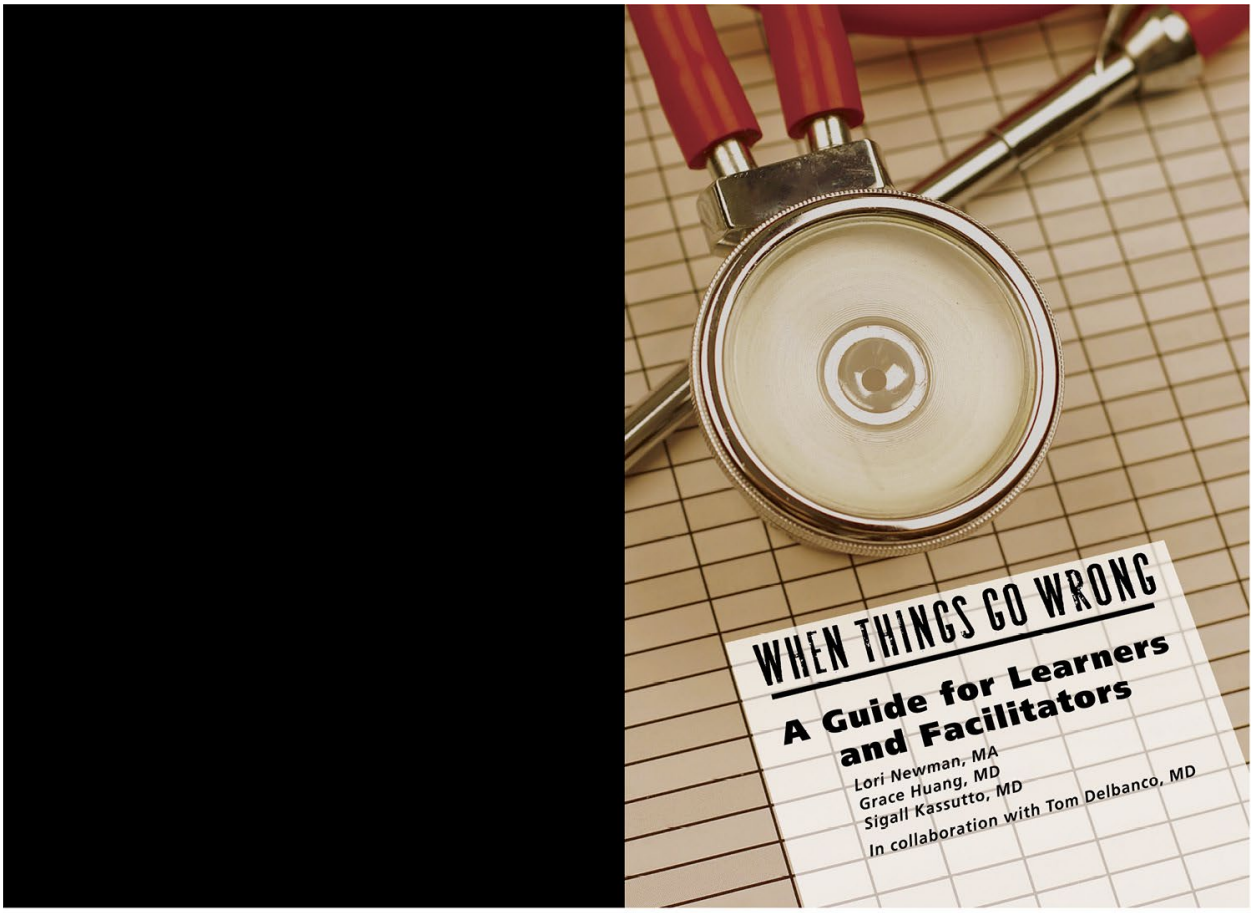
When Things Go Wrong: A Facilitator's Guide



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FROM WRONG TO WRONG

THE EXASPERATED SPIRIT

PROCEEDS, UNLESS RESTORED
BY THAT REFINING FIRE

WHERE YOU MUST MOVE IN
MEASURE, LIKE A DANCER.

—T.S. Eliot, Little Gidding

PURPOSE OF THE FILM

What do patients and their families experience after a medical error? By viewing and discussing *When Things Go Wrong*, clinicians and other healthcare professionals will come to understand how medical error affects the lives of patients and their loved ones. Engaging with the experiences of those who have suffered from medical error can stimulate frank and open discussion on effective interventions for both preventing and responding to medical error. This film and guide can help participants to recognize and understand the physical, social, and psychological consequences of medical error from the patient and family perspectives. The intended audience includes medical students, practitioners-in-training and seasoned health professionals. The film and patient narratives may also be shown to others, such as hospital administrators, board members, trustees, patient support groups, and the general public.

CONTENT DESCRIPTION

The film features a 26-minute film, five patient and family narratives, and six video segments that highlight the themes of emotions, communication, isolation, trust, apology, and moving on. These recurrent themes become apparent as patients and their loved ones reflect on their experiences with medical error. The film, themes, and narratives may be shown alone or in combination to meet the needs of a particular course or curriculum.

Film: Enhanced by dance and music, the film depicts eight patients and families and their reactions to medical errors.

Themes: Six themes—emotions, communication, isolation, trust, apology, and moving on—weave through the patients' and family members' stories, and are presented in detail, using additional footage and commentary absent from the film and narratives.

Patient Narratives: Explored in greater depth, five narratives by individual patients and their families serve as triggers for discussions about particular causes and impacts of things that have gone wrong.

WELCOME TO WHEN THINGS GO WRONG: VOICES OF PATIENTS AND FAMILIES

From the Sponsor

Medical professionals are extremely dedicated and diligent. Things usually go right and patients usually voice appreciation. However, as you can see from the title of this film, there is a small slice of life in medicine where things go wrong. We are focusing on this to improve the experience of everyone involved: patients, families, and providers.

You no doubt already have a sense of the pain that patients and their providers experience after a medical error. As the professional liability carrier for the Harvard medical community, the producer, and the major sponsor of this film, CRICO hopes to do more than call attention to this pain. We hope you can use these patients and families' voices to get a fuller picture of the impact of preventable adverse medical events and consider what you can do to ease that impact.

This is deliberately not the provider's story. Instead, it is a perspective that is usually difficult for medical professionals to see. Each of the patients and families in this film can teach the healthcare system and individual providers how to do better than we do today. If we can be open to their messages and gain insights to become better healers, we may prevent further harm—and the urge to seek retribution out of anger and frustration.

Many of the people in this film talk about being victimized by poor communication after an event. Even the patients and family members who are doctors themselves experience this. Certainly, long before something goes wrong, good communication needs to be established in the patient-provider relationship. But what are the information/dialogue needs after an event?

