Error, disclosure and health authorities: Revealing and healing

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introduction

Pathologist

- System therapist
- Quality and patientsafety

Pediatrician – neonatologist
- Different perspectives
- Disclosure: do’s and don’t’s
- Erasmus MC, Tripod method, Cases
- Take home messages
Different perspectives

- Patient
- Family
- Caregivers: clinician, pathologist etc.
- Hospital
- Health inspectorate
Different perspectives: Patient & Family

- Vulnerable
- Dependent
- Unknowing
- Dissapointed
- Sad
- Angry
Different perspectives: Caregivers
Different perspectives: Hospital

- Blaming & shaming - No blame no shame – just culture
- Incidents, complications, calamities
- Complaints
- Claims
- Insurance
- Reputation, Healthcare inspectorate
- Peer support
- Process and results, transparency
Different perspectives: Dutch Healthcare inspectorate

- To assess the quality of all Dutch medical institutions
- To evaluate the application of law and regulations

- ‘Waar angst regeert wordt niet geleerd’
  i.e. ‘where fear’s reign there is not taught’

- Safety culture
- Governance
- Hospital as ‘Learning Organisation’
Different perspectives: Erasmus MC 1

- Differentiate between:
  - complication
  - calamity
  - incident
Different perspectives : Erasmus MC 2

- If a calamity is considered
  - Report (also in doubt) and investigate
- Disclosure
- Analysis according to Tripod method
- Participation of patient and family, patient support
- Participation of caregivers, peer support

- Close links with
  - Incident reports, complication registration
  - Complaints, claims - legal department
Disclosure: the do’s

- Prepare the dialogue
  - Analyze what happened, when and with which consequences
  - Inform all involved caregivers
  - Ask a colleague to be present, e.g. a complaint officer
  - Discuss who takes over the treatment relationship with the patient
  - Plan enough time
  - Check the communication protocol of your hospital
  - Practise the dialogue with a colleague or with an expert
  - Select the caregiver in whom the patient has most confidence
  - Choose an appropriate room without telephone calls and bleepers
Disclosure: the don’t’s

- No reaction or (too) late reaction
- Asking the patient for empathy towards the caregiver: ‘it’s also for me very …’
- Submissive behavior; empathy yes, submissive no!
- Rude behavior: ‘no problem, we are insured …’
- Defensive behavior: ‘we followed the protocol …’
Methods to analyze a calamity

- Prevention and Recovery Information System for Monitoring and Analysis (PRISMA)
- Systematic Incident Reconstruction and Evaluation (SIRE)
- TRIPOD beta method
AEO – diagram: *WHAT* happened?

![Diagram](image)
Barriers: failed, inadequate, missing or ineffective
Human Behaviour and Tripod

Influencing Environment
- Management
- Colleagues
- Regulator
- Public
- NGO's
- Family
- Friends
- Neighbours
- Religious Leaders

Past Experiences
- Individual's Perceptions and Beliefs
  - Gap
  - Outcome
  - Power

Intention/Plan
- Behaviour/Action

Feedback

Source of harm

Undesirable consequences

Barrier that should have stopped the incident

Underlying Cause

Precondition

Immediate Cause
Barrier failure by Human Error and Violations

**Human error**
- Slips and lapses
  - ‘Oops’
- Mistakes
  - ‘I thought I did the right thing’

**Routine**
- ‘Does this happen often?’

**Violation**
- Unintended
  - ‘I was not aware’
  - ‘I did not understand’
- Situational
  - ‘I cannot get the job done if I follow the rules, but I did the job anyway’
- Organisational Optimising
  - ‘It was better for the company to do it that way’
- Personal Optimising
  - ‘It suited me better to do it that way’
- Reckless
  - ‘I did not think or care about the consequences’

**Routine**
- ‘Would others do it that way?’
- and/or
  - ‘Does this person have a history of violating’
Case 1: Losing tissue after ESD (endoscopic submucosal dissection)

- Basic Risk Factor: procedure in Endoscopy Department
- Use of a urine container with removed tissue in formaline
- Failure in transport to pathology department
- Uniformity in formaline containers also for larger tissues
- New written procedure for always applying order sticker on containers directly after Endoscopic Submucosal Dissection (ESD)
Case 2: Mix up of biopsy, misdiagnosis of malignancy

- Basic Risk Factor: procedure in Pathology department

- Algorithm for allocation of the machine for every tissue type, size, form and consistency, so biopsies smaller than 1.5 mm are always processed by Cellient

- Purchase of thermal pincers

- Implementation of describing the size of tissue obtained by a biopsy, so a discrepancy between macroscopic and microscopic assessment will be noticed
Case 3: Failure of completeness - during pBSO (profylactic bilateral salpingo ovariectomy)

- Basic Risk Factor: communication between clinician and pathologist
- Make a video of the identification process of both ovaria
- Use an Endo-Catch for every ovarium and tuba (left and right)
- Make the primary operator responsible for checking the completeness of both ovaria and tubae
Case 4: Failure of clinical FU after cervical smear - HSIL

- Basic Risk Factor: procedure Clinicians
- Integration of 2 digital systems with medical charts
- Notification system for new pathology results for clinicians
- Standardisation of call appointment by clinician after every cervical smear
Take home message

- Notify incident, complication, calamity as soon as noticeable damage
- Narrow collaboration between clinician and pathologist
- One spokesman for the patient and family
- Disclosure as soon as possible, but stick to facts, no suggestions
- Organize peer support for caregivers
- Make a thorough analysis e.g. with Tripod method
- Give all the information there is to patient & family and caregivers
- Help the patient to understand, to ‘digest’ and try to accept
- Help the patient to make the next step – claim or lawsuit
- Evaluate your processes and results
For both patient & family, as for the caregiver

Revealing your feelings is the beginning of Healing

www.homegrownhospitality.typepad.com
TIME FOR QUESTIONS
If you want to connect about this topic …

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