A case to illustrate the relationship between ethics and risk management

- 60 y.o. for CABG
- Case proceeds uneventfully
- Chest closed, skin closure occurring
- Plan for extubation
- Surgeon leaves to speak with family
- Perfusionist hands cell saver blood to anesthesia resident
- Put under pressure
- Cardiac arrest
- Only resident notices air in line
- What next?

A case to illustrate the relationship between ethics and risk management: Old and New Challenges

- Barriers
- Benefits
Overview of history of the ethical imperative of Patient Safety and Risk Management in Anesthesia

- April, 1982 ABC 20/20 show: “The Deep Sleep – 6,000 will die or suffer brain damage…from carelessness”

Some more background

Institute of Medicine: 1999 report that shook the medical world

Some more background

Institute of Medicine: 1999 report that shook the medical world
Culture, ethics and communication linkages to risk management

- Disruptive behavior – unsafe, increased risk
- Unprofessional behavior – unsafe, increased risk
- Poor communication – unsafe, increased risk
- Poor design – unsafe, increased risk
- Poor teamwork – unsafe, increased risk
- Lack of standardization – unsafe, increased risk

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Ethics and Risk Management

HealthAffairs

February 2012, Volume 31, Issue 2

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

Lisa I. Iezzoni1,2, Sonny R. Naul3, Catherine M. DesRoches1, Christine Vogel3 and Eric C. Campbell1

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Adding to equation

Journal of Trauma, September, 2010

All Trauma Surgeons Are Not Created Equal: Asymmetric Distribution of Malpractice Claims Risk

Keval K. Matheny, MD, MSCI; James W. Pichert, PhD; M. Romalda Corwin, MD; C. Tan, MS; Gerald W. Hobson, MD, and Jose J. Diaz, Jr., MD, FACS

- 8% of physicians generated 34-40% of unsolicited patient complaints
- Same 8% generate 50% of risk management expenses
- Physicians in bottom q-tile of patient satisfaction have 110% malpractice risk
More value to communication

Health Affairs
July 2011, Volume 30, Issue 7
Dropped Medical Malpractice
Claims: Their Surprising Frequency,
Apparent Causes, And Potential Remedies
Dwight Gelbman
50-60% of claims dropped once information shared

University approves CandOR process
comprehensive “communication and optimal resolution” process

- Comprehensive
- Integrate safety, risk, quality, ethics and credentialing
- Linkage to claims and legal
- Longitudinal patient safety education plan
  - UGME
  - GME
  - CME
  - Institute for Patient Safety Excellence

The Candor Project

Communication and Optimal Resolution
The Candor Project

What do patients want?
- To know what happened.
- Empathy.
- Apology, if indicated.
- Non-Abandonment.
- Future prevention.
- Remedy.

What do caregivers want?
- To know what happened.
- Empathy.
- Fairness.
- Accountability for all.
- Non-Abandonment.
- Future prevention.
- Candor

A Comprehensive Response to Patient Incidents: The Seven Pillars.
McDonald et al Quality and Safety in Health Care, Jan 2010
- Reporting
- Investigation
- Communication
- Apology with remediation – including waiver of hospital and professional fees
- Process and performance improvement
- Data tracking and analysis
- Education – of the entire process
Goals of the Seven Pillars

- Reduce harm thru transparency and learning
- Reduce lawsuits through early, effective communication (candor) with all parties
- Resolve inappropriate care cases early, efficiently
- Defend appropriate care vigorously
- Support patient and family engagement
- Support care professionals following harm events

The Original Candor Process: A Comprehensive Approach to the Prevention and Response to Patient Events

An Ethical Imperative: the Candor Process : Immediate “Emotional First Aid” Delivered to Patients, Families and Care Professionals
Highlights of IOM report

- Preventing and mitigating fatigue
- Specialty-specific educational focus
- Enhance “culture of safety”
- Engage residents in detection of errors, quality improvement (“moral agents”)
- Use “near misses” and unsafe conditions as educational opportunities for learners
- Protected reporting

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An Assessment of an Educational Intervention on Resident Physician Attitudes, Knowledge, and Skills Related to Adverse Event Reporting

Robert C. Arroyo, MD
Debra J. Coyle, MD, PhD
Marc A. Eisenberg, MD, MSc
David United States
Cecilia Santos, MD, PhD
Anthony, MD
Terrence G. O’Rourke, MD, PhD

108 Journal of Graduate Medical Education, June 2010

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Resident physician occurrence reporting data

Journal of Graduate Medical Education, June 2010

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The Seven Pillars:
A Comprehensive Approach to the Prevention and Response to Patient Events

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Pillar 2 - investigation

- What happened and why?

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Communication

- Timely
- Effective
- Coordinated
- Ongoing
- Engagement of highly competent communicators – case example
- Just in time support
- Interdisciplinary

Creating a communication consult service

- Communications assessment tool
- Measures emotional intelligence
- Assesses cognitive complexity
- Identifies highly skilled communicators in complex social situations
- Balances out the “special colleague” issue

Creating a candor consult service

- Communications assessment tool
- Measures emotional intelligence
- Assesses cognitive complexity
- Identifies highly skilled communicators in complex social situations
- Balances out the “special colleague” issue
Individual Differences in Communication Competence

- Some people are more skillful communicators than others.
- Some communication tasks/situations are much more difficult than others
  - Easy: describe your apartment
  - Hard: disclose a medical error to a grieving family
- Differences in skill most visible in hard situations

The Candor Process:
A Comprehensive Approach to the Prevention and Response to Patient Events

Process Improvement

Elements of optimal resolution

- Patient Safety Compensation Card – given to patients if harm caused by inappropriate care, serves as their ongoing “insurance card”
Putting it all together: proof of concept

Pillar 6 – data

- 13 years of data
- 6 years before and 7 years after implementation of Candor Process
Patient Safety metrics
- Large improvement in HCAPS
- Substantial reduction in SSEs
- Mortality
  - Was lower 50%-ile
  - Now in top 15% of UHC

Other stakeholder buy-in prior to grant
- Medical Societies
- Professional liability companies – hospital and physician
- Hospital Association
- Legal groups
- Consumers Advancing Patient Safety
- Project Patient Care
- Individual hospital boards, medical staffs
AHRQ Grant

- 10 private hospitals, self insured
- Open medical staffs, private professional liability coverage
- 7 from faith-based system
- 2 from a “for profit”
- 1 underserved inner city
- Most with resident physicians

Next steps

- AHRQ Task Order

- Create comprehensive set of validated and tested tools to facilitate the implementation of the Seven Pillars across all hospitals
Next steps

- AHRQ Task Order
- Create comprehensive set of validated and tested tools to facilitate the implementation of the CandOR process across all hospitals
- Working with AHA HRET