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Ebola, Team Communication, and Shame: But Shame on Whom?

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Examinied as an isolated situation, and through the lens of a rare and feared disease, Mr. Duncan's case seems ripe for second-guessing the physicians and nurses who cared for him. But viewed from the perspective of what we know about errors and team communication, his case is all too common. Nearly 440,000 patient deaths in the U.S. each year may be attributable to medical errors. Breakdowns in communication among health care teams contribute in the majority of these errors. The culture of health care does not seem to foster functional, effective communication between and among professionals. Why? And more importantly, why do we not do something about it?

Keywords: education, ethics committees, health care delivery, medicine, nursing, organizational ethics

THE FIRST CASE OF EBOLA IN THE UNITED STATES

Late in the evening on September 25, 2014, Thomas Eric Duncan walked into Texas Health Presbyterian Hospital in Dallas, TX, accompanied by his fiancée. He had flown 5 days earlier from Liberia, where he had helped a pregnant woman suffering from Ebola. In the emergency department (ED), he waited an hour before being seen by the triage nurse, who noted his temperature was 100.1 degrees Fahrenheit and that he complained of abdominal pain, nausea, headache, and dizziness. Once admitted, the ED nurse who assessed Mr. Duncan noted that he had recently traveled to Africa in his electronic medical record (EMR). A short time later, he was assessed by the emergency medicine physician, who noted that his physical exam was “remarkable only for nasal congestion and a runny nose along with mild abdominal tenderness.” The ED physician ordered an IV and some tests, and prescribed acetaminophen. Suspecting sinusitis, one of the tests ordered was a computerized tomography (CT) scan of the head. The CT results were “unremarkable” according to the medical record.

At 3 a.m., Mr. Duncan’s temperature had risen to 103 degrees. But just 16 minutes later, the ED physician made an entry in the EMR saying Mr. Duncan was “feeling better and comfortable with going home.” He was discharged from the ED—4 hours after initially being seen by the triage nurse—with a diagnosis of sinusitis, a prescription for antibiotics, instructions to return if his symptoms worsened, and a recommendation to follow up with his “own” doctor.

Two days later, Thomas Duncan returned to the hospital by ambulance. He was much sicker. Within 48 hours, tests confirmed he was positive for the Ebola virus. On October 8, a little more than 2 weeks after he had first arrived in the United States, Mr. Duncan died from complications from the Ebola virus (Berman 2014; Dunklin 2014; Dunklin and Thompson 2014).

WHAT WENT WRONG?

While this case occurred at Texas Health Presbyterian Hospital, it could have been any hospital in the United States. Instituting a cordon around the United States in an attempt to prevent people who have been exposed to Ebola from crossing the borders, would not have fixed the systemic issues encountered by Mr. Duncan and any others who will seek help in the U.S. health care system. A cordon will not prevent Ebola and drug-resistant tuberculosis, or other global health issues, from reaching the United States. Creating legal sanctions against patients who do not fully disclose risk factors will not prevent people from being reluctant to share embarrassing, illegal, or highly personal information. Instituting mandatory quarantines for people who have traveled to affected areas in Africa or been exposed to Ebola will only sacrifice individual liberty for a false sense of national protection.

Unfortunately, while the disease affecting Mr. Duncan was exceptional, what happened to him was not an exception. Ebola is a new threat, much as HIV was several decades ago. Mr. Duncan was the first patient to present with Ebola to any hospital in the United States, yet patients seek help every day with unique and puzzling situations and symptoms. Many patients may have difficulty recalling...
their medical histories; many do not share important information with their providers out of fear, shame, or simply not seeing the relevance to their health (Reddy 2013; Tam et al. 2005). The basic challenges faced by the ED team when Mr. Duncan arrived with a low-grade fever and other complaints were not unique to Ebola (Dunklin 2014; Dunklin and Thompson 2014).

