health System*"

- How should we talk to patients and their families when an error occurs?
- How should we talk to each other when an error occurs?

What about an Extremely Honest "Principled Approach"?

- Barriers
- Benefits

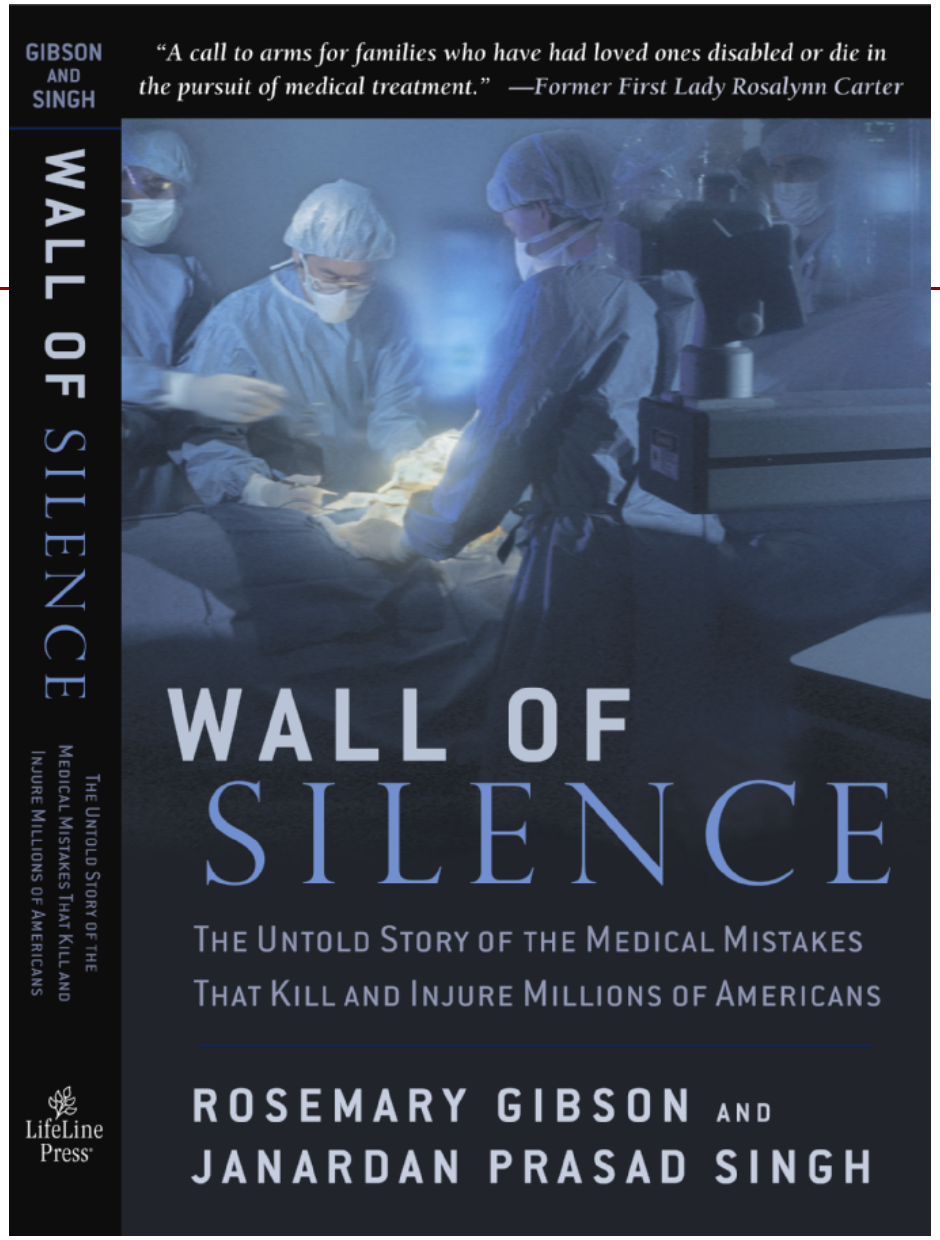
Taking a “Principled Approach”

- Barriers
  - Lack of skill
  - Reputation
  - “Shame and blame”
  - Loss of control
  - Loss of license
  - Resource intense
  - Skills uncertainty
  - Fear of lawyers, litigation
  - Non-standard process
  - Bad advice from lawyers
- Benefits
  - Maintain trust
  - Learn from mistakes
  - Improve patient safety
  - Employee morale
  - Psychological well-being
  - Accountability
  - Money
  - Less litigation

Condition Predicate to the “Principled Approach”

Condition Predicate to a “Principled Approach”