Perhaps as we use this film and the guide for learning that goes with it, we can try to put ourselves in the shoes of these families and patients. What information would we want after an adverse event? How would we feel? What threatens our trust? Can we prevent it from happening to someone else?

CRICO reviews medical malpractice claims every day, and we see how important the patient's perspective is. This understanding led us to create these materials, in keeping with our mission to help providers deliver the safest healthcare in the world. We hope they also help you in your efforts to enhance patient care.

Luke Sato, MD
Chief Medical Officer
CRICO/RMF

From the Writer and Director

Why is *When Things Go Wrong* a film I felt compelled to create? First, I believe we spend far too little time drawing on the perspectives of our patients and families, forgetting that they are truly expert witnesses to our care. Second, while many institutions work hard to improve quality of care, we rarely solicit viewpoints from our patients and their partners, let alone tap their expertise. I have found time and again that when we seek their input, they almost always have insights and suggestions that both surprise and help us. And finally, we know remarkably little about patient and family experiences when things go wrong. We need to bring their voices into this discussion.

A word to my fellow clinicians: The film focuses on "bad news" stories; I believe they make the most powerful teaching cases. Though they may make you uncomfortable, the last thing I intend is to attack or condemn health professionals. The film and patient narratives may also make you think, "This could never happen to me." Try to let your defenses down as you listen and consider carefully the converging messages of these diverse individuals. They weren't interested in attacking us; they all agreed to participate because they hoped that telling their stories would somehow improve care for others.

For my own part, the interviews led to three unexpected realizations: First, all too often, we shy away from those who have been harmed. We isolate them at just the time they need us most. Second, while we know how guilty clinicians feel about mistakes, the film reveals that family members may feel similar, or even greater, guilt. And third, patients do not feel empowered to talk with us about medical error. While recruiting for this film, we were turned down by many patients who said they feared retribution from the medical establishment. This was especially true of recent immigrants.

Our primary goal in this exploration was to stimulate change that will help patients and health professionals alike. These materials focus on the experiences of patients and families. In the future, I hope to bring cameras to the health professionals' side of medical error. While medical literature and film have begun to address this side of the story, I know clinicians, managers, and students have important insights they are waiting to offer. But we shouldn't wait any longer. In this guide, we jumpstart the process and ask you to bring your own feelings and ideas to the issues patients and families raise.

The film, the patient narratives, and the learning guide suggest strongly that patients and health professionals need to work together, both to make sure things go better the next time error occurs, and to make sure the "next times" become fewer and fewer. I look forward to your ideas.

Tom Delbanco, MD
Koplow-Tullis Professor of General Medicine and Primary Care
Harvard Medical School
Beth Israel Deaconess Medical Center

Advice for Presenters

ADULT LEARNING AND FACILITATION

Adults bring a distinct set of learning characteristics to each educational encounter.[1] Before starting this program, you may find it useful to review the principles of adult learning. Understanding these principles will help you use the film and guide, either in self-study or as a group facilitator.

- Adult learners are self-directed. They want to participate actively in defining, planning, implementing, and evaluating their learning.
- They apply prior experiences to their learning. Adults draw on a rich source of existing knowledge and life experiences as they learn. By creating connections to prior experience, their learning becomes more meaningful.
- Adults need to see the relevance of learning to actual practice. They seek knowledge and skills that meet their educational needs, whether vocational or personal.
- They focus on problem-centered learning, rather than on subject-centered learning. Adults prize practicality and goal-oriented instruction.

The role of the facilitator is to incorporate these principles in an active learning environment. The facilitator encourages participants to express thoughts and reactions to the material, supports diverse viewpoints, promotes deeper understanding of issues, and identifies and addresses underlying biases.

Suggestions for achieving these outcomes follow:

- As the facilitator, keep in mind that adults need to feel safe in order to express themselves freely. Establish ground rules for interactions. Explain that participants must treat each other with respect and consideration.
- Get to know your learners. Who is in the audience? Are they clinicians, hospital administrators, trustees, students, or a varied group? Determine if participants have particular expertise you might call upon during the discussion.
- Seek the learners' reactions and understanding of the film. An effective strategy is to ask open-ended questions, allowing enough time for participants to answer thoughtfully. Be sure to stop and summarize the discussion.
- Encourage the participants to share ideas and propose solutions. Use phrases such as:
    - "When I see this segment of the film I feel _____. What do others think?"
    - "It seems that these two participants disagree. Do you agree with either or want to share your own viewpoint?"
- Avoid the pitfall of allowing a few participants to monopolize the discussion with lengthy stories of their personal experiences. Prior to the discussion, emphasize that participants should focus on the patients' experiences in the film.
- Before starting, ask yourself what the one idea or suggestion is you want participants to leave with by the end of the session. Be sure to communicate this to the participants.
- Direct participants to additional readings or resources.

A FRAMEWORK FOR DISCUSSION

[1] 1 Knowles MS. *The Adult Learner: The Definitive Classic in Adult Education and Human Resource Development*. 5th Edition. Houston: Butterworth-Heinemann; 1998.

Throughout this guide we present a framework to facilitate group discussion. The objective is to move the participants beyond a superficial understanding of the film and the narratives in order to address their assumptions about patients who have experienced medical errors. Each of the three sections—reactions, understanding, and solutions—contains questions designed to advance the conversation toward this end. We encourage you to use these questions as a springboard for further analysis and discussion.

Preparation

Some sections recommend an optional activity to help frame the topic at hand. These activities prepare the learners for an interactive discussion after viewing the film.

Reactions

Questions in this section are designed to elicit participants' initial thoughts and immediate responses after viewing the film or a particular segment.

When asked about initial reactions, learners tend to censor their comments, which may limit the depth of the discussion. One strategy to overcome such hesitancy is to ask participants to report, without deliberation, one or two words that characterize their first thoughts.

The rapid response technique effectively "breaks the ice" and raises issues for discussion. It may be used for any of the narratives or for the film as a whole.

Understanding

Questions in this section aim to uncover participants' biases about patients and their families who have experienced medical error.

Start with a particular response from the "Reactions" section. Ask the participants to describe what they observed in the film that led them to that reaction. Emphasize that learners' reactions often result from observations shaped by underlying assumptions.

assumptions ➤ observations ➤ reactions

Example reaction: *"I think the patient exaggerated what the surgeon said to her."*

Facilitator: *"What did you observe that made you think this?"*

Observation*: "She mimicked the surgeon, using cruel words and an affected tone of voice."*

- Urge the participants to consider what underlying assumptions influenced their observations.
  Facilitator: "*What was going through your mind when you had this reaction? Why do think what she said was an exaggeration*?"
  Assumption: *"Surgeons do not use cruel words."*

- Once participants recognize their biases about clinicians, patients and their family members, they are better equipped to propose solutions that take patients' viewpoints, emotions, and needs into account.

