Communicating Adverse Outcomes to Patients and Patients’ Families

Jane Case, DNP, APRN-BC
Assistant Director of Advanced Practice
Department of Medicine
Virtually every clinician knows the sickening feeling of making a bad mistake. You feel singled out and exposed - seized by the instinct to see if anyone has noticed. You agonize about what to do, whether to tell anyone, what to say. Later, the event replays itself in your mind. You question your competence but fear being discovered. You know you should confess, but dread the prospect of potential punishment and of the patient's anger.

Albert Wu, “The second victim”: 2000
Why talk about Disclosure?

• Disclosure is nothing new….part of our ethical duty to patients
• There are barriers to doing what we believe is right by patients, families, and institutions
• Lecture will develop principles that will help each of us recognize circumstances that may require different approaches
Adverse Events and Negligent Injuries

All U.S. hospital stays

Adverse events (6% of stays)

Negligent injuries (1-2% of stays)

Negligent Medical Injuries and Liability Claims

Valid claims, lawsuits filed: 2% of potential

Potential claims (legally valid)

Total suits actually filed (5-7 times more invalid than valid)

Complaints about Communication

• “He did a very poor job of communicating. He did not do what he said he would do. He discounted everything that we said as though we were brainless turds that just happen to be in the way during his busy day.”

• “NP X offered no information. I felt she was hiding information. Never even tried to speak to my husband.”
Complaints about Access and Availability

• “...never gives me more than 5 minutes.”
• “He was terrible with this pregnancy and was even worse (if it’s possible) with the next one, but the HMO said I had to stay with him. I kept hoping to get his partner, but never lucked out. I’m not getting pregnant any more because of him.”
Patient Complaints

• “I had questions about my medical condition and treatment. Dr.____ looked up and asked, ‘Are you illiterate?’ I said, “No.” Dr.____ responded, ‘Oh, I just gave you several pamphlets that explain all of this. Since you didn’t get it, I thought that maybe you were illiterate.’ ”

• “Dr. _____ told me, ‘You are not sick enough to stay at this hospital...besides, this is not my problem.’ When I asked what I should do, Dr. _____ responded ‘perhaps you should go to a homeless shelter’ ”
Case 1
Case 1

• A 68 year old man, J.V. was admitted to the Morgan service in acute hepatic failure on April 15, 2010. He had an extensive past medical history but was last seen by the ID service on February 17, 2010 just 8 weeks earlier when he was hospitalized for an infected right hip arthroplasty.

• During the February hospitalization, Mr. V. underwent intraoperative debridement of his hip; however the hardware was left intact. Although the gram stain revealed 3+ polys and 2+ GPCs, the cultures remained negative. The ID consultants recommended 8 weeks of vancomycin and rifampin followed by chronic suppressive antibiotics.
Case 1

**PMH:**
- HTN
- Coronary artery disease; s/p stent placement 2007
- Hyperlipidemia
- Diverticulitis
- Hypothyroidism
- GERD
- s/p cholecystectomy in 1999; appendectomy in 1987
- Left hip replacement in 2006
- NSCLC diagnosed in 2004, treated with chemoradiation
- Depression/anxiety

**Social:**
- Widower; wife died last year of colon cancer.
- Alternates living alone or with daughter and son-in-law when ill.
- 30 pack year history of tobacco; none since 1992
- Former heavy alcohol user; now rare
- Cruise ship vacation in Caribbean in 2006; no travel since

**Family:**
- CAD, HTN, stroke, cancer
• Vancomycin 1000 mg every 24 hours for 8 weeks with a goal of keeping the trough between 15 and 20.
• Rifampin 300mg po BID for 8 weeks.
• Weekly CBC with differential, creatinine, vancomycin trough and weekly CMP
• Follow-up in ID clinic was scheduled for April 18, 2010
• Mr. V will likely need chronic suppression with oral antibiotics following completion of IV vancomycin; agent to be determined by clinic attending.
• Results of outpatient laboratory monitoring should be faxed to the ID Clinic (615) 343-3123.
## Laboratory Studies

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<tr>
<th>Date</th>
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<td>36 U/L</td>
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<td>1288 U/L</td>
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<td>22.3 mg/dl</td>
<td>3328 U/L</td>
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What Happened?