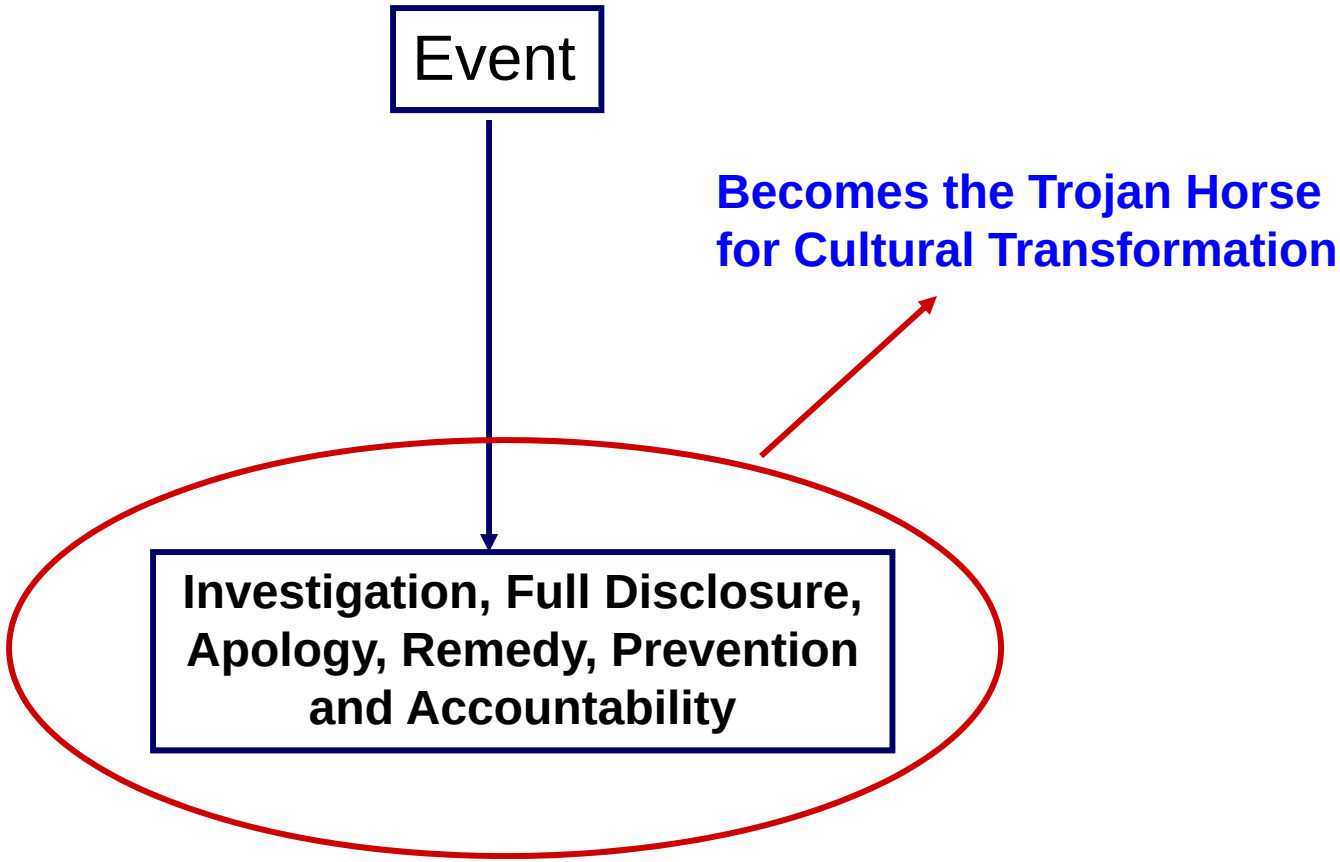
- Courage…… and Leadership


GIBSON AND SINGH
WALL OF SILENCE
The Untold Story of the Medical Mistakes That Kill and Injure Millions of Americans
LifeLine Press
"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
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