The Provider's View

This section of the guide allows participants to explore health professionals' perspectives and experiences that are not represented in the film. By examining events from the provider's point of view, the group will be able to reach a more comprehensive understanding of what happens to all parties when things go wrong.

Solutions

By exploring and better understanding the patients' and families' experiences, participants can begin to consider ways of thinking or acting differently when confronted with similar situations. Use the questions in this section to help participants think about novel and practical ways to respond to medical errors and to consider what they can do to prevent the recurrence of negative patient experiences.

METHODS FOR USING THE FILM AND GUIDE

Venues

The film may be used in a variety of teaching venues, depending on the learning objectives. For example, it is readily adaptable to residency curricula, faculty development sessions, retreats and seminars, or support group activities. The main purpose of the accompanying guide is to provide questions and activities that will engage participants in open and meaningful discussion about medical error and patients' experiences.

Small Group: We recommend a group of six to ten learners, led by a facilitator, as the optimal size to generate a useful discussion and allow everyone to participate.

Large Group Settings: If you choose to present this work to a large audience, an interactive group discussion will yield better understanding of the film than a lecture format. To create an interactive discussion:

- Encourage those in the audience to generate their own insights, rather than using a didactic approach.
- Create smaller groups of participants to address particular questions; then bring the audience back together to share thoughts and ideas.
- Promote openness and safety in dialogue by having the audience call out responses instead of requiring the raising of hands to speak.
- Refrain from responding immediately to an audience member's comments and allow silence to provoke conversation.

Consider the following examples of effective large group facilitation:

- Immediately after the film concludes, ask audience members to call out one- or two-word reactions, without raising their hands. After hearing several, ask a particular audience member to elaborate on why he or she had that reaction.
- Ask audience members to break out into groups of four to six people (by row or table). Give them the following tasks. Discuss: their immediate reactions to the film (ten minutes), the reasons behind their reactions (10 minutes), and how they might foster change as an individual or as an institution to address medical errors (15 to 20 minutes). Bring the participants back together and ask for insights that arose in their discussions, focusing particularly on strategies for change.
- Have audience members pair up for fifteen minutes to discuss their immediate reactions and to share any medical error experiences that the film may have provoked.

Self-study: Learners may choose to watch the film and narratives on their own. If doing so, consider the questions included in this guide as a means for self-study and reflection. Pick one or two questions and spend ten minutes writing down a response.

Viewing Options

You can use the film in several ways to engage a group discussion.

Feature Film: Show the film in its entirety so that participants may see and consider all six themes that arise from medical error. Re-play selected themes or any of the five narratives to further group analysis and discussion (see page 10).

Themes: You may choose to focus on one or more of the specific themes in the film (see page 12). This approach is particularly effective if used in conjunction with pre-existing curricula, such as an ethics course.

Patient Narratives: You may choose to present a single narrative (see page 20). This approach is particularly effective to trigger discussion on a recent clinical event that may have similarities to the narrative.

Annotated Bibliography

An annotated bibliography is available for download. All citations listed as (REF) can be found there. The bibliography focuses on the issues around medical errors and adverse events. The selected articles and books are valuable tools in understanding the importance of disclosure, apology, communication, and trust, as well as the patient's feelings of isolation, anger, and frustration after a medical error occurs.

Feedback Form

A feedback form is available for download. Questions are designed to elicit responses that you can use to plan future sessions. You can print the appropriate number of copies. Please feel free to adapt the form to meet your own needs and goals. Allow five to ten minutes for participants to complete the form.

"WHEN **THINGS GO WRONG,**
WE CAN IMPROVE CARE
BY FIRST UNDERSTANDING
WHAT THE PATIENT AND
THE FAMILY EXPERIENCE."

Feature Film

Enhanced by dance and music, the film depicts eight patients and families and their reactions to medical errors. Common themes and experiences are presented in a montage of patient stories and family reflections.

About the dance: The film is framed by excerpts from Still/Here, a dance created, in part, by patients suffering from fatal illnesses. As a presenter, it will help to let the audience know this before they view the film. In that way, viewers are prepared for the artistic context of these transitions and can incorporate the visual metaphors that complement themes our patients identify after something goes wrong.

PREPARATION

One way to elicit the group's understanding of patients' experiences with medical error is to ask them about their personal experiences. A discussion of their experiences will engage the participants in the topic and help you tailor later teaching activities.

Questions could include:

- "Have you or a family member ever been a patient who has suffered medical error? What happened and how did you feel?"
- "Have you ever apologized to a patient? Why?"
- "Has a patient of yours experienced a medical error? Was it handled well? Should the response have been different?"

REACTIONS

You may experience a range of emotional reactions from the participants. Some may feel defensive, others angry, or tearful. Allow the group to express their emotions, but don't let these emotions become barriers to understanding. Remind them that the goal of the film is to understand medical error from the patient's viewpoint. To elicit the participants' responses, ask them to write freely about their reactions immediately following the film. Limit these to one- or two-word phrases that come directly to mind. Afterwards, encourage the participants to share their responses. If you find the audience particularly defensive or hostile, ask them to imagine that one of the patients in the film is sitting in the audience. Challenge the participants to rephrase their comments so that the patient feels heard and understood.

UNDERSTANDING

In this section, you aim to uncover the participants' biases about clinicians, patients and their families involved in medical error. Use questions like the following to explore the group's underlying assumptions:

"Why did the family members feel guilty about their loved one's experience?"

"How did the patients and their family members feel about the providers' lack of response to their questions and concerns?"

"How did the patients and their families compensate when communication was not ideal?"

"Why might health professionals avoid patients and their families once a medical error has been identified?"

"How does the act of apologizing contribute towards the goal of a trusting clinician-patient relationship?"

"What is the role of an apology when multiple factors contributed to medical error?"

"How did patients and family members seek closure after experiencing a medical error?"

SOLUTIONS

This section will help participants to think about innovative and practical ways to respond to medical errors and to consider what they can do to prevent the recurrence of errors. Sample questions include:

"What rights do your patients have in their treatment and care?"

"How do you involve patients in decision-making?"

Assume the role of a hospital leader.

- What procedures might the hospital staff follow in the event of a medical error?
- Which key personnel should learn immediately of the event?
- What steps would ensure that timely information and support are provided to the patients and their families?
- What data would you collect, and how would you analyze them in order to understand the cause of an error and ways to prevent its re-occurrence?
- Describe how your institution engages in continuous quality improvement to prevent medical errors.