- The decision to use rifampin in this patient was reasonable and appropriate.
- The attending and fellow notes describing the necessary monitoring on rifampin and the appropriate reporting of those results were done properly.
- Each week, the home health agency dutifully collected the blood and ordered the studies as recommended by the ID consultants.
- The results were faxed to the orthopedic clinic where staff dutifully sent them in a message basket to the ID attending.
“Listen up, my fine people, and I’ll sing you a song ‘bout a mostly good doctor who done something wrong.”
Response Strategies Balance Beam

No disclosure/"safe" facts

Facts, Limited disclosure, more later

Fully disclose error right away

Disclose error, assign responsibility
1. No disclosure/safe facts: “Hepatitis is a serious condition. Your father has several risk factors for hepatitis. Under these circumstances liver toxicity just happen sometimes, and I’m sad to see that Mr. V has this. Now we need to focus on managing ...”

2. Facts, more later: "I don’t yet know why Mr. V has hepatitis. He was on rifampin which might have contributed ... we need to review his condition, and the results of his most recent tests... to see whether we can find out the cause of his liver condition“

3. Disclose error: “Mr. V was continued on rifampin despite his rising liver tests which may or may not have contributed to his hepatitis. We need to review his condition and the results of his most recent tests to see whether we can find out the cause of his hepatitis“

4. Disclose error, assign responsibility: “Mr. V was continued on rifampin despite his rising liver tests and that has caused his hepatitis. The home health agency sent the labs to the wrong clinic and the nurses there should NEVER have tried to communicate these labs to me in a message basket. I am so sorry that this probably resulted in Mr. V’s hepatitis..."
An angry family member

• Mr. V’s daughter, T.V.C, is a speech therapist and had some understanding of the importance of monitoring liver tests while on rifampin. Ms. C had even complained to the supervisor of the home health agency nurse because she was one day late in collecting her father’s blood during his first week home. She is angry and upset that the rifampin had been continued in spite of the rapidly rising LFTs.

• “I assumed that when Dad’s blood was sent in each and every week and the medicines were not changed, that everything was OK. We trusted you to take care of Dad, to help him, and instead you poisoned him.”
If a patient reacts angrily

- Be professional
- Remain calm
- Anticipate
- Avoid defensiveness (challenging!)
- Consider possible sources of anger
- Acknowledge patient/family’s anger
- Use empathetic statements
- Avoid making excuses, blaming
If a patient reacts angrily

- Use calm, soft voice
- It is okay to disagree, just don’t argue
- 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
General Elements* of Disclosing Obvious, Harm-Causing Errors

- Apology (be precise); nature of error, harm
- When, where error occurred
- Causes, results of harm; actions taken to reduce gravity of harm; actions to reduce or prevent re-occurrence

• The ID attending, a physician-scientist without an outpatient clinic, had rotated off service and had not opened StarPanel in the previous 6 weeks.

• Although the first set of labs were faxed to the ID clinic and reviewed, the patient had been briefly hospitalized for an arrhythmia in late February. Because he was discharged to his daughter’s home in a nearby town, a different home health agency began collecting and reporting the labs.

• The patient was taking 4 grams of acetaminophen per day for arthritis pain.