What seems to have happened in Mr. Duncan’s care is all too common in health care. It now appears certain that errors occurred when he first presented to the ED. There is no way to know whether Mr. Duncan would have lived if treatment had been timely. Yet what we can conclude with certainty is that the ideals of care that the most costly health care system in the world espouses were not realized. Close to half a million Americans die from preventable adverse events—medical errors—every year in the United States (James 2013). At this time, the worldwide death toll from the current Ebola outbreak is less than 5,000 and the U.S. death rate is 2 (Goodnough and Trenchard 2014). Finding individual fault and punishing the physician or nurses who cared for Mr. Duncan in the emergency department on the night of September 25 will not prevent another thousand patients—a day—from succumbing to the more pernicious issue of errors in health care.

A CRISIS IN HEALTH CARE: TEAMS AND COMMUNICATION

In 1999, the Institute of Medicine (IOM) published the landmark report “To Err is Human: Building a Safer Health System” (Kohn, Corrigan, and Donaldson 2000). At that time, deaths resulting from medical errors in the United States were estimated at 44,000 to 98,000 per year (Kohn, Corrigan, and Donaldson 2000). The IOM report called for a 50% reduction in errors within 5 years. Yet in 2013, a carefully designed meta-analysis of four studies, using a common data collection method, estimated deaths in the United States from preventable medical errors at 210,000–440,000.1

1. Using current data, James (2013) updated estimates of U.S. mortality resulting from preventable adverse events (PAEs), that is, medical errors. Through a literature search, James identified four recent, rigorous studies using the Global Trigger Tool (GTT) and a two-tier approach for evaluating evidence of PAEs in medical records. The GTT method uses nurses or pharmacists to review medical records for suspected errors, such as use of naloxone (Narcan). All incidents are then reviewed by at least one physician evaluator to confirm that an error occurred and to weight the resulting patient harm. The GTT method is biased toward errors of commission rather than errors of omission (such as a missed or delayed diagnosis). The four identified studies involved 4252 patient record reviews and identified 32 patient deaths resulting from PAEs (0.8%). James calculated a weighted average for U.S. mortality based on the four study samples, resulting in an estimate of 210,000 lethal PAE each year. Factoring in errors of commission, this estimate increases to 440,000 deaths per year from PAEs that occur in hospitals. James reported that based on these new estimates, PAEs are the sixth leading cause of death in the United States.

Historically, health care professionals who made an error in care were named, blamed, and shamed. Nurses, physicians, pharmacists, and other clinicians who harmed patients through their mistakes were viewed as incompetent, uncaring, sloppy, lazy, or even malicious (Wu et al. 1997). As the role of systems design in health care errors gained credibility, the idea of creating a “culture of safety” became pervasive within health care. Attention shifted, at least officially, from blaming individuals to looking for the system failures that allow or even enhance the likelihood of human error.

Yet many years of research on patient safety continue to affirm that the leading factor in health care errors is communication breakdowns among the health care team. The Joint Commission, in examining sentinel alerts such as delays in treatment, infant abductions, and patient falls, has consistently reported that communication is the most common root cause failure (Joint Commission 2014). While some communication failures are simple transmission errors, such as not hearing clearly or mis-speaking, others are more complex communication failures related to hierarchy, interpersonal conflicts, or unclear role expectations (Sutcliffe, Lewton, and Rosenthal 2004; Thomas, Sexton, and Helmreich 2003; Zwarenstein, Goldman, and Reeves 2009; Zwarenstein et al. 2013).

Thomas Eric Duncan sought treatment in an emergency department that should have been able to provide some of the best health care in the world. He was seen by highly educated health care professionals in a modern, fully equipped health care facility. In addition to other tests, he received a CT scan to rule out rare but serious causes for his headache and nasal congestion. Yet in all likelihood his assessment, like that of most patients in the U.S. health care system, was fragmented between different care providers and recorded in a complex EMR that further parcell information (Fernandez, Shear, and Goodnough 2014). Basic but key information, such as vital signs, was assessed and recorded, but not communicated. Social history, such as recent travel, was gathered and noted, but not synthesized. Critical but routine decisions, such as readiness for discharge, were made, but not discussed. In an ED setting, an ill patient is seen by multiple nurses, physicians, nursing assistants, and others, answering questions, providing information, being assessed, and assuming that the health care team is integrating important information into a cohesive plan.