THEMES

Six themes—*emotions*, *communication*, *isolation*, *trust*, *apology*, and *moving on*—weave through the patients' and family members' stories. This section of the guide explores each theme in depth. All questions are addressed directly to the learners.

"…A WHOLE MYRIAD OF **EMOTIONS**… WHEN HE SUFFERS, I SUFFER…"

EMOTIONS

Reactions

In this section of the film, the patients and their families reflect on their emotions.

Which feelings did you expect to hear? Which ones surprised you?

Understanding

Several family members express guilt about what happened to their loved one.

They make statements such as:

> *"I feel guilty."*
>
> *"You feel like you failed your family."*
>
> *"I feel very guilty. That's what it's done to me…I feel like I haven't done enough to help him. I just don't think I ever did."*

What might explain the family members' feelings of guilt?

An emotional state such as anger often compels people to take action. Strong feelings of guilt, however, can inhibit a person from further involvement with the care of their loved one. Why might feelings of guilt cause this reaction?

Another emotional state expressed in this film is the feeling of powerlessness, which can prevent patients and families from taking an active role in their care. What might cause this feeling?

The Provider's View

What types of emotions are acceptable for healthcare providers to show to their patients?

With whom do you speak if you are upset about a patient?

What systems within your institution are available to support the emotional well-being of its staff members?

Solutions

What can you do in your work or practice to encourage your patients and their loved ones to express their feelings?

How do you help your patients and their families deal with emotions, particularly negative ones?

What actions might your institution or department take to encourage patients and their loved ones to express how they feel, and to take into consideration how emotions may affect the provision of care?

What can your institution do to empower patients to feel they are active participants in their own healthcare?

"…INCOMPLETE **COMMUNICATION** ACTUALLY CREATED MORE STRESS AND MORE CONCERN…

"…THERE WAS AN ASSUMPTION THAT WE KNEW IT ALL. WE DON'T KNOW ANYTHING…"

COMMUNICATION

Preparation

Ask the participants which of the following statements describes their communication style. Have them explain when they might use a particular response and why they believe it is the best choice.

"Sometimes I tell my patients only what they need to know."

"For some patients, I share only positive news."

"I hesitate about getting my patients' hopes up."

"I have complicated matters by telling my patients too much information."

"I encourage my patients to participate in decisions about their healthcare."

Reactions

When did the patients and family members commonly experience lapses in communication after an adverse event?

In what ways did patients and their family members respond when they received any acknowledgment that something went wrong?

How did the patients try to overcome communication barriers and obtain more information about the medical errors?

Understanding

Some family members described being treated as if they didn't understand anything, others as if they knew everything. Why are such opposite viewpoints expressed in the same section of the film?

A patient's sister who comes "*from another country*" describes the added stress of "*trying to prove…just because there's a language barrier, there's not a 'smarts' barrier.*" Why might non-native born speakers feel this way?

The Provider's View

As a clinician, how do you balance self-preservation and the need to reach out to your patients and their families?

During which types of encounters do you find it difficult to communicate with patients or their family members?

Are there times when you have withheld information from a patient? When is this appropriate?

Describe the culture of your institution. Does it support or prevent open communication?

Solutions

The Joint Commission in 2001/2002 instituted requirements related to disclosure of unanticipated outcomes. What obligations do healthcare providers and hospital administrators have in communicating with their patients and families about medical errors? Who should participate in a disclosure conversation with the patient and family?

Consider the difference between what a patient wants to know and what is truly known. How can this gap be managed and filled in over time?

"…THE MOST OVERWHELMING EMOTION I FELT WAS **ISOLATION**…

"WHO'S HERE FOR ME? WHO'S HERE FOR MY HUSBAND?"

ISOLATION

Reactions

Are you surprised by the prominent feeling of isolation in many of the patients' stories?

Why or why not?

What do patients say caused their feelings of isolation?

What do their family members say?

Understanding

Why might experiences of medical error make patients and their families feel isolated?

The mother of a patient states, "*Inevitably caregivers protect their hearts, and sometimes opening up their hearts helps a patient a lot.*"

Why do you think health professionals avoid sharing their feelings with patients and their families after an unexpected event has occurred?

Another patient, in this case a physician, states, "It was really the lack of response, the feeling of isolation, dependency, and the realization…that I was being penalized in terms of my medical care because I had experienced a medical error for which they were responsible." Describe how a patient might be treated by health professionals after a medical error incident. What types of clinician behavior, communication style, and attitude might make patients feel isolated and penalized?

The Provider's View

Have you experienced feelings of isolation while caring for a patient?

Can you recall a time when you expected moral support from the healthcare team and did not receive it?

Is there someone to whom you feel comfortable speaking when you have concerns about the care of a patient?

What type of support systems does your institution offer providers when they need to discuss concerns about the care of a patient?

Solutions

What can you do in your work to ensure that patients and their families feel connected?

As a clinician, what can you do in your work to ensure that you do not experience isolation when a medical error occurs?

What steps might your institution or department take to increase feelings of connection and alliance among patients, families, and health professionals?

What can be done to ensure that health professionals engage in timely, open, and ongoing discourse with a patient and their family after a medical error has occurred?

"I EXPECT THEM TO OWN UP TO IT… THAT'S WHAT'S GOING TO GET MY **TRUST**…

"IF HE OR SHE ISN'T TELLING ME THE TRUTH ABOUT THIS, WHAT ELSE AREN'T THEY TELLING ME THE TRUTH ABOUT?"

TRUST

Preparation

In pairs, have participants describe a time in their lives when they had to trust someone and consider how that person earned their trust. After several minutes ask the pairs to switch and hear their partner's story. As a group, have people share their experiences, noting on the blackboard the ways to build trust in a relationship.

Reactions

In the film, what factors cause a patient to lose trust in his or her healthcare provider?

Once trust is lost, how might a patient or family member act toward the healthcare provider?

How will this loss affect their relationship?

Understanding

Hall et al1 describe "trust" as "inseparable from vulnerability, in that there is no need for trust in the absence of vulnerability. The greater the risk, the greater the potential for either trust or distrust." What function does trust play between vulnerable patients and their health professionals?

In the film, one patient declares, "I was frightened to complain anymore. Scared that, you know, you hear stories about being mistreated in the hospital." Does this patient have cause for fear? How might a clinician dispel a patient's fears? What type of information and emotional support does the clinician have to offer?

In developing this film, the director discovered that many patients feared retribution if they were to speak openly about their experiences with medical error. What factors might contribute to that fear? Why might fear be especially acute for patients who are immigrants?

In the film, a daughter describes how her mother's physician apologized to the mother and daughter and regained their trust. How does the act of apologizing contribute to the goal of a trusting provider-patient relationship? Is it, in itself, sufficient to accomplish this goal? What else needs to be done?

