The How and When of Communicating About Unexpected Outcomes and Errors

Office of Advanced Practice
and
The Center for Patient & Professional Advocacy
Case: Epileptic with SDH

- An patient with epilepsy presents for an elective procedure
- Procedure was completed without incident
- Anticonvulsant was not restarted post-procedure
- While showering, patient has a seizure and falls
- A subdural hematoma is now noted and the patient is transferred to the ICU
Case: Epileptic with SDH

- You are the ICU provider
- Tearful and anxious family members are waiting to obtain an update after patient’s transfer
- “What has happened to our Mom? Why wasn’t she getting her Dilantin?”

- How do you respond?
Why do we teach communicating about unexpected outcomes, errors?

Unnecessary variations exist in professionals’ responses post an unexpected outcome:
• Provide no information (or seem not to)
• Speculate prior to having the facts
• Families get different/conflicting info from team members
• Team “jousting”
• Conflicting info leads some patients to suspect... increase risk... even when no error

Professionals are willing to engage in all aspects of the job – tedious or otherwise – to the best of one’s ability.

Professionals commit to:

- *Technical and cognitive competence*
- *Clear and effective communication*
- *Being available*
- *Modeling respect*
- *Self-awareness*

Professionalism demands self- and group regulation.
• **Obvious error → obvious outcome**

• When there is uncertainty about:
  – Care provided by you or your team
  – Suspected error by a colleague

• **No error but patient/family believes so**

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Is there really a problem related to communications about unexpected pt outcomes & errors?

1. Absolutely
2. Yes
3. Uncertain
4. Probably not that big of a problem...
5. Not so much, except for a few people...
VUMC has a disclosure policy

1. True
2. False
3. Probably, but I don’t know what it is
4. I have no earthly idea
See OP 20-10.03 Disclosure of Unanticipated Outcomes

https://vanderbilt.policytech.com/dotNet/documents/?docid=3145&mode=view
Will “open disclosure” reduce litigation costs?
Vanderbilt Medical Malpractice Suits Per 100 Physicians
2000-2017

# Filed Lawsuits/100 Physicians

SVMIC

VUMC

00 02 04 06 08 10 12 14 16

2001

PARS®

2003

Claims Review

2005

MM&Is

2007

Allocation Rebates

2012

CORS™

Tort Reform in TN
2008 & 2011

VUMC Risk Prevention Initiatives

Confidential and privileged information under the provisions set forth in T.C.A. §§ 63-1-150 and 68-11-272; not be disclosed to unauthorized persons

Data sources: With permission of State Vol Mutual Insurance Company, mutual insurer of 10,500 non-VUMC TN physicians, all specialties, 29% to 33% who practiced in Middle TN during the target date; ASHRM/Aon Hospital and Physician Professional Liability. October 2012-2016.
Will “open disclosure” reduce litigation costs?

Probably.

But is this the right question anyway?
1. Apology (be precise); nature of error, harm
2. When, where error occurred
3. Causes, results of harm; actions taken to reduce gravity of harm; actions to reduce or prevent re-occurrence

What makes an apology effective?

Ineffective?
Apologies

- Sincere body language, tone of voice
- Follow through with anything promised
- Beware of:
  - The “sorry, but...” apology
  - The “sorry you feel...” apology
  - The “sorry for my sorry colleagues...” apology
  - Any apology with failure to follow through
  - Narcissistic apology (‘‘...this is so tough on me...’’)
- Pts may be more willing to forgive than family/ friends who doubt your sincerity
- Others?
Issues Looking Forward:

4. Who will manage ongoing care (you or someone else...pt’s choice)
5. Describe error review process, reports to regulatory agencies; how systems issues are identified
6. Provide contact info for ongoing communications
7. Offer counseling, support if needed
8. Address bills for additional care

• Do you know all the facts?
• Do you really want to handle this issue for the medical center?
• Do you have authority to make a promise?
• When in doubt, “You raised an important issue... I am not authorized, but will get review...for now, let’s focus on taking care of you/your loved one...”
• Other?
• Obvious error → obvious outcome