Implementing a principled approach to adverse patient events

Decide upon and adopt “full disclosure” principles

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

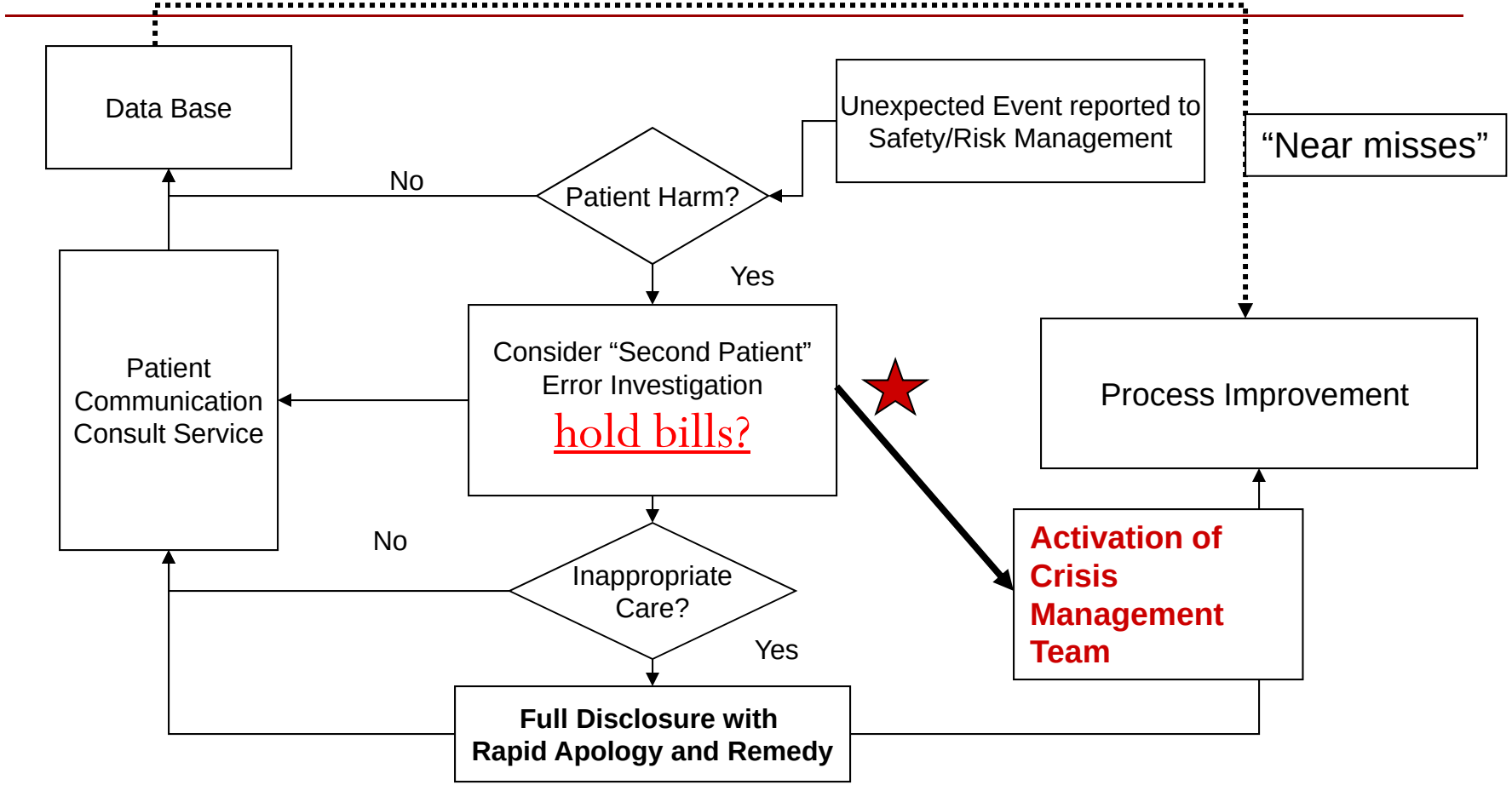
Credit to Rick Boothman, CRO, University of Michigan

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

Responding to patient safety incidents: the "seven pillars"

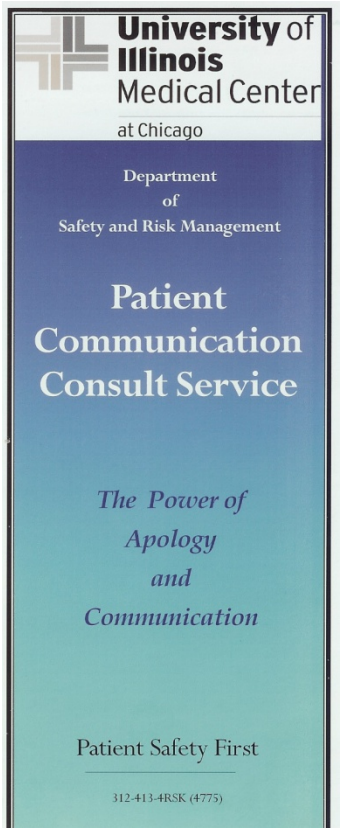
T B McDonald,[1,2] L A Helmchen,[3,4] K M Smith,[1,2] N Centomani,[5] A Gunderson,[1] D Mayer,[1,2] W H Chamberlin[5]

Establish a Comprehensive Approach to Adverse Patient Events



The Patient Communication Consult Service

- PCCS
- Available 24/7
- **All unexpected adverse events with patient harm**
- Just-in-time training from **well-trained** experienced communicators
- Absolutely necessary when tragedy strikes
- Major role for SPs