• He had also begun drinking again although he reported that he almost always limited himself to no more than 2 or 3 beers per evening.
Why do patients and their families sue providers?
Reasons Parents Sued

- Advised to sue by influential other: 32%
- Needed money: 24%
- Believed there was a cover-up: 24%
- Child would have no future: 23%
- Needed information: 20%
- Wanted revenge, license: 19%

*Participants could provide more than one reason

What do we know about the distribution of lawsuits within groups of physicians?
Malpractice Risk

• Malpractice activity is disproportionate among physicians by discipline
• 75% - 85% of awards, settlement costs over a 5-year period made on behalf of
  – 1.8% of internists
  – 6.0% of obstetricians
  – 8.0% of surgeons
• High risk today = high risk tomorrow

Sloan et al. (JAMA, 1989), Bovbjerg (JAMA, 1994)
Case 2
A 38 year old woman H.K.T. is referred to the ID clinic for consultation because of a concern for Lyme Disease. She has been experiencing persistent fevers, profound fatigue, and disabling myalgias. She was treated with doxycycline for 3 weeks but did not improve.
Case 2

- Ms T has never traveled to a Lyme endemic area. She does not recall having a tick bite herself but frequently finds them on her dog. No history of ECM.

- She has been experiencing low grade temperatures as high as 99.5 for the past 6 years. Because her normal temperature is only 97.0, she explains that this means that she is really having fevers > 100. Ms. T is no longer able to take care of her grandson because she is tired all the time. Her joints hurt so she is unable to exercise. She has gained 36 lbs during her illness despite a poor appetite. She is frequently constipated. She complains of dry itchy skin but does not have any rashes.
### Western Blot for Lyme Disease

<table>
<thead>
<tr>
<th>Lyme Diseases Ab IgG, WB</th>
<th>Lyme Diseases Ab IgM, WB</th>
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<tr>
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<td><strong>Positive</strong></td>
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<tr>
<td>Lyme Diseases 93kD IgG</td>
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**PMH**

HTN  
Fibromyalgia  
Irritable bowel syndrome  
Endometriosis  
Chronic low back pain  
Mitral valve prolapse  
Anxiety/depression  
s/p hysterectomy  
s/p “back surgery”  
Silicone breast implants  
Carpal tunnel release X2

**Social History**

Single, divorced  
2 adult daughters  
Smokes ½ PPD  
No alcohol or other drugs  
Disabled due to back pain

**Family History**

HTN, diabetes, cancer, depression.  
Father died in MVC in 1992

**Physical Examination**

T= 97.8; P = 80; RR = 14; BP 142/88  
Morbidly obese woman, anxious in appearance, NAD, unremarkable exam
Work-up of illness

- Fever diary – no temperature > 99.2
- CBC with differential, CMP, ESR, CRP, ANA, and HIV are all normal
- Thyroid studies are normal
- CT of the chest and abdomen also are normal
Your Assessment

• No infectious illness is likely the cause of Ms. T’s symptoms.
• You counsel smoking cessation, healthy diet, increased exercise, and suggest she may want to pay a visit to your colleagues in rheumatology.
• Ms. T is insistent – couldn’t this be Lyme disease? Her friend was diagnosed with Lyme and her symptoms are very similar.
• You explain that because she has not traveled in a Lyme endemic area this is unlikely. Further, because she has just completed a 3 week course of doxycycline for chronic RMSF, she would have been treated for Lyme in any case.
4 months later

- You receive a call from patient affairs.

- Ms. T has been diagnosed with Lyme Disease by another physician. After 6 weeks of IV ceftriaxone she is already feeling much better although she is still not completely well.

- Because of your refusal to see how sick she was, you failed to make an accurate diagnosis and start appropriate therapy.
• Drat! I guess I screwed up.

• I doubt she really has Lyme disease. She had no exposures, no clinical illness consistent with Lyme.

• This lady has a lot of problems. My only mistake was referring her to rheumatology. What she needs is a psych consult.
• Ms. T has no interest in seeing you again. She just wants you to acknowledge that she really did have a serious infectious illness and that you missed it. She wants an apology.

• Laboratory reports are faxed to you. A positive test for Lyme disease is, indeed, in the packet of material.

• Name of the laboratory: Igenex
Case 3
Case 3

A 54 year old man, A.K. is admitted to the cardiothoracic surgery service after he is seen in their clinic and noted to have a temperature of 101.5F. He is one month status post CABG.