• When there is uncertainty about:
  – Care provided by you or your team
  – Suspected error by a colleague

• No error but patient/family believes so


In cases with **uncertainty**, until resolved:
Response Strategies Balance Beam

- No disclosure/ "safe" facts
- Fully disclose error right away
- Facts, limited disclosure, more later
- Disclose error, assign responsibility

A Case of Hematuria

• Mr. M, a 69 yo M, was about to go golfing when he told his spouse he had “the worst pain in my back I’ve ever had,” pointing to his left flank area.
• Mr. M had seen the NP at his PCP’s office two days prior with a similar, but less severe complaint.
• NP did a dipstick assessment, found blood in his urine, treated Mr. M for a urinary tract infection.
• Mr. M’s wife called, reported all this to their adult child, Terry.
A Case of Hematuria

- Terry advised them to call 911, get Dad to the ED.
- CT reveals a large left renal mass with expanding perinephric hematoma and evidence of acute, ongoing hemorrhage.
- Urologist was called to ED, assess, recommends Mr. M be transferred to angiography lab for rescue angiographic embolization.
- Urologist explains findings to patient and Terry... Mr. M says, “Fine, let’s go.” Terry says, “I have a quick question...”
A Case of Hematuria

• “How could Dad’s NP have treated this two days ago as nothing more than a urinary tract infection?”

• How would you recommend the urologist respond?
1. **Support NP, Reassure Pt**: “Renal tumors can bleed suddenly…I know the family practice…deliver good care…”

2. **Support NP, Some reassurance**: “…Mass unlikely related to previous pain.”

3. **Equivocate**: “don’t have records…so can’t comment.”

4. **Support Patient Inquiry**: “…the symptoms suggested need for testing, so you would want to know if testing was conducted and what was found…”

5. **Support Patient Concern**: “…if tests were done, would have caught, likely prevented”

How would you recommend the urologist respond?
Response Strategies Balance Beam

Support NP, Reassure Patient

Support NP, Some reassurance

Equivocate

Support Patient Inquiry

Support Patient Concern

1. **Support NP, Reassure Pt:** “Renal tumors can bleed suddenly ...practice delivers good care...”

2. **Support NP, Some reassurance:** “…Mass unlikely related to pain.”

3. **Equivocate:** “don’t have records...can’t comment.”

4. **Support inquiry:** “…symptoms suggest need to test... if testing conducted, need to know what was found...”

5. **Support concern:** “…if tests done, would have caught, likely prevented”
Many choose #3: “don’t have records, don’t know care provided, so cannot comment”

• So Terry responds, “Well, if I get Dad’s records from the family practice, would you agree to review them? I need to know for sure.”

• How would you respond?
  1. Agree to review
  2. Disagree
  3. Not sure, Maybe
  4. Something else
Would you agree to review records?

1. Agree to review  
2. Disagree  
3. Not sure, Maybe  
4. Something else
• Remainder of Mr. M’s 3-day hospital stay is uneventful. Now, on the day of discharge, you (NP) walk into Mr. M’s room.

• Terry is there. You greet them, sit, say discharge orders are being finalized, and you imagine Mr. M is eager to start proposed renal mass mgmt plan.

• All good, right?
But Terry is unconvinced, glares at you, flashes anger saying, “I am certain that if you had diagnosed the kidney mass earlier, the bleeding and ER trip could have been avoided.”
When a Pt/Family Reacts Angrily:

- Anticipate
- Avoid defensiveness (challenging)
- Consider possible sources of anger
- Acknowledge patient/family’s anger
- Use empathetic statements
- Avoid making excuses, blaming
- If the data are clear, stick to the message (kindly)
- If data are not clear cut, offer a referral for a second opinion, or suggest that a second opinion from another physician might be useful

When a Pt/Family Reacts Angrily:

• Use calm, soft voice
• If they make angry assertions with which you disagree, kindly but firmly tell them it is okay for you and them to disagree
• If apology is appropriate, make one; be specific
• If apology is not appropriate, avoid blaming others, the system, etc
• May have to call time out