The Provider's View

Has a friend, colleague, or staff member ever betrayed your trust? How did this affect your relationship?

Has a patient ever caused you to distrust him or her? If so, how did you handle communicating with the patient?

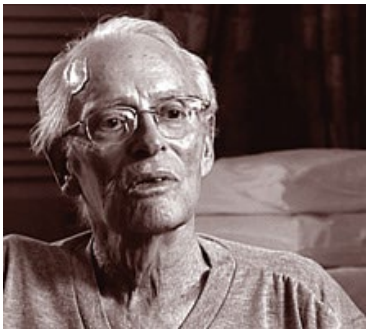
Solutions

Is it possible to regain the trust of patients after the occurrence of a medical error?

If so, what steps must be taken?

What can you do to ensure that patients trust you?

How might your institution or your department demonstrate to patients that they can trust your organization? How might your department prove itself credible and honest?



"…HAD THAT PERSON **APOLOGIZED** IT WOULD HAVE ENDED RIGHT THERE…

"YOU HAVE NO IDEA HOW FAR A 'SORRY' WILL GO…"

APOLOGY

Preparation

Suggested activity (five minutes): Pose the following to the group, "In pairs, reflect on a time when you apologized to someone. Describe your feelings before and after the apology. How was your apology received?" Have participants share their experiences. Generate a list of emotions commonly associated with the act of apology.

Alternate activity (two minutes): Imagine that you hit a parked car while you were backing up, witnessed by the owner of that car. Think about what you would say to the owner. In pairs, conduct a role play, with one participant as the driver, and one as the car's owner.

Reactions

During the film, we hear different patients and family members express their perspectives on apology. The violinist states, "*The head surgeon approached me as if I was a piece of meat, but the biggest issue that I have is he didn't say he was sorry.*" What might an apology have done for this patient?

A patient's sister states, "*If you are going to say 'sorry,' mean it, if not, don't say it.*" What might she need to make an apology meaningful?

The father of a young child tells us, "*Every time something went wrong or didn't go perfectly, those times when somebody said…'I'm sorry that didn't go well'…it was over. It was done with.*" Why was this apology sufficient for the father?

Understanding

What is the difference between apology and disclosure?

What purposes does an apology serve those offering it and those receiving it?

What is the role of an apology when multiple factors contributed to medical error?

How might a provider's apology help the healing process?

The Provider's View

In his book, *On Apology* (REF), Aaron Lazare, MD emphasizes that, "As a result of the apology, the relationship is usually preserved and often enhanced."1 Have you experienced similar results after apologizing to a patient? Please describe.

Have you apologized and/or accepted responsibility for a medical error you didn't cause? Why?

Are there times when a provider should neither apologize nor accept responsibility for an error?

In which circumstances might a patient apologize to the provider?

One family member believes that clinicians think, "Maybe they'll sue me if I say,

'I'm sorry, I was wrong.'" Is there evidence to support or refute this belief?

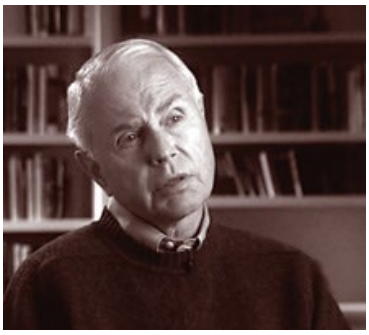
How have concerns about legal or professional ramifications influenced your decision to disclose or apologize to a patient?

What type of training have you received on how to apologize to patients and their families?

Solutions

Usually when something goes wrong, the cause is unclear in the immediate aftermath. Accepting or assigning blame without a complete investigation can cause further harm to the providers, and the patient and family. Yet disclosure without an apology feels hollow. The minimum appropriate "apology" should include a heartfelt expression of empathy (e.g. "I am so sorry for what you're experiencing" or "I'm sorry things didn't turn out the way we'd have wanted.") Role play different apology scenarios with another member of your group. Pay close attention to the concept of taking responsibility, especially responsibility going forward to make the patient clinically whole.

What is your institution's policy on medical error disclosure and apology?



"...I'VE TRIED TO **MOVE ON**...

TIME HEALS, BUT IT DOESN'T HEAL WHEN THERE ARE SO MANY QUESTIONS THAT HAVE NOT BEEN ANSWERED..."

MOVING ON

Reactions

Imagine yourself as one of the patients or the family members. What would you need from the clinician and the hospital to move on after a medical error?

Understanding

Patients and family members seek various responses to find closure after experiencing a medical error:

- An apology
- Results from the post-event investigation and analysis
- Continuing dialogue with the providers and hospital administrators
- Changes to ensure another patient won't suffer the same fate

Choose one patients' experience shown in the film. Consider which particular response or combination of responses might lead to a sense of closure and healing after the occurrence of the medical error. What factors might lead patients and/or their families to sue or not after experiencing medical error?

The Provider's View

Describe a time when you were able to negotiate a satisfactory solution with a displeased patient while maintaining a therapeutic relationship.

There are times when a provider and patient are unable to repair a damaged relationship and must end it. What are constructive ways to terminate such a patient-provider relationship?

Healthcare providers are also deeply affected following a medical error, especially if they feel blamed. How might providers find closure to such an experience? What support might providers need in order to rebuild self-esteem and continue with their professional responsibilities?

Solutions

You are a hospital administrator receiving the violinist's wife's letter regarding her concerns about the care of her husband. How will you respond?

The violinist's son states, "The objective of a lawsuit...is for the education of the system. It is to put the system under a microscope such that the system itself can benefit." What are other ways a hospital can demonstrate to patients and their families that it is taking the prevention of error seriously?

What types of teaching activities might help students and practitioners-in-training learn how to apologize for a medical error, analyze its causes, and foster change in their institution?

PATIENT NARRATIVES

In this section, five of the patient stories are explored in greater depth to provide further learning and reflection about the nature of medical errors. Each narrative is less than ten minutes long and may be shown in a variety of settings, including student or residency teaching sessions, seminars, retreats, patient or physician support groups, and faculty development workshops. This section of the guide will help facilitators organize and navigate topics for group discussions. Each narrative encompasses all of the themes highlighted in *When Things Go Wrong*; however, listed in the margin of each narrative are the more prominent themes that emerge from the case. Facilitators may use this listing as a quick reference and easy way to organize educational objectives for a particular session.

THE PERSON WHO **APOLOGIZED** WAS THE OLDER PHYSICIAN. I HAVE RESPECT FOR HIM BECAUSE HE ACKNOWLEDGED THAT HE HAD NOT LISTENED…

"THE REASON WHY HIS APOLOGY FELT GENUINE WAS BECAUSE IT WAS DIRECT. HE DIDN'T BEAT AROUND THE BUSH; HE DIDN'T TRY TO COVER THINGS OVER…"

THE ACCOUNTANT

Accountant with known allergy… severe allergic reaction and delayed steroid therapy… life-threatening hemorrhage and prolonged recovery.