Patient Safety

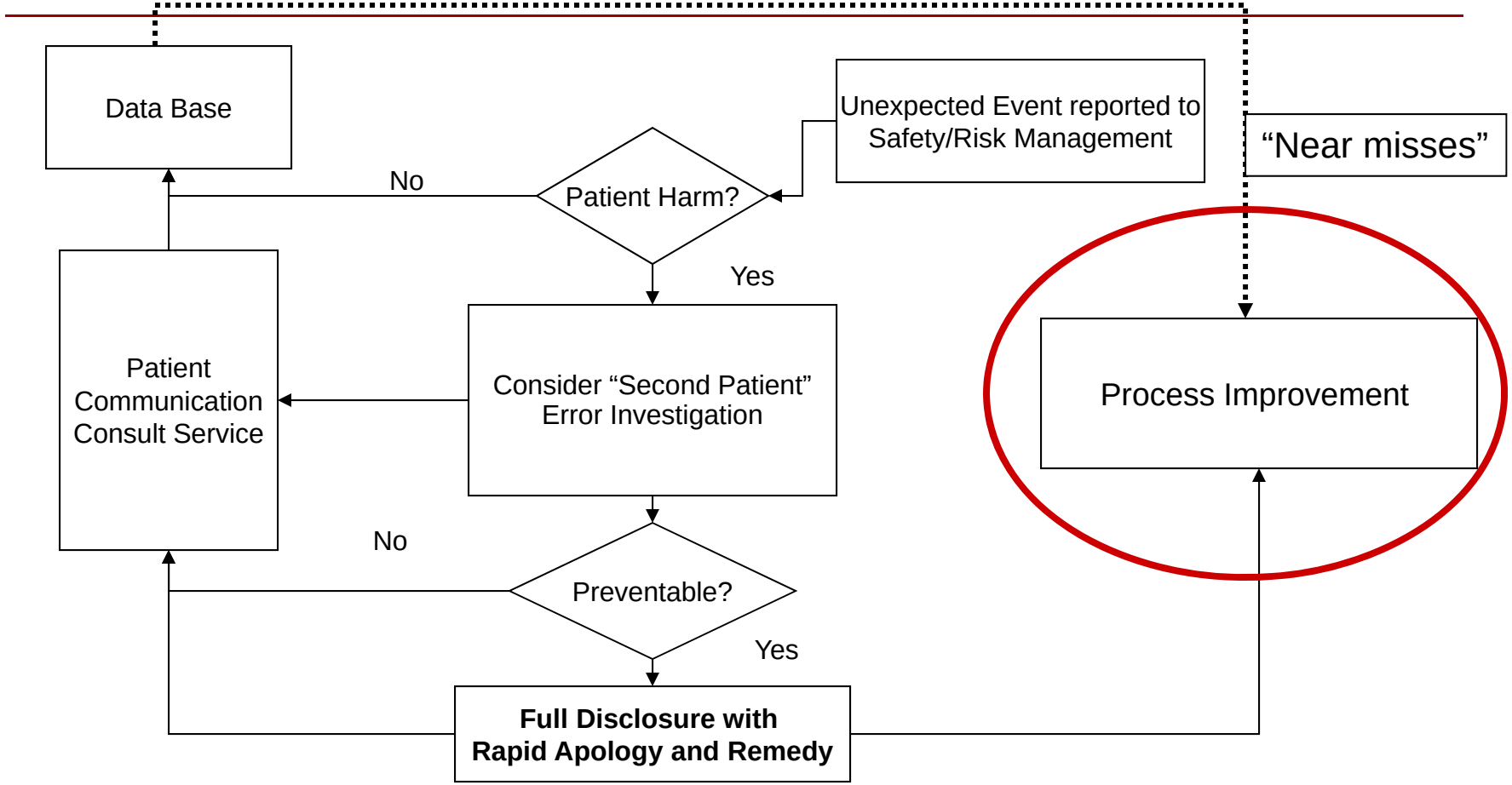
MEDiC Act of 2005

Association of perceived medical errors with resident distress and empathy: a prospective longitudinal study

- West et al. *JAMA*. 2006 296(6): 1071-8.

"Self-perceived medical errors are common among I.M. residents and are associated with substantial personal distress. Personal distress and decreased empathy are associated with increased odds of future errors…reciprocal cycle."