When YOU get angry (at a patient, family member, someone who has jousted...):

- Feeling angry is okay. Being aggressive is different.
- Focus on breathing, focus on the task not the feeling
- Choose non-attacking words: word choice is important. Polite tone of voice and respectful body language convey as much information as words.
- Break the anger-causing issue into specific steps
- Be wary of/refrain from sending emails (limit to a draft, review later) and writing in the Medical Record
- May need to disengage to regain control
But Terry is unconvinced, glares at you saying, “I am certain that if you had diagnosed the kidney mass earlier, the bleeding and ER trip could have been avoided.”

You respond (kindly), “Terry, help me understand... how did you arrive at this conclusion?”

Terry: “One of Dad’s golfing buddies is a physician (a noted neurologist), who told me it should have been caught earlier. I am convinced you missed it...and now you are covering up.”
Principles to Handle the Unexpected

- Listen carefully; remain calm, professional (position)
- Ask questions to learn reasons for new behavior
- Remain confident in known facts, stick to message
- Understand flooding, when to call time out
- Be ready to handle anger
- Others?
• Obvious error —> obvious outcome

• When there is uncertainty about:
  – Care provided by you or your team
  – Suspected error by a colleague

• No error but patient/family believes so
When pt/family believes an error has occurred, but none apparent: Guiding Principles for Agreeing to Disagree

- Be prepared: objective review/evaluation complete, you are confident in the medical judgment, you know your message
- Affirm that you heard and understood the patient/family member
- Stick to your message (may have to repeat 2-3 times)

Guiding Principles for Agreeing to Disagree

- Congenially ‘agree to disagree’ with the patient/family member, “It is OK for us to disagree on this point...”
- If patient/family member persists, “You may wish to take your concerns to others...From this point on I want us to focus on...”
- Assure patient/family member of your continued commitment to their care “if they allow”
- [What if precipitated by speculation/jousting by another professional?]

Key Concepts about Jousting (public turf battles or negative comments when you don’t have all the data)

- **Professionalism is the essential concept**—it’s who we are, who you are. It’s all about professionalism.
- **Jousting is not professional**
- **So, don’t joust**...but when jousting happens, professionals will address it in a professional way.
- **Where it happens**: orally in front of patients, families, staff, visitors; in medical records; and/or in electronic media.
- **Why address it**: Poses a threat to culture of safety, pt confidence, reputations, drives lawsuits, etc. But the main reason: **Jousting is not professional**.
Why is this topic important?

• Jousting is not consistent with professionalism and our VUMC Credo
• The Risk Management Trust Committee has seen expensive but medically non-meritorious cases driven by internal—not just external—jousting
• As VUMC grows to include more practices in other communities, the opportunity to promote our culture of safety becomes paramount, and jousting undermines a culture of safety
So why does jousting occur?
When jousting occurs, professionals address it by sharing respectful, professional feedback
Addressing jousting may require some courage, and “cup of coffee” communication skills can help
Under some circumstances, someone else in the chain of command (yours or another chain) may be called upon to help
Chairs want to hear about concerns being expressed about their service(s)
“Jousting,” that is, public “dueling” or “turf battles”*

For example

• APP to patient: “The reason your heart is now damaged is because of the drugs the specialist doctor gave you."

• APP to neighbor: “Don’t let Dr. ___ see your kids...not great with younger patients.”

• APP to family: “I’m sorry the lab lost the sample...happens way too often...very inefficient.”

“Pt given 10x more [dose] than needed...puts pt at significant risk...pt didn’t get a required treatment... plan to “VERITAS“ this...inappropriate, exposes pt to...a [boatload] of risk...”

“We had a long conversation, including my profuse apology for [another department’s] negligence. I told patient this is not our standard of care, nor the level of care patients should expect from us.”