PMH:

- Type II diabetes
- Hypertension
- Hyperlipidemia
- s/p MVC in 1999
- Pneumonia in 2006

Social history: Married with 2 adult children; 1 still at home
- Lives in Clarksville
- Currently disabled; former barber

Former smoker; none X 15 years
Rare alcohol use
Case 3

- Infectious disease consultation is requested after blood cultures drawn on the day of admission reveal Group B streptococci in two of two sets.

- The “ID final recs” states the diagnosis is Group B strep septicemia. The likely source was determined to be lower extremity cellulitis at the site of saphenous vein harvest.

- The following recommendations are made:
  - Start ceftriaxone 2 grams every 24 hours for 2 weeks
  - Repeat blood cultures
  - Check CBC with differential and CMP now
  - Weekly CBC and creatinine while on this regimen.
  - Patient may follow-up in ID clinic
Case 3

- Two weeks after discharge, A.K. is brought by his wife to the Emergency Department because of weakness and anorexia.
- Mr. K’s temperature is 100.2, pulse is 132, RR 28, and blood pressure is 104/54.
- He is admitted to the MICU and empirically started on vancomycin, piperacillin/tazobactam, and doxycycline. His blood pressure falls despite numerous fluid boluses and he is started on pressors. Blood cultures are drawn. A CXR shows bilateral patchy infiltrates and one cavitary lesion in the right middle lobe. ID consultation is again requested.
Case 3

• MRSA is isolated from all blood cultures drawn, and from his sputum and urine.

• The ID fellow notes while reviewing Mr. K’s chart, that blood cultures drawn before his discharge from the hospital two weeks previously were also positive for MRSA.

• Mr. K develops ARDS and acute renal failure. Despite aggressive treatment and supportive care, he continues to decline. On hospital day 5, the decision is made to withdraw care.
Case 3

- Mrs. K and her sister are understandably tearful and distressed. Although you signed off the case when plans were made to withdraw care, Mrs. K sees you near the elevator and approaches you saying

  “I just want to thank you for all that you did for Al. I know that you did everything you could for him and we have to trust in God’s will and understand that he is going to a better place.”
Response Strategies Balance Beam

No disclosure/ "safe" facts

Facts, limited disclosure, more later

Disclose error, assign responsibility

Fully disclose error right away
1. Thank you Mrs. K. I know this is hard and I am so sorry for your loss. We did all we could do.

2. Thank you. I think we could’ve honed in on the seriousness of his infection sooner. I will go through Mr. K’s chart carefully to see if there is anything that we might have done differently.

3. Mrs. K, I appreciate your kind words. One of the sets of blood cultures drawn 2 weeks ago was positive for MRSA. I am going to go through Mr. K’s chart carefully and see if I can find anything that we might have done differently or better.

4. I’m glad you brought this up Mrs. K. I just learned that Mr. K’s blood cultures were positive for MRSA 2 weeks ago. If the cardiothoracic surgeons had bothered to check the chart, we might have been able to cure this infection before things got so bad.
What Happened?

• The blood cultures for MRSA were entered into StarPanel just as Mr. K was being discharged from the hospital.

• The technician in the Microbiology lab documented that she notified “the” ID fellow of these results.

• “The” ID fellow had actually already rotated off the consult service and received the call while she was at the airport.

• The fellow then texted the “right” fellow with the results.

• The “right” fellow says he never received the page.
“A somewhat different challenge may present itself when healthcare professionals witness harm being committed or discover that a patient experienced harm in the past when someone else was caring for the patient ... even if a MD is not responsible for the harm, that MD still has the ethical obligation of protecting patient welfare in general by disclosing incompetence and promoting operational improvements that enhance patient safety.”

What makes an apology effective?
Apologies

• Sincere body language, tone of voice
• Beware of:
  – The narcissistic apology
  – The “sorry, but...” apology
  – The “sorry you feel...” apology
  – The “sorry for my sorry colleagues...” apology
• Patients may be more willing to forgive than family/friends who doubt your sincerity
• Others?
Sympathy/Apology Statutes

• 29 states with “sympathy/apology” statutes. “I’m sorry, I regret” etc. **not** admissible.
  – However, in most of these states, admitting “fault” **IS** admissible, e.g., California, Florida, Louisiana, Maine, Missouri, New Hampshire, **Tennessee**, Texas, Virginia, Washington
  – 4 states (Colorado, Connecticut, Arizona, Georgia): “fault” apology inadmissible
The Patient’s Bill

• 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?
What about malpractice claims?