The University of Illinois
Comprehensive Approach to Adverse Patient Events



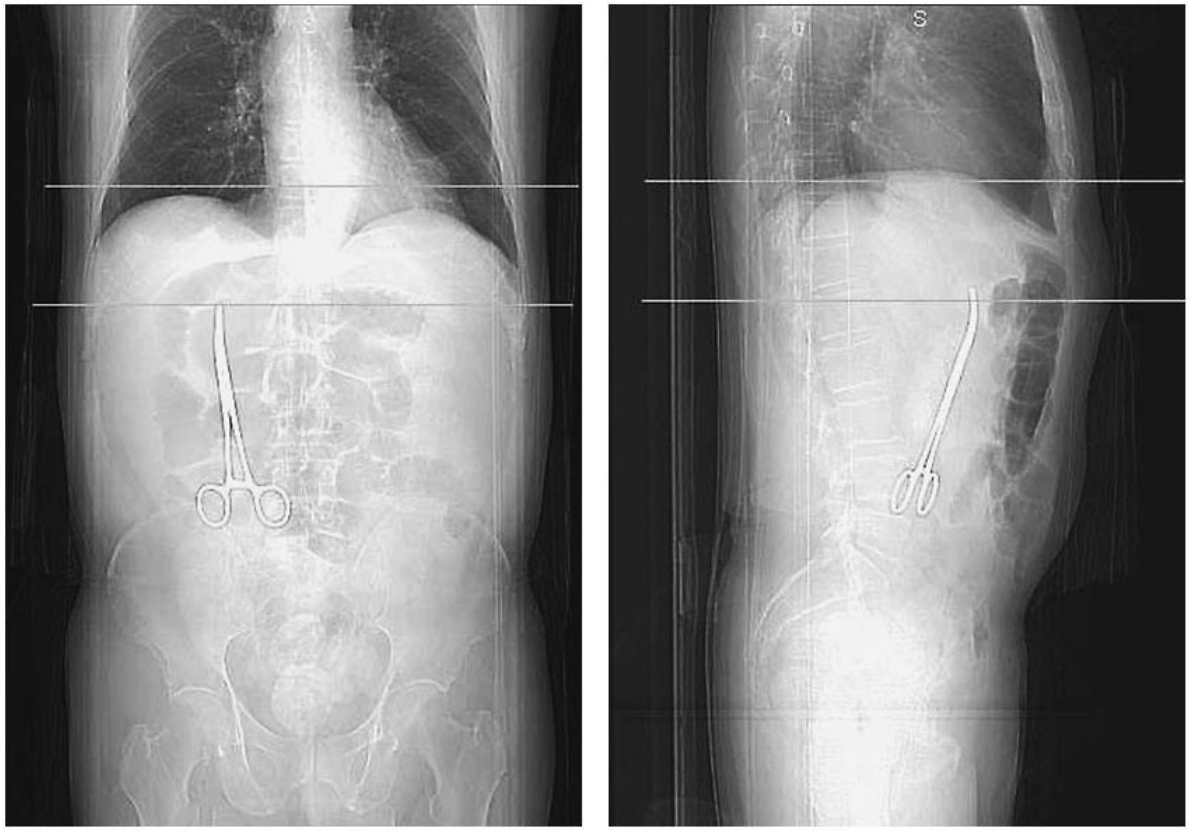
August 23, 2009

THE WALL STREET JOURNAL.
TUESDAY, AUGUST 25, 2009 - VOL. CCLIV NO. 47

Hospitals Own Up to Errors

Some Find That Confronting Mistakes Reduces Litigation—and Future Mishaps

Retained instruments: a ‘never’ event

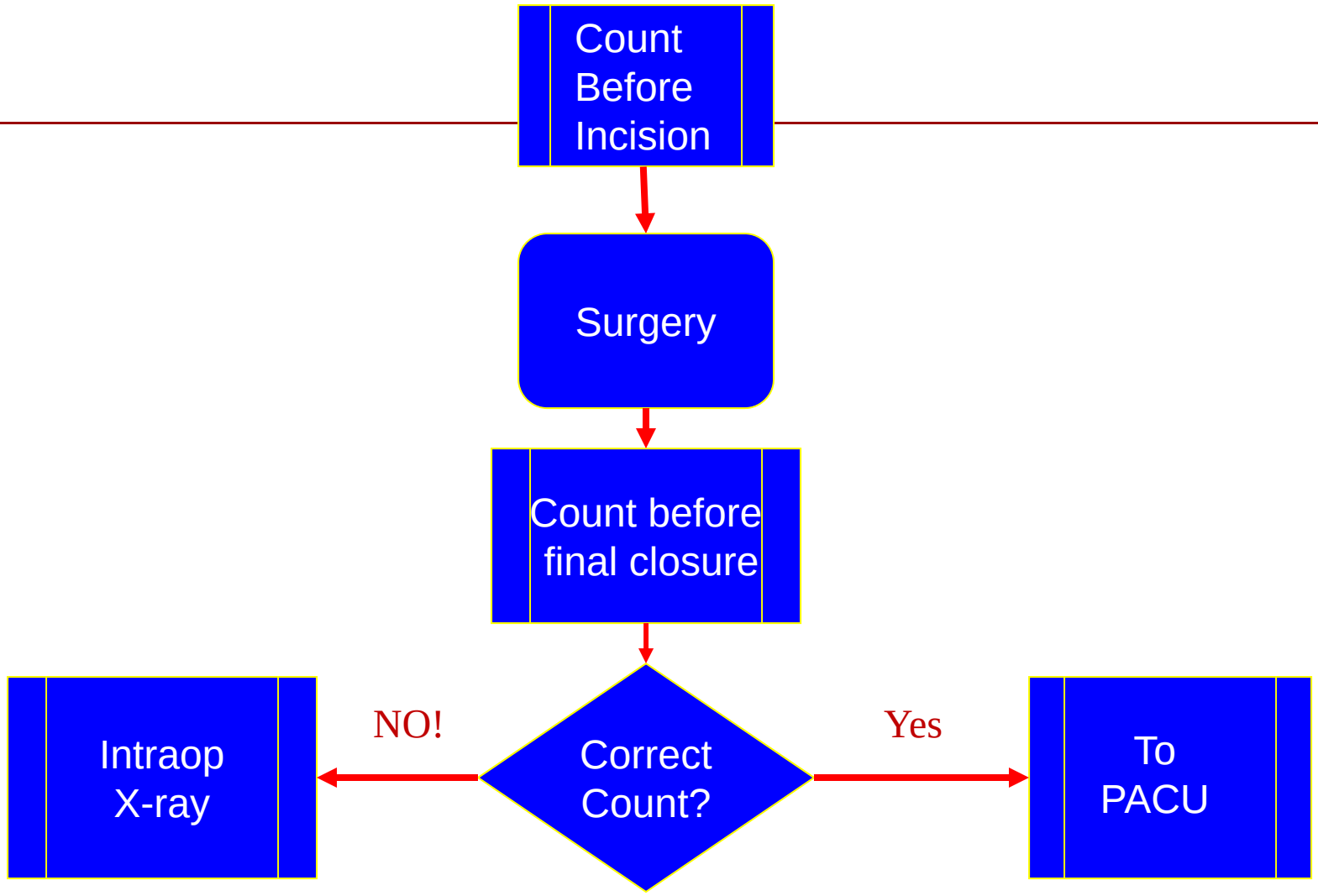


A B

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”