It is always appropriate to report errors and concerns to Risk Management; NOT appropriate to note report in MR—the note may make the report discoverable.
“Jousting,” not just public “dueling” or “turf battles” —

It’s also the “little stuff” – death by 1000 cuts

For example:

• “This happens all the time”
• “They haven’t fixed that yet?”
• “I don’t know what has happened to the quality of our hiring process recently…”
• In a Medical Record: “NP notified. No response.... notified second/third time...still no response.” (Consider alternatives)
What about some kind of follow-up with a colleague who has jousted?
Guiding principles for conversation with someone who jousted

- Indicate you want to talk privately with a jouster about a patient you share, then objectively recount what you heard was said
- Seek jouster’s recollection of conversations
- Aim for agreement or at least understanding on medical issue/error in question
Guiding principles for conversation with a jouster

- Express desire to partner with Jouster in giving patient/family consistent communications about their care
- “If you or patient have concerns about care, please let me know...”
- Professionalism requires the ability to give and receive feedback (at first, having a “cup of coffee” conversation”)
- Personal conversation is almost always best, but if for some reason that can’t be done by you, report it, get help from chain of command
Guiding Principles When You ID an Error or Potential Error

- Maintain a little humility
- How sure are you?
- Engage appropriate expertise (perhaps previously treating phys/team)
- If an error – say so
- Reduce unnecessary inflammation (don’t speculate, “just the facts”)
Emotional Impact of Medical Error Involvement
• Increased anxiety about future errors (61-96%)
• Fear of punishment (50%)
• Loss of confidence (in self or system) (44-93%)
• Sleeping difficulties (42-54%)
• Reduced job satisfaction (42%)
• Harm to reputation (13%)

What coping strategies are commonly employed?

Positive Approaches to Coping:

- **Discuss**: the events/issues/feelings
- **Disclose internally**: report errors promptly; gain assistance for disclosing to patients/families
- **Departmental initiatives**: fairly balancing individual responsibility and system issues that need to be addressed, blended with supportive listening and understanding
  - “Rapid response teams” for immediate assistance
  - Multidisciplinary Morbidity, Mortality and Improvement Conferences for follow-up review

Know anyone who has experienced...?

1. Yes
2. No (not yet)
3. Not sure, Maybe
4. Something else
Conclusions of Those Associated with Errors

- Need/desire peer and organizational support
- Frontline supervisors/peers could be trained to provide immediate, targeted, early support
- For the later stages, seek out persons trained to provide emotional support, including
  - Risk managers
  - Chaplains, Social workers
  - Holistic or Mental Health Professionals
  - Child Life Therapists
  - Palliative Care Practitioners

Scott, SD et al. The natural history of recovery for the healthcare provider “second victim” after adverse patient events. Qual Safe Health Care 2009; 18: 325-330
Any positive outcomes of all this?

• Improvement in practice (personal practice changes, departmental and hospital-wide actions)
• Improved professional relationships after discussing an error
• Improved communication in the workplace (related to increased assertiveness)
• Error outcome, subsequent patient relations, and team/institutional response to error can mediate negative psych outcomes (*reverse is also true*)

• Early reporting is VUMC’s policy (OP 10-10.24);
  – Call Risk Mgmt (x6-0660; “0” on campus); Or use Veritas
  – Available 24/7 (615-878-0705) for expert advice

• **What to report:** errors, errors causing harm, adverse outcomes, behavior concerns (patient or professional)

• **Why:** gives you timely expert help and support; objective, fair reviews; promotes quality; may delay an “empowering” bill

• **Reporting can be anonymous, no negative repercussions for good faith reports**

• **When:** Complete event reports as soon as possible.
Six “Stages”

1. Chaos and accident response
   – Turmoil leads to self chastising
2. Intrusive reflections
   – “What if”
3. Restoring personal integrity
   – Seeking support and regaining trust
4. Enduring the inquisition
   – Concerned about repercussions
5. Obtaining emotional first aid
   – Seeking confidential support
6. Moving on
   – Dropping out, Surviving, Thriving

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Comments and Questions

www.mc.vanderbilt.edu/cppa