Does disclosure make a difference?
Does Open Disclosure Reduce Litigation?

• Lexington, KY VA Med Center adopted full disclosure policy late 1980s → Increased settlements with reduction in the mean malpractice settlement payout

• University of Michigan Health System began disclosure program in 2002.
  – Open claims halved between 2001 and 2004 (Boothman 2004).
  – Attorney fees: $3MM → $1MM (Berg 2004)
Error by a Colleague
&
Jousting
What is Jousting?

• Public criticism of care provided by another individual or institution

• Public means
  – In the medical record
  – To or in front of:
    • Other care team providers/staff
    • Non-care team providers/staff
    • Patient & family

This material is confidential and privileged information under the provisions set forth in T.C.A. §§ 63-1-150 and 68-11-272 and shall not be disclosed to unauthorized persons.
Why focus on this topic?

• Jousting is not consistent with professionalism
• Medically non-meritorious cases have come to the attention of Risk and Insurance management that were driven by internal jousting
  – Expensive and time-consuming
  – Reflects poorly on us as an organization
• Jousting undermines a culture of safety
Patients tell us that “disclosure” is routine: One MD/RN “Jousting”/Criticizing Another

• “He ordered what???”

• Dr. told the pt, “It will probably take a week to get your blood work back. This place is horribly inefficient, you know. You can't imagine how hard it is to get things done here.”

• To a care team, in front of staff: “…you’re killing this patient with what you’re doing.”
Unsolicited Patient Complaints:
“Jousting” by Physicians

- “Dr. Surgeon said my internal medicine doctor is harsh when patients don't take good care of themselves.
- “My endocrinologist said that my surgeon should never have done the surgery on me…”
- “Surgeon apologized...said my admission was not appropriate but she could do nothing since the ED attending admitted me.”
- Pt reported, “Dr. Surgeon made a mistake ..., but blamed my hometown physician for it.”
“Jousting,” not just public “dueling” or “turf battles”—

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

For example

• “Oh, they do that all the time”
• “She means well, bless her heart, but...”
• “I don’t understand why his supervisor permits such sloppy work...”
• In a Med Record: “Physician notified. No response.”

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A VUMC example

• E-Note: Pt given a massive dose...10x more than needed...put [pt] at significant risk... additionally pt didn’t get [another treatment]...I plan on reporting him... this is inappropriate and exposes the patient to...a boatload of other risks...

• It is always appropriate to report errors and concerns to Risk Mgmt; it is NOT appropriate to make a note about the report in a MR because doing so may make the report discoverable.

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Documenting a Professional Disagreement--Professionally

- Dispassionate description of findings/facts/data
- No adjectives or adverbs
- Be objective
- Present issues related to the case, not other professionals
- Make sure it’s true and not misleading
- How would it look projected on a courtroom wall?
- For example...
Acute Renal Failure: Tobramycin level is 20. High levels are associated with renal toxicity. He did have tobramycin impregnated orthopedic cement that contained 20 gm of tobramycin.

NOT

Acute Renal Failure: the orthopedic surgeon put in way too much tobra. This has obviously caused the patient’s renal failure.
It Has Occurred

Now What?
Guiding principles for conversation with someone who jousted

• Be professional – Don’t “react”
• Indicate you want to talk privately with Dr. Jouster about a patient you share, then objectively recount what you heard from the patient or read in the chart
• Seek Dr. Jouster’s recollection of events
• Aim for agreement or at least understanding on medical issue/error in question
Recognize Triggers/Symptoms

• Fight, flight, or freeze reaction
• Many feel intense fear, anxiety and/or rage
• Causes a feeling of “system overload, swamped by distress and upset”
• Changes in heart rate, respiration, sweating, voice
• Controlled expression, chin tightens, set jaw
• Thinking becomes difficult