The reality is that communication within health care teams, particularly in the United States, is a tacit embarrassment. It might be tempting to conclude that the problem lies with individuals: physicians too difficult to approach, nurses overwhelmed or disconnected, or silent pharmacists. The actual issues are less personal but more complex.

CIVILITY, BULLYING, AND PATIENT SAFETY

Health care workplaces remain predominantly—and anachronistically—segregated. Physicians and nurses
have separate workspaces within the same unit; pharmacists and social workers are relegated to different areas entirely. Social spaces are often segregated with separate lounge areas, and sometimes even library and reference areas are physically disconnected. For most health care professionals in the United States, this strict division begins with the start of professional education where shared prerequisite classes give way to isolated professional learning, often in physically disconnected buildings. Separation of people within environments makes sense when based on privacy issues, such as separate spaces for staff versus families, or task completion efficiency, such as geographic proximity. Yet health care teams continue to function in an oddly segregated environment until innovative workspace remolds abolish these artificial barriers.

A questionnaire study of nearly 2,000 intensive care physicians in 21 countries found that U.S. physicians were the least likely to report they would involve nurses in end-of-life decisions (29%) compared to their peers in Northern and Central Europe (62%), Japan (39%), Brazil (38%), or Southern Europe (32%) (Yaguchi et al. 2005). In a study conducted in the United States, attitudes toward collaboration and interprofessional conflict were collected with a cross-sectional survey from 320 intensive care physicians and nurses in eight critical care units in six hospitals in Texas (Thomas, Sexton, and Helmreich 2003). While 73% of physicians rated their quality of collaboration and communication with nurses as high or very high, only 33% of nurses shared that opinion, rating the quality of nurse–physician collaboration and communication significantly lower. These investigators concluded that physicians and nurses experienced remarkably different work climates and cultures. Nurses in that study reported that it was difficult to speak up when they perceived problems, that disagreements with their physician colleagues were not appropriately resolved, and that they needed more participation in decision making, yet when they offered input it was not well received. A large, cross-sectional study exploring conflict in critical care found that the most frequent source of conflict was not difficult, end-of-life patient care decisions but intradisciplinary disputes (Azoulay et al. 2009). Poor communication was perceived as common, and the most frequently reported source of behavior-related conflict was personal animosity within the health care team.

Health care is accepted as hierarchical (Paradis et al. 2013). Attending physicians oversee more junior physicians. Supervising nurses manage day-to-day operations. Hierarchical systems of leadership have been found to foster bullying and incivility (Johnson 2009; Paradis et al. 2013). Medical, nursing, pharmacy, and dental students report being bullied by their faculty (Anderson 2013; Knapp et al. 2014; Rowland et al. 2010; Timm 2014), by their preceptors (Timm 2014), and as new professionals (Fnais et al. 2014; Steadman et al. 2009). Health professionals also report being bullied by each other. Residents and medical students report being routinely harassed by nurses during their training years, sometimes in cruel and demeaning ways (Crutcher et al. 2011; Fnais et al. 2014; Schlitzkus et al. 2014). Nurses report experiencing incivility from physicians (Brewer et al. 2013; Laschinger 2014; Tang et al. 2013). Finally, health professionals report that they are bullied and suffer incivility from their own professional colleagues; dentists report being bullied by their own colleagues (Steadman et al. 2009), and nurses report frequent incivility on the part of their colleagues, sometimes referred to as horizontal violence (Baltimore 2006; Center 2011; Johnson 2009).

Does this discord among health care teams have an effect on patient care quality and safety? Johnson (2009) completed a literature review concluding that nurse–nurse bullying created a negative work environment that threatened patient safety. Nurses who are bullied or who witness bullying by other nurses or physician colleagues report feeling less compassionate toward their patients, more susceptible to making errors, and more reluctant to tell a colleague they have made an error (Covell 2010; Johnson 2009; Laschinger 2014).