Major Themes: Communication, Trust, Apology.

Reactions

Reflect on interactions with patients who have a family member who is a clinician. Share your positive and negative experiences in those circumstances. What happens when the family member requests medical intervention with which the healthcare team disagrees?

Understanding

Discuss the difference between error and complication.

Medical students are often taught to seek the patient's "explanatory model" or what the patient thinks caused or contributed to the problem. The patient offers her own explanation ("*It's the prednisone*") to the question of what was causing her hip dislocations. The patient may well have been correct. What might the attending have said to the patient to acknowledge an insight that the team had overlooked? Even if a patient's explanation is incorrect, how should providers acknowledge the value of the patient's interpretation?

The patient's daughter made the point that the "*person who apologized was the older physician.*" What relationships may exist between a clinician's age or seniority and disclosure?

The patient's daughter felt the physician's apology was "heartfelt" because it was direct. "This is what happened, this is what I might have done differently, this was the outcome," she explains. Explore the "anatomy of an apology." What are the critical components?

Duclos reports that effective communication is an important determinant in whether professional relationships continue after an adverse event (REF Duclos, 2005). In this narrative, despite medical error

and subsequent serious complications, the daughter says, "My mother trusts her doctor. She went in totally trusting her doctor, and she came out totally trusting that doctor. I trust him." What elements of effective communication contributed to the preservation of trust in this case? (Contrast this with other narratives where patients or families felt they still had unanswered questions and/or lack of closure.)

Describe the dual role played by family members who are clinicians. How might their professional background affect the guilt they might feel after a medical error? How might this affect trust and the response to error?

In this case, the daughter says, "*I felt like even as a physician I was being dismissed….Had I not been a physician, I would have been much more furious….I would have kicked it higher a lot sooner*." Discuss the group's interpretation of this statement. What are the implications?

The Provider's View

As a clinician, do you or your family members feel that you are responsible for your family's medical issues? How do you set limits on your involvement in the care of your loved ones?

What has your experience been when a friend or family member is hospitalized? Have you provided advice or suggestions (or requests?) to the clinicians taking care of your family/friend? Describe your interactions with the healthcare team.

Discuss the effects of medical error on clinician confidence. What resources are available at your institution to help clinicians?

Solutions

Ask two members of the group to role play as a clinician and a patient (or family member). Have the "clinician" apologize to the "patient" for a medical error. Reflect on the scenario as a group. What aspects were particularly effective? List them on the board. Which were awkward? List them on the board as well.

Consider the following:

- Did the clinician use the word error or mistake?
- Did he/she take responsibility for the error?
- Were the patient's emotions acknowledged or validated?
- Was there a discussion of how similar errors would be prevented in the future?

The daughter notes that an apology is made effective not only by what is said, but in how it is said. "*It was done in the spirit of, 'I'm still working with you. We are still in this partnership.*' You didn't feel abandoned." Ask the group to think back on the role play and comment on the clinician's body language, tone, and word choice when he or she apologized to the patient.

Imagine the following scenario: You are the attending physician caring for a patient with a reported history of penicillin allergy. You ask the team to start aztreonam, but instead the patient is given ampicillin. You catch the error the next morning, after she received one dose. There was no adverse effect, and the medicine is stopped. Should further measures be taken? Should the patient/family be notified? This exercise can be done as a role-play (attending physician and house officer or attending physician and patient), or as a group discussion. Another option is to ask each group member to write down what she or he would do in this scenario, collect the responses and tally them on the board to stimulate discussion.

Discuss why respondents chose their course of action and what factors would influence them to respond differently. How did they balance truth-telling with trust preservation? Explore different methods of disclosure.

"…IT'S AMAZING HOW A DOCTOR CAN ALTER YOUR **EMOTIONS**…

"…TO ACTUALLY REACH OUT AND CONNECT WITH US IN HUMAN TERMS…"

THE VIOLINIST

Violinist with perforation of the small intestine during colon cancer surgery… subsequent infection, colostomy, diarrhea, and debilitation

Major Themes: Emotions, Isolation, Apology, Moving On.

Reactions

This narrative often strikes viewers as particularly powerful. Take a few minutes to discuss the group's overall reactions. What parts of the narrative impressed you most? Why?

Understanding

An acute hospitalization can often feel like a confusing and intense "storm," especially when medical error is involved. The patient's son describes the experience by saying, "*It was as if a tornado came in and out….By the time that the tornado left, there was a whole wake of questions, conflicts, and emotional traumas and dramas.*" What factors in a hospital setting lead to the turbulence, intensity, and confusion expressed in this statement?

The narrative showcases a positive reaction to a caring clinician. The patient states, "*It is amazing how the aura of a room can change when this spirited, wonderful person enters.*" As a patient, have you experienced this type of reaction towards a clinician? What was it about this person that made you feel comfortable or safe? What other effects did you experience?

The potential healing effects of apology are often underestimated and frequently under-utilized. "You have no idea how far a 'sorry' will go," says the violinist. Why does this gesture carry so much weight, even though it does not reverse the medical error? What may prevent a clinician from saying, "I am sorry"?

The family in this narrative wishes the healthcare team would "*reach out and connect with us in human terms*." How might this have been accomplished? What constitutes "connecting" with patients? What comprises "human terms"?

In *Well Rounded*, Kirkpatrick discusses strategies for reducing isolation by coming to know patients as individuals.[2] He suggests asking patients, "What are you famous for?" as part of the history and physical. Write down one question you might ask your patients during the initial interview that will elicit their own unique qualities and enable them to feel appreciated as "whole persons." Share these with the group. Which might you try to introduce into your own practice?

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[2] 1 Kirkpatrick JN, Nash K, Duffy TP. Well rounded. *Arch Intern Med*. 2005;165:613–16.

How do clinicians assume accountability for their decisions and actions on a daily basis in their own practice or clinical setting? How is this accountability relayed to patients?

The Provider's View

Have you ever received a hug from a patient or his/her family member? How did you react? Are there particular situations in which this interaction would feel more or less comfortable? How do you respond to each?

Have you ever received a complaint letter or an angry phone call? What did you do?

Have you ever been sued? What was the objective of the lawsuit in your opinion? How might it have been prevented?

Solutions

The violinist felt powerless and without recourse after experiencing medical error. What resources are available to patients in your institution to inform them about their rights? What steps could have been taken for (or by) the violinist?

