Welcome to the fourth module on medical error disclosure. In this module you will consider ways to address the family’s need to know how you are going to avoid similar errors in the future.

Recall the Error Disclosure Model we presented in Module 1. After explaining the facts and working to re-establish trust, providers should address a final issue of considerable importance to family members; and that is, how the error which contributed to their loved one’s injury or death will be prevented in the future.

In an interview study of 227 patients and family members, Vincent and colleagues discovered 4 primary motivations that motivated them to take legal action following an adverse event. While most interviewees cited more than one motivation, the primary one was to ensure “that this would not happen to anyone else.” This sentiment was especially strong among bereaved relatives. Vincent speculates that the desire to prevent future incidents stems from two main sources: to safeguard others, and to find some way of coping with their own pain or loss.

The pain may be assuaged if they feel that the system learned from the error and took action as a result; so at least some good came out of this very bad experience. This viewpoint is well expressed by the following quote, taken from a qualitative study by Iedema and colleagues.

“At the end of the day, you know, when an unfortunate accident happens...it would be good to know that my dad’s death sort of prompted some changes in that area...and I’m sure that if he was around, he would like to know that as well.”

Sometimes, if providers bring a rigid and defensive mindset to the conversation, they can miss what may be most important to patients or families – which is practice improvement – as seen in this quote.

“What I said to them was that the entire investigation had totally missed the point of my concerns; and, instead of addressing them, they tried to cover the hospital’s position from a legal point of view, and that was basically the last thing I had on my mind.”

Much of the litigation literature speaks to unaddressed feelings of patients and families. Relationships can deteriorate quickly if families are made to feel that they are the ones who need to get help or change as a result of the error, rather than the system. For example, in this quote:
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“I could have had counseling until the cows came home, but it would not have the same effect as talking to those people about improving the way they transport babies.”

But what changes can be made to prevent future errors? What have you learned? What will you do differently next time as a result of the error? It can be hard for trainees to answer this question. This might be due to lack of self-reflection on the trainee’s part, or lack of systems knowledge.

Reviewing the patient safety literature may help you analyze the root causes of your error, and in so doing, the opportunities for individual and systems level practice improvement. (See articles by Vincent, Rogers, and Greenberg on the Moodle website.) Some of the more prevalent errors involve communication (especially during handoffs and transfers) and organizational issues, such as failure to use existing safety checklists or protocols, overloading work schedules, and unclear roles and responsibilities.

In this video, a provider explains how a communication error involving a delayed reading of an EKG result will be avoided in the future. What else can you imagine saying to the family in this circumstance?

Talking as a team...making sure there is a clear hand-off so incoming staff know explicitly what to follow up on...placing the EKG right in the chart...these are all good things to say. Additional remedies might include: training incoming PGY-1 residents on hand-off procedures during orientation; specific meeting with staff to review protocols that support care coordination; using electronic “flags” in the chart for films waiting to be read, or other alert systems for incoming staff.

In this second example, a provider explains current procedures in place to avoid retained sponges during surgery, and changes that might be made as a result of this error. Can you think of anything else to say?

This is a challenging situation because there WAS an existing protocol (that is, double counting the number of sponges prior to closing). Unfortunately, it was apparently ineffective. Perhaps it wasn’t even done. But the solution of ordering a chest e-ray after every surgical procedure, just to check for retained sponges, is probably not cost-effective, or in patients’ best interests. The provider was right to bring up the QI conference, as it is the best place to learn why the existing protocol didn’t work. Did the staff skip the second count because of fatigue, or because someone was going off duty? Was the count rushed because the case ran long and staff needed to turn the room over quickly? As the provider explains,
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the goal of the QI conference is analyze the system to ensure it protects us from making “human mistakes.”

Hindsight is always 20-20, but there is a lot to be learned from debriefings, M+M, and QI conferences about how to prevent errors. Nearly every type of error – be it individual, team or system; be it an error of judgment, execution, or environmental – when analyzed back to its root causes leads to the need for some kind of education or training (or re-training). In speaking with the family, if you are unsure how to prevent future errors, emphasize that you and the care team are committed to learning from this event and will be studying it in a systematic way.

Okay, time to go. We close with several reminders. First is that it is important to talk about future error prevention with families. It is part of the error disclosure conversation. Second, the greater the harm done, the more crucial it is for the family to hear that you are working to understand why and how the error occurred in order to identify honest, thoughtful, and “real” solutions. You need to express some ownership for ensuring this doesn’t happen again. Also recognize that some of the best solutions come from patient and family observations and feedback. So don’t rule them out as sources of the learning process.

Second, the timing of this part of the error disclosure conversation may vary from case to case. This is because it may not be possible to know all that can be done to prevent a certain error right away. It may take a while to fully analyze its root causes. Also, if family members are still processing the shock of the bad outcome, they may hear your “solutions” as defensive attempts to gloss over the impacts of their error. In these situations, instead of giving family a detailed list of changes, briefly describe the investigation that is underway and ensure them that you will tell them the outcomes.

In closing, learning from our mistakes is the most we can ask of ourselves when a horrible event we never wanted to happen occurs. Thinking this through can be healing for you as well as the patient and family. While some remedies are obvious, others may require some really thoughtful reflection and conversation with others. In our last and final module of this series, we will review some of the important principles and steps of how to end an error disclosure conversation.