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When YOU get angry

- 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.
- Be wary of/refrain from writing in the Medical Record and sending emails (limit to a draft, review later)
- May need to disengage to regain control
Principles for “Informal” Conversations

• Your role:
  – To report an event
  – To let the colleague know that the behavior/action was noticed (surveillance)
• It’s not a control contest. (“I am coming to you as a colleague...”)
• Know message and “stay on message”
• Know your natural default (your communication style; your “buttons”)
• Appreciation may not be expressed by the recipient
Principles for “Informal” Conversations

• Maintain trust and respect (no “gotcha”s)
• Minimize distractions (have in private or semi-private area if possible: not about embarrassing, but relating an observation/event/report)
• Have sufficient humility to listen to your colleague. After all, not every report we hear is true ("innocent until proven guilty")
• Avoid any tendency to downplay seriousness
• Balance empathy and objectivity
• Anticipate range of responses (push-backs) – from rage to non-response
Principles to Handle the Unexpected

• Listen carefully; remain calm, professional (position)
• Ask questions to learn reasons for assertion/jousting, be prepared to respond with next steps
• It’s okay to say you don’t know or aren’t sure, but you want to find answers (but sometimes there are none)
• Remain confident in known facts, stick to message
Opening the Conversation

• Offer appreciation (if you can): “You’re important, I value your expertise and care. If not, I wouldn't be here.”

• Use “I” statements: “I heard...,” “A family told me...,” “I received a report...”

• Review incident, provide appropriate specifics

• Ask for colleague’s view...pause...

• Respond to questions, concerns...
Ending the Discussion

• Appreciation, affirmation
• Empathy: “Now I feel I understand..."
• Accountability: "But we've all got to respond professionally..."
• Reminder of behavior standards: “incident did not appear consistent with..."
• If asked what to do use phrases: "reflect on the issues, think about ways to prevent recurrence."
• If appropriate, Assure: conversation confidential, known only to...
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 disagreement persists, “You may wish to take your concerns to others...From this point on I want us to focus on...”

• Offer assurance of your continued commitment “if they allow”
Guiding Principles for Agreeing to Disagree

• Be prepared: objective review/evaluation complete, you are confident in the medical judgment, you know your message
• Affirm you heard and understood
• Stick to your message (may have to repeat 2-3 times)
• Body language, eye contact, tone of voice matter (e.g. professionals often nod to signal ‘I’m listening,’ but nods may be interpreted as agreement by the accuser)
Professionals commit to:
• Technical and cognitive excellence
Professionals also commit to:
• Clear and effective communication
• Modeling respect
• Being available
• “Self-awareness”

Professionalism promotes teamwork
Professionalism demands self-regulation

Requires the ability to give and receive feedback
What if there appears to be a pattern of suboptimal care by a well established doctor?

Weigh the pros and cons for:

1. Initial and, if needed, follow-up private conversations (cups of coffee) by you and/or someone in the chain of command; report to Risk Management

2. Grand rounds or other facilitated group discussion about variation in group practice, the evidence base, and desire to increase reliability

3. MM&I discussion around a case—only with the doctor’s knowledge her/his case will be discussed

4. Peer review conducted by established process and established committee

5. Something else
Reporting

- **What to report:** errors, errors causing harm, adverse outcomes
- **Who to call:** Risk Mgmt, Office of Gen Counsel
- **When:** ANY time
- **How:** 0 x 6-0660, 24/7 number 615-878-0705, online VERITAS
- **Why:** gives you timely help and support; objective, fair expert, reviews; promotes quality
- **Complete event reports as soon as possible.**

VUMC policy OP 10-10.24 Occurrence Reporting: Patient and Visitor
Vanderbilt is committed to disclosure of errors

Disclosure
- Should not be “impromptu”
- Includes Risk Management
- Done only after gathering the facts
- Avoids blame
- Accompanied by plan for patient