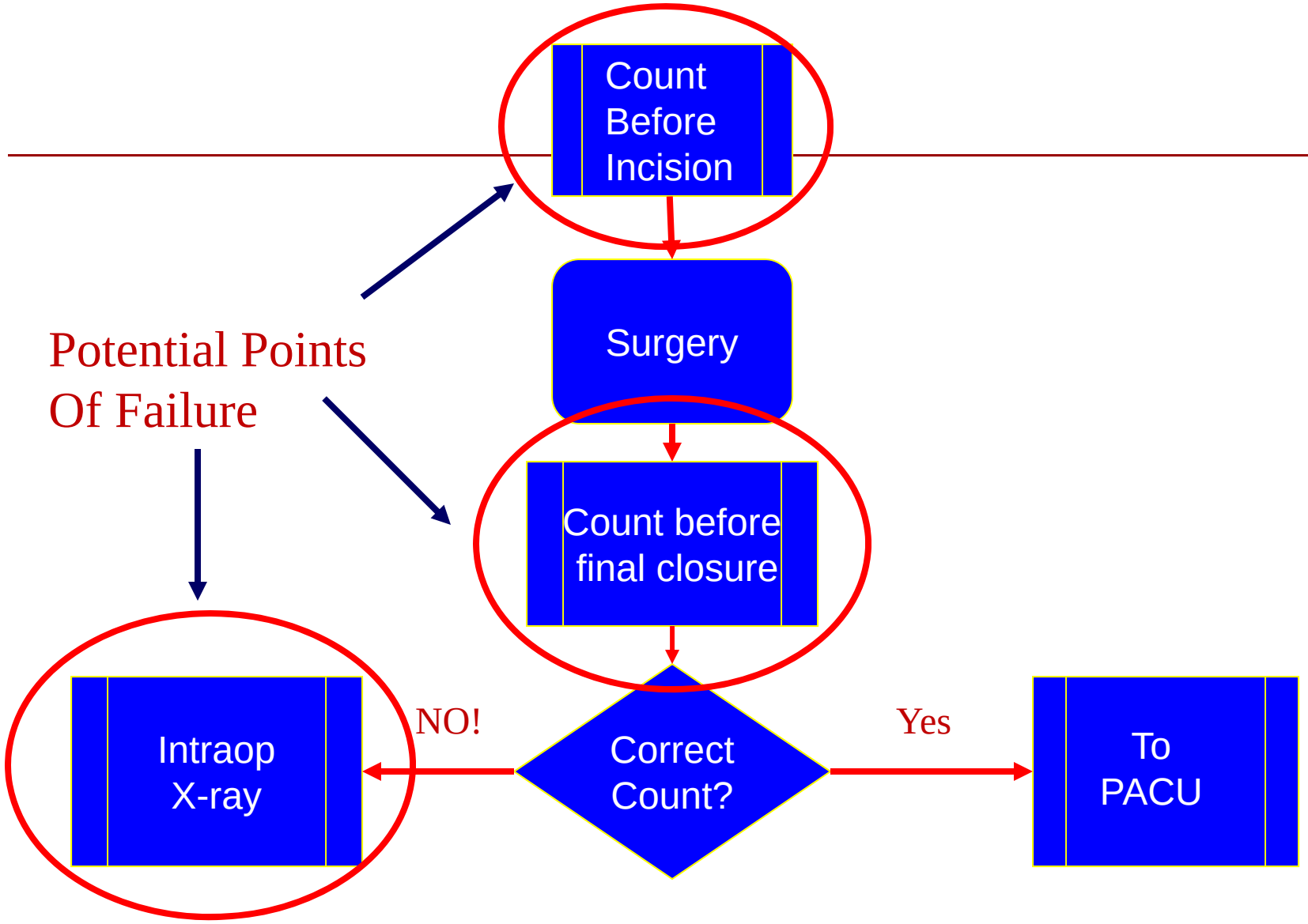
A standard process for intraop instrument/sponge management



