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

Patient Safety and Reducing Your Risk for Malpractice
Introductions

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

ROSEMARY GIBSON AND JANARDAN PRASAD 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
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
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
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
Establish a Comprehensive Approach to Adverse Patient Events

Data Base

Unexpected Event reported to Safety/Risk Management

“Near misses”

Patient Harm?

Consider “Second Patient” Error Investigation

hold bills?

Inappropriate Care?

Patient Communication Consult Service

Yes

Process Improvement

No

Full Disclosure with Rapid Apology and Remedy

Yes

Activation of Crisis Management Team

No
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


“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

Data Base

Patient Communication Consult Service

Patient Harm?

Consider “Second Patient” Error Investigation

Preventable?

Full Disclosure with Rapid Apology and Remedy

Unexpected Event reported to Safety/Risk Management

“Near misses”

Process Improvement
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

1. Count before Incision
2. Surgery
3. Count before final closure
4. Correct Count?
   - NO! Intraop X-ray
   - YES 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?
   - Yes: To PACU
   - NO: Intraop X-ray
“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
   - Intraop X-ray
     - No!
     - Correct Count?
       - Yes
       - Other Indication?
         - Yes!
         - No
         - To PACU or ICU
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

Scalp electrode remnant
Gratified Patient

THE NEW YORK TIMES NATIONAL SUNDAY, MAY 18, 2008

Saying to Say ‘I’m Sorry’ Long Before ‘I’ll See You in Court’

that a second operation was required to retrieve the removed organ. Recognized the error had been accidental. She rejected the advice to call a lawyer, saying that she did not want to bring the issue to court. She said that her injuries were not that severe.

Ms. Valdez said she was gratified that the hospital acknowledged its mistake and resolved the issue without charge and improved procedures for tracking of electrodes. “They gave me the time to explain it to them and told me they were sorry,” she said. She felt good that they were taking care of what they had done.

There also has been a cultural shift among plaintiffs who recognize that a second operation was required to retrieve the removed organ. Recognized the error had been accidental. She rejected the advice to call a lawyer, saying that she did not want to bring the issue to court. She said that her injuries were not that severe.

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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%