Receiving copies of bills sent to the insurance company for "care that we feel led to my father's death" made the patient's family furious. Should medical costs be waived after a medical error occurs? Should insurance companies still be billed, but patients spared any financial imposition in these cases? If so, how should "medical error" be defined? Would alleviating financial burdens reduce the frequency of litigation? Discuss or research factors that have been shown in the literature to reduce the likelihood of legal action[3] (REF Witman, 1996; Hobgood, 2005).

The hospital's response to the wife's letter expressing her concerns about her husband's care was a phone call querying whether she planned to pursue a lawsuit. What might be a different response to such a letter? Write out (or role play) what you might say to the wife during the phone call. Who should ideally respond to such a letter?

The patient's son states that, "*The objective of a lawsuit is not about monetary gain, it is for education of a system….To put the system under a microscope, such that the system itself can benefit.*" How else can the system, or parts of it, be "*put under a microscope*" short of a lawsuit, for periodic review and improvement?

The son's comments mirror many of the major themes that have emerged in the literature for reasons why patients and relatives sue clinicians. These reasons include: concern with standards of care (preventing similar incidents in the future), the need for an explanation, compensation for loss and suffering, and accountability (REF Vincent, 1994).

After losing their loved one, the family states, "there are still so many questions left unanswered." What type of system may be set up to address these questions? Explain how you might design this system, including when the family would be invited to pose their questions, who would be available to answer them, and what kind of follow up would be provided. How might this system ensure that patient's needs are met?

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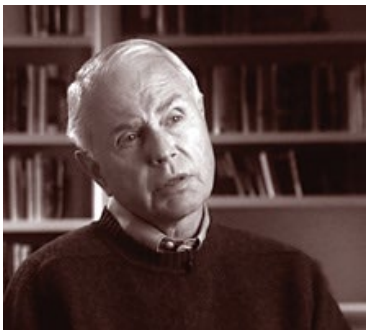
[3] 2 Schwappach DL, Koeck CM. What makes an error unacceptable? A factorial survey on the disclosure of medical errors. *Int J Qual Health Care*. 2004;16:317–26.



"IT WAS REALLY THE LACK OF RESPONSE, THE FEELING OF **ISOLATION** DEPENDENCY…

"WHAT I NEEDED WAS THE SENSE THAT SOMEBODY COULD EMPATHIZE AND KNOW WHAT I WAS FEELING. THAT WAS ALMOST TOTALLY LACKING."

THE DOCTOR

Doctor with third-degree burns from an over-heated warming blanket placed on anesthesized skin

Major Themes: Isolation, Communication, Apology, Trust

Reactions

Empathy has been likened to imagining "I could be you."[4] Recall a patient or family member with whom you have identified. Describe the patient and discuss what factors about the situation or the people involved made you feel connected to the patient's or family's plight.

Imagine being the patient in this narrative. How would you react to the medical error as a patient who is also a clinician?

Understanding

What is empathy? Can it be taught?

What personal characteristics build your trust in someone?

What specific events, behaviors, or circumstances might threaten that trust?

What specific actions could be taken to rebuild trust?

The patient's wife remarks, "*My sense was that people were afraid of what we would do… they were all gathering together in silence…*"

While medical error calls for a prompt response, this action is often slowed by clinicians' fears. What specific fears block a direct and timely response to the patient's family?

In his book, *The Story of a Shipwrecked Sailor*, Marquez reflects on the therapeutic effects of "just being heard".[5] Have you ever experienced a similar effect? Why does this promote healing?

The wife states, "*I would have still felt great pain, but I wouldn't have felt as alone.*" What factors contribute to a feeling of isolation when patients are hospitalized? How does medical error compound this emotion?

Explore the relationships between apology and trust. Now consider powerlessness and dignity.

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[4] Spiro H. What is empathy and can it be taught? *Ann Intern Med.* 1992;116:843–46.
[5] Garcia Marquez G. *The Story of a Shipwrecked Sailor*. Vintage (International); 1989.

Consider the interactions between the healthcare team and a patient who is a clinician. How does this affect communication? Expectations? Perceptions? What additional factors are in play when the patient experiencing medical error is a clinician?

The Provider's View

Reflect on your own experience as a patient. How has being a patient affected your practice of medicine?

Imagine you are the attending physician caring for a patient who just received the wrong dose of medication. You have just been notified by the nursing staff that the patient received 10 times the correct dose due to an incorrect order entered by the intern. The patient is currently stable; the medication was administered 10 minutes ago. How do you handle mistakes that others make in caring for your patients? Who is ultimately responsible, and who should apologize?

Solutions

After interviewing patients who have suffered from medical errors, Lamb reports that, "most patients were not so angry about the adverse event itself, but how they were treated afterward" (REF Lamb, 2004). In this segment, the physician-patient offers, "*The most important point would be to go see the patient **more**, not less."* What other solutions would mitigate a patient's sense of anger after a medical error?

Imagine that you are a member of your hospital's risk management team. You have been charged with developing a campaign for an immediate response to medical error. What slogan would you use? What kind of acronym could you craft to remind clinicians of the immediate steps for action?

Suggest effective strategies to teach trainees how to respond as individuals to medical error. How does your institution currently address this subject with medical students and residents?

Effective communication leads to emotional healing after a medical error. The patient's wife states about the nurse, "*I'd like to say to her, 'We don't blame you….' I'd like her to say to me, 'I am sorry for what I did. I know it caused you great pain.*'" Engage in a role play in which the nurse meets with the patient and his wife to discuss what happened. Working in groups of three, have one participant assume the role of the nurse; another, the patient; and the third, his wife. Have each group make note of their word choice, tone, and body language. After five minutes ask the groups to switch roles. Once you have brought everyone back together, write on the board the themes that are raised. Note the emotions, words, and themes common to each role. How many participants playing the nurse felt comfortable apologizing during the role play?

"THEY NEED TO **TRUST** US AND **COMMUNICATE** WITH US, JUST AS WE TRY TO COMMUNICATE WITH THEM…

"ISN'T THAT THE FAMILY'S RESPONSIBILITY, TO KNOW WHAT IS GOING ON?"

THE IMMIGRANT

Man disabled by sickle cell anemia and graft-versus-host disease. Despite family's repeated warnings, morphine was administered; it induced shock, coma, and renal failure

Major Themes: Communication, Trust, Isolation

Reactions

In this narrative, the patient's sister says, "*Coming from another country it is very stressful, because you are trying to prove to them, just because there is a language barrier, doesn't mean there is a 'smarts' barrier.*" Reflect on this comment as a group.

What other phrases or quotes stand out from the video? Respond with a word or phrase that immediately comes to mind. Participants should call out their responses spontaneously. Next, spend time discussing why these phrases made such an impression. (*Examples: we are not aliens from outer space, …a doctor has to communicate with you whether he wants to or not…I felt deceived… felt like a slap in the face… a threat…you know too much…*).

