THE WISCONSIN SOCIETY OF ANESTHESIOLOGISTS, INCORPORATED

2014 Annual Meeting
Pediatric Anesthesia for the General Practitioner and More

Ethics and Risk Management in Anesthesia: Old and New Challenges
September 6, 2014

Timothy B McDonald, MD JD
Weil Cornell Medical College
Sidra Medical and Research Center,
Doha, Qatar

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 anesthesiology 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
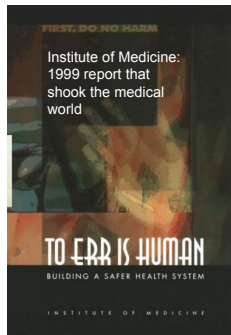
- Barriers
- Benefits

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

abc 20/20

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

Some more background

FIRST, DO NO HARM

Institute of Medicine: 1999 report that shook the medical world

TO ERR IS HUMAN

BUILDING A SAFER HEALTH SYSTEM

INSTITUTE OF MEDICINE

Some more background

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INSTITUTE OF MEDICINE

"A call to arms for families who had loved ones disabled or die in the pursuit of medical treatment." —Former First Lady Rosalynn Carter

Making Matters Worse

WALL OF SILENCE

THE UNTOLD STORY OF THE MEDICAL MISTAKES THAT KILL AND INJURE MILLIONS OF AMERICANS

ROSEMARY GIBSON AND **JANARDAN PRASAD SINGH**

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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

Ethics and Risk Management

Health Affairs

- February 2012, Volume 31, Issue 2

Survey Shows That At Least Some Physicians Are Not Always Open Or Honest With Patients   [→ Expand]

Lisa I. Iezzoni[1,*], Sowmya R. Rao[2], Catherine M. DesRoches[3], Christine Vogeli[4] and Eric G. Campbell[5]

Adding to equation

- Journal of Trauma, September, 2010

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

  Kaushik Mukherjee, MD, MSCI, James W. Pichert, PhD, M. Bernadette Cornett, MA, Ge Yan, MS, Gerald W. Hickson, 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

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More value to communication

HealthAffairs

- July 2011, Volume 30, Issue 7

Dropped Medical Malpractice Claims: Their Surprising Frequency, Apparent Causes, And Potential Remedies   → Expand

Dwight Golann[1]

- **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

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The Candor Project

What do patients want?

- To know what happened.
- Empathy.
- Apology, if indicated.
- Non-Abandonment.
- Future prevention.
- Remedy.

The Candor Project

What do care givers 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

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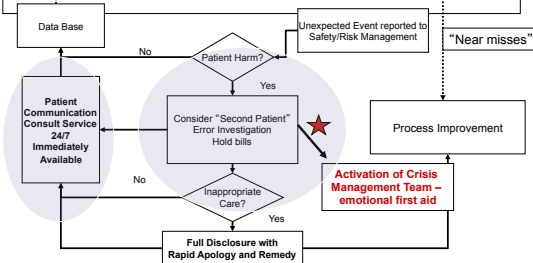**UIC** Institute for Patient Safety Excellence

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

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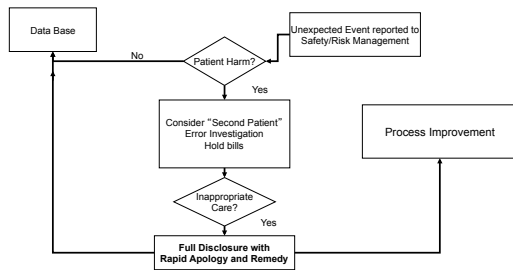
An Ethical Imperative: the Candor Process :
Immediate "Emotional First Aid" Delivered to Patients, Families and Care Professionals

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Highlights of IOM report

RESIDENT DUTY HOURS
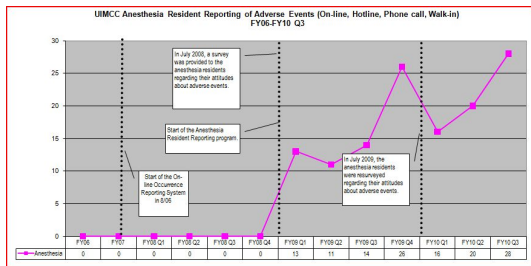ENHANCING SLEEP, SUPERVISION, AND SAFETY

- 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**
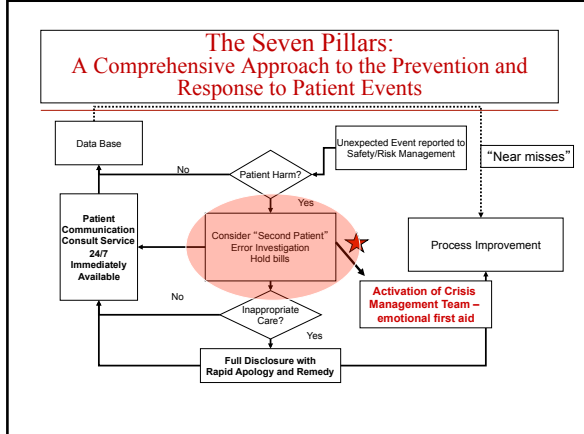- **Protected reporting**