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

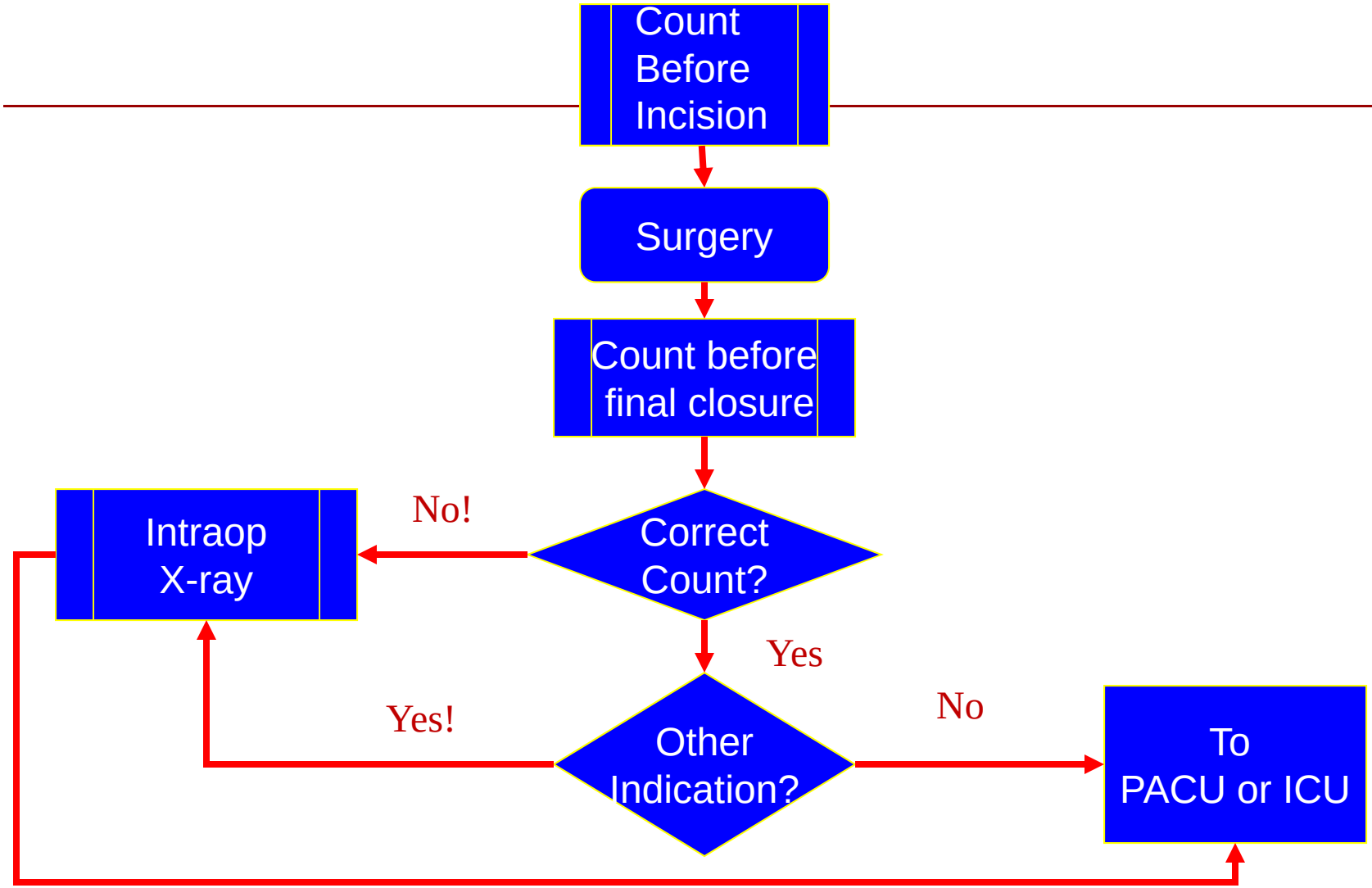
Risk factors for retained objects

- 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

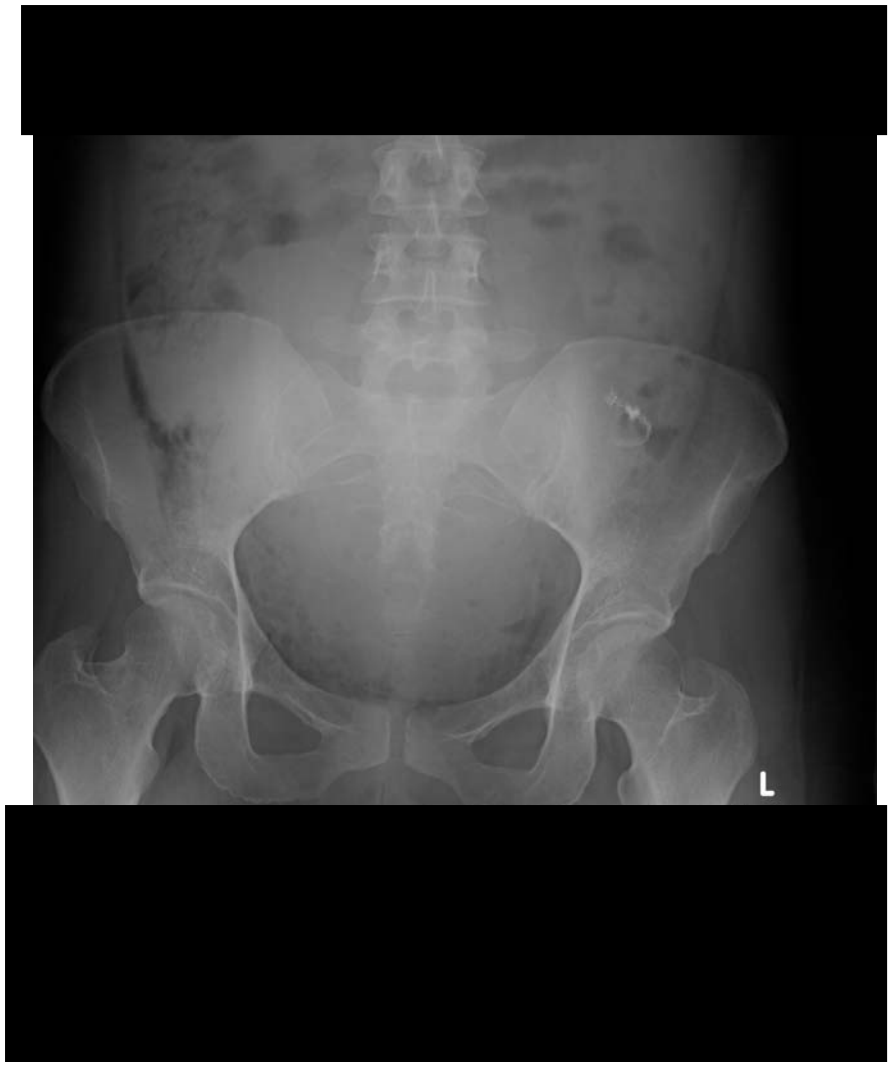


Lessons learned in past 40 months

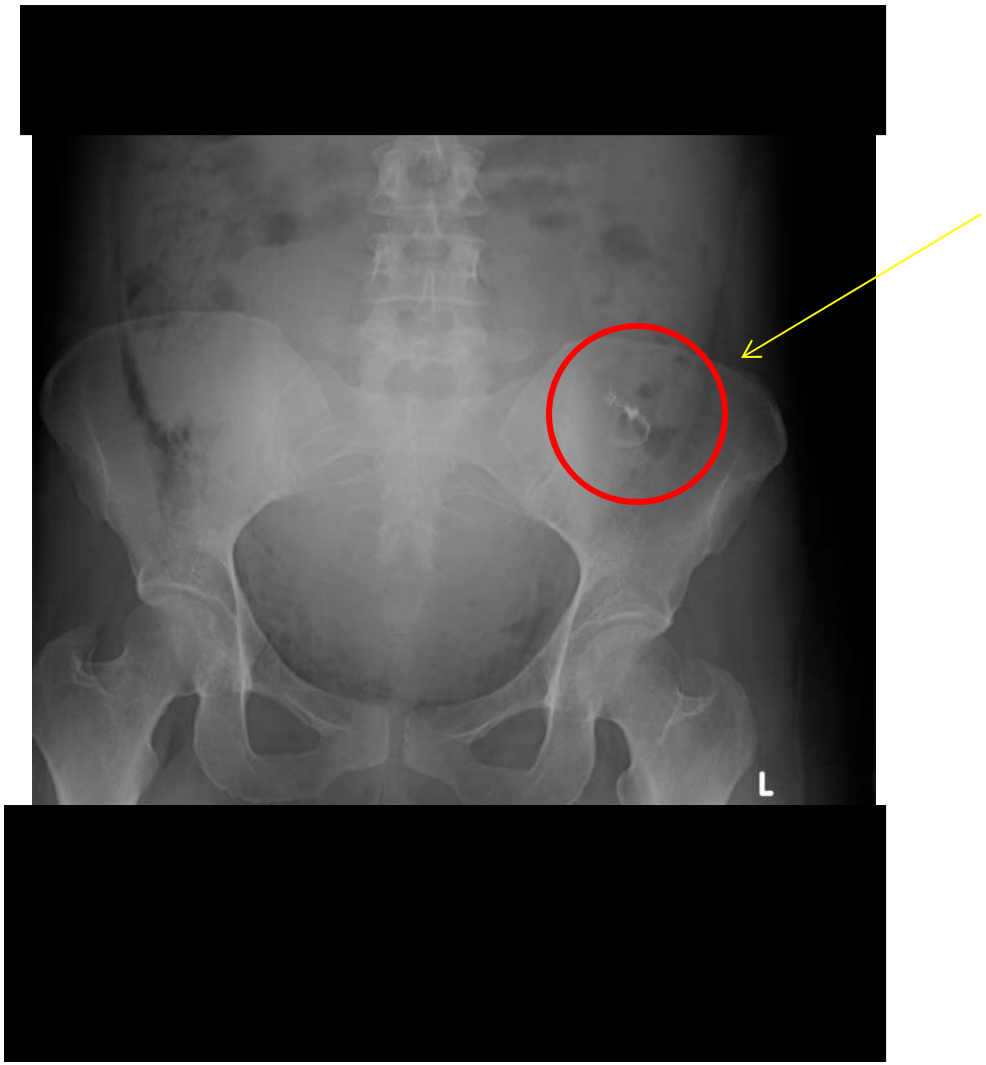
9 objects identified in “correct count” cases

- 2 neck case
- 1 OB case
- 1 ortho case
- 1 chest
- 4 abdominal cavity
- No claims since implementation

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 operatic
quired to retrieve the
recognized the error ha
cidental. She rejected h
advice to call a lawy
that she did not want
and that her injuries
that severe.

Ms. Valdez said she
ified that the hospital
knowledged its mistak
ed it without charge an
proved procedures fo
track of electrodes. "
the time to explain it
me they were sorry," s
felt good that they w
care of what they had d

There also has been a
nal shift among plain
yers who recognize th

Data to date

- > 300 patient communication consults
- > 75 full disclosures
- >110 process improvements
- Numerous rapid early offers with settlement
- One case in litigation over amount
- No financial Armageddon
- $6,000,000 premium reduction in 2010
- Cultural transformation
  - Nursing vacancy rate < 2%