Understanding

Imagine that you are a hospital patient in a foreign country whose language you do not speak fluently. A team of clinicians enters your room, but you do not understand what they are saying. How might you feel? Would you trust them with your medical care? Now reflect on how trust and communication are related.

Berlinger suggests that knowledge of cultural expectations regarding ethical responses to unintentional harm can help clinicians better understand patient and family distress, and guide appropriate reactions (REF Berlinger, 2005). In this vignette the notions of "respect" and "trust" are often used interchangeably by the family. What is the difference between these two terms? How do clinicians come to trust family members? How should clinicians demonstrate respect?

The patient envisioned that his health would be better by coming to the United States. It was one of the major reasons for his family's move to this country. How might his expectations on the efficacy of healthcare differ from those of a native-born U.S. citizen?

The Provider's View

In your experience, how does a healthcare team react when a patient refuses a medication or procedure that a clinician feels is indicated?

What resources are available to you to optimize patient care when cross-cultural issues come in to play?

What has been your experience with patients or families that are "too well informed"? Think of positive and negative encounters with families who are deeply invested and informed about their loved one's care. What made the difference between the positive and negative encounters?

Solutions

The patient's sister relays her impression that the family's knowledge of her brother's healthcare became "*an issue that started separating the medical team from the family*." She was told, "*You know too much; you are overstepping your boundaries.*" In your experience, who sets the boundaries for family involvement? Who should?

Today's healthcare environment emphasizes "shared decision making" and encourages patients to be active participants in their own healthcare. The patient's sister does not feel this sense of inclusion when she is told, "You are too well-informed…you have way too much information." She responds by asking: "Isn't that the family's responsibility, to know what is going on, to know what is out there, to know what the choices are?" Discuss this conflict and its potential resolution. How might patient and family education be promoted without precipitating the scenario experienced by the family in this narrative?

The patient's sister further reflects, "*There shouldn't be boundaries; we are all on the same team, the team of making him better*." What factors in your hospital environment create boundaries (either appropriate or not) between the clinical team and families. If these boundaries are inappropriate, what can you do to address them?

Part of an effective apology is explaining to the patient and family what steps will be taken to prevent the same error from occurring to someone else. In this vignette the patient states, "*I wouldn't want to see another kid go through the same thing I have gone through*." Discuss systems-based practices that could be implemented to avoid medication error. What are the advantages or limitations of each?

What are three steps that can be taken to avoid confusion and chaos when language creates a barrier for a family member upset about issues related to medical care?

"I FEEL VERY **GUILTY**....THAT IS WHAT IT HAS DONE TO ME. I JUST DON'T FEEL LIKE I HAVE DONE ENOUGH...

"THE ONLY PERSON WHO **APOLOGIZED** WAS HIS PRIMARY CARE PHYSICIAN..."

THE ENGINEER

Engineer with treatable elevated intracranial pressure... family's observations ignored... dementia and paraplegia following delayed diagnosis

Major Themes: Emotion, Communication, Isolation, Apology

Reactions

Reflect on the following statement from the video: "I pay for my mistakes every day at work. But sometimes in healthcare, it's like people don't pay for their mistakes."

Understanding

Broaden the discussion above to the concept of accountability. What does it mean? How is it measured and practiced? How is it related to transparency?

Several aspects of this narrative revolve around communication. The patient's wife states several times that she felt the clinicians did not listen to her. ("*Why don't you listen to me? I am not a doctor, but I know enough about this illness...*"). She also felt people avoided her. ("I asked him why the CT scan wasn't done and he just acted like I never asked the question"). What are the barriers to communication in this case?

In your practice, what barriers to communication exist? How does the act of listening play a role in effective communication? Consider how the act of listening contributes to effective communication with your parents, your partner, your child, your friends, your doctor, and your patients.

The patient's wife is anguished by guilt, although she herself advocated for the patient and suggested the correct diagnosis. Why do patients or their families feel guilty about errors made by others? How are communication and guilt related?

The patient's wife says, "*I felt very angry that the doctors did not listen to me. I got the impression that they just thought I was stupid, and that I would just go away. And I don't go away very easily. If they had listened to me, we wouldn't be here. He wouldn't be in the shape he's in.*" Explore the perceptions expressed in this comment. How can they be effectively addressed?

The daughter states, "*It's sad to watch my mom because her life is completely changed now. She's going to be forced to retire.*" Consider the ripple effects of medical error on individuals other than the patient. How should these effects be recognized? Should the wife be compensated?

The Provider's View

Some clinicians struggle with a sense of failure if a diagnosis remains evasive. How do you feel when you cannot find what is "wrong" with a particular patient? What do you say to the patient in such instances?

In this vignette, the MRI did not show evidence of shunt malfunction, although this was ultimately found to be the cause of the patient's symptoms in the OR. Reflect on clinician dependence on technology or test interpretation. What happens when technology fails?

What happens when a patient queries you about a mistake made by a colleague? How do you respond? (i.e., "*Why wasn't the CT scan done?*")

Solutions

Quill suggests that barriers can be overcome using basic communication skills including acknowledgement, exploration, empathy, and legitimization (REF Quill, 1989). How could each of these tools have been specifically applied in this case?

In this narrative, the son gives voice to one of the biggest obstacles in disclosing error—"*To come back and say they were wrong makes it very hard to deal with… as opposed to 'we don't know what's wrong and we'll keep looking and try to figure it out.*'" Discuss how a clinician might respond to the son and maintain confidence, trust, and a sense of unity between the healthcare team and the patient or family.

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Dance Sequences from Still/Here
Created and choreographed by Bill T. Jones

Still/Here, which premiered in 1994, is the work of MacArthur Fellowship awardee and internationally celebrated dancer and choreographer, Bill T. Jones and the Bill T. Jones/Arnie Zane Dance Company. In preparation for this dance, Mr. Jones conducted participatory workshops with individuals suffering from fatal illnesses and incorporated their experiences throughout. The dance won worldwide acclaim. Mr. Jones has kindly contributed filmed sequences from Still/Here to our film.

Performed by Arthur Aviles, Gabri Christa, Josie Coyoc, Torrin Cummings, Lawrence Goldhuber, Rosalynde LeBlanc, Odile Reine-Adelaide, Daniel Russell, Maya Saffrin, and Gordon White.

Composer, Kenneth Frazelle
Music performed by Odetta and the Lark String Quartet
Dance Film by Gretchen Bender & Bill T. Jones
Dance footage used with kind permission of the Bill T. Jones/Arnie Zane Dance Company

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When Things Go Wrong: A Facilitator's Guide

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