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

Barbara G. Jericho, MD
Rosalie F. Tassone, MD, MPH
Nikki M. Centomani, RN, BSN
Jennifer Clary, BA
Crescent Turner, RN, MS
Michael Sikora, MD
David Mayer, MD
Timothy McDonald, MD, JD

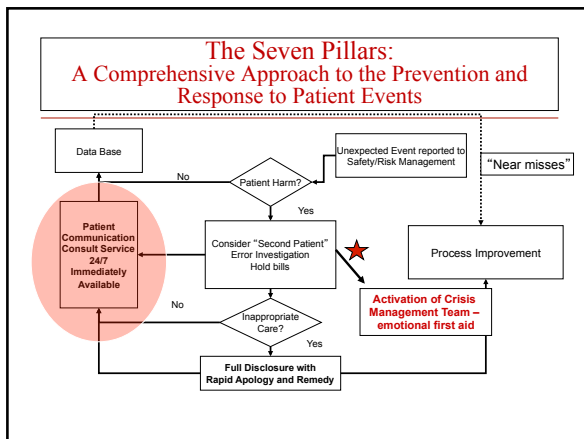**188** Journal of Graduate Medical Education, June 2010

Resident physician occurrence reporting data
Journal of Graduate Medical Education, June 2010

UIMCC Anesthesia Resident Reporting of Adverse Events (On-line, Hotline, Phone call, Walk-in)
FY06-FY10 Q3

	FY06	FY07	FY08 Q1	FY08 Q2	FY08 Q3	FY08 Q4	FY09 Q1	FY09 Q2	FY09 Q3	FY09 Q4	FY10 Q1	FY10 Q2	FY10 Q3
Anesthesia	0	0	0	0	0	0	13	11	14	26	16	20	28

In July 2008, a survey was provided to the anesthesia residents regarding their attitudes about adverse events.

Start of the Anesthesia Resident Reporting program.

Start of the On-line Occurrence Reporting System in 8/08.

In July 2009, the anesthesia residents were resurveyed regarding their attitudes about adverse events.

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

Pillar 2 - investigation

■ What happened and why?

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

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
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- 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

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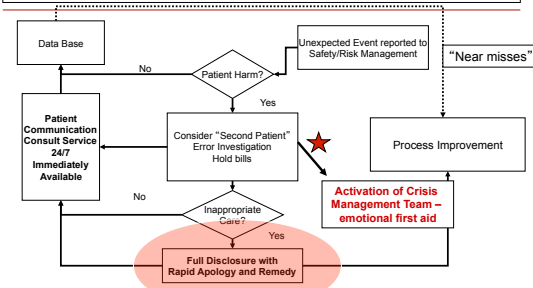
Elements of optimal resolution

- Patient Safety Compensation Card – given to patients if harm caused by inappropriate care, serves as their ongoing "insurance card"
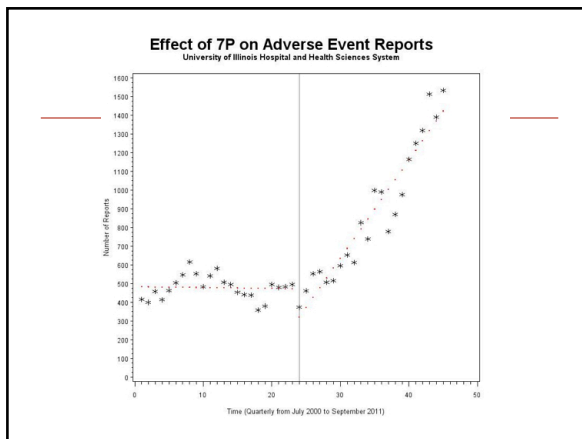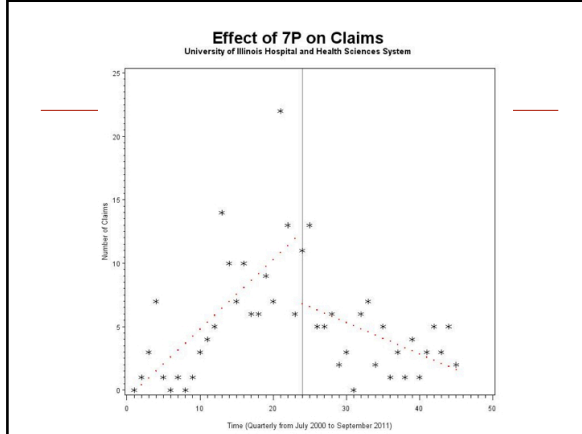
Patient Safety Compensation Card

University of Illinois Medical Center
at Chicago

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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

Effect of 7P on Adverse Event Reports
University of Illinois Hospital and Health Sciences System

Effect of 7P on Claims
University of Illinois Hospital and Health Sciences System

Number of Claims

Time (Quarterly from July 2000 to September 2011)

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

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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

Next steps

- AHRQ Task Order
- Create comprehensive set of validated and tested tools to facilitate the implementation of the Seven Pillars across all hospitals

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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

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