A study of 43,000 nurses in the United States, England, Canada, Scotland, and Germany found nurses in the United States had the greatest job dissatisfaction, though they were the most satisfied with their salaries (Aiiken et al. 2001). In this large study, nurse–physician relationships were not rated as problematic as was having adequate nursing staff to achieve quality patient care. Another study of 1,328 U.S. nurses found that verbal abuse by physicians was significantly associated with lower workgroup cohesion, lower job satisfaction, and greater nurse–colleague verbal abuse, but also perceptions of greater workload (Brewer et al. 2013). The authors question causality: Do strained working conditions create more incivility or does incivility cause the negative work environment?

The United States has higher rates of patient deaths from medical errors than countries such as Australia, the United Kingdom, Germany, or Canada (Schoen et al. 2005), which has raised the question for some of whether the poorer overall health outcomes of the United States are related to the higher rates of medical errors (Starfield 2000). Ethics consults are often requested for reasons related to conflict (Fox, Myers, and Pearlman 2007), yet the complex issue of medical errors, poor team communication, and interprofessional discord is not viewed as an urgent ethics issue. Are we inured to the pernicious conflicts that exist within health care?

EBOLA, ETHICS, AND BLAME

Mr. Duncan died on October 8. Before his death, and in the weeks after, several things happened. The hospital offered explanations for what had occurred in Mr. Duncan’s care. The first explanation for the delayed diagnosis when Mr. Duncan originally presented to the ED suggested that the nurse did not share crucial information about Mr. Duncan’s recent travel from Africa with the ED physician. That misleading statement was quickly retracted and an
explanation was offered that the nurse had recorded the information in the EMR, but the structure of the EMR was such that the physician did not have access, or ready access, to the information. This second explanation also was retracted quickly. Then one of the nurses who had cared for Mr. Duncan tested positive for the Ebola virus. Again, initial explanations appeared to blame the nurse—and later a second nurse—for not following infection control protocols. Again, these were eventually retracted (Dunkin 2014; Fernandez et al. 2014). Following a settlement reached between the family of Mr. Duncan and the hospital (Associated Press 2014), the ED physician was interviewed about his decision making the evening of September 25 when Mr. Duncan walked into the ED feeling ill (Dunkin and Thompson 2014). Other news reports have quoted care providers who suggest Mr. Duncan was not forthcoming about his exposure to an ill person when he was in Liberia.

Blame lies just below the surface of our professional demeanors. We blame our patients for their health (Gunderman 2000) and each other for mistakes. Acknowledging our complicity in a culture that creates the magnitude of patient harm that medical errors are associated with is disorienting. The majority of physicians, pharmacists, dentists, nurses, and others enter their professions with the ideal of helping others, not contributing as the sixth leading cause of death in the United States (James 2013). There is a cognitive dissonance between this information and our personal knowledge of caring, decent, hardworking, and conscientious colleagues.

We live in a society where systematic injustice exists around factors such as race, ethnicity, gender, disability, and socioeconomic status. As clinicians, we are challenged to consider the role this plays in the lives of our patients. But accepting that we live in a society that is unfair is necessary for being willing to see when we contribute to injustice. Similarly, accepting that the culture of healthcare is dysfunctional is critical to recognizing that we all contribute to conflict, blame, and harm. We have created a culture where we seem to not like each other, or ourselves.

CONCLUSION

Examined as an isolated case, and through the lens of a rare and feared disease, Mr. Duncan’s case seems ripe for second-guessing. But viewed from the perspective of what we know about errors and team communication, his case is all too common. Nearly 100,000 patients die annually from hospital-acquired infections in the United States alone (Joint Commission 2014). Leaders in patient safety have called for the health care culture to set aside the barriers that impede addressing this emergency, such as physician overconfidence, even arrogance, around quality of care (Pronovost 2010).

Teams, not individuals, provide care for patients such as Mr. Duncan. To provide high-quality and safe health care, we need to educate, plan, practice, and deliver care as effective teams. Achieving the changes that make that possible will take revolution not evolution in educational models, workplace designs, and team communication. Hierarchy, conflict, and blame are endemic in health care and need to be eradicated to truly improve patient health outcomes.

REFERENCES


