The Human Experience of Giving and Receiving Care: Collective Thriving and Disclosure of Unanticipated Medical Outcomes
The Surprising Science of High Functioning Teams

The Surprising Science of High Functioning Teams:

1. On the good teams, members spoke in roughly the same proportion, a phenomenon the researchers referred to as “equality in distribution of conversational turn-taking.”

2. The good teams all had high “average social sensitivity” — a fancy way of saying they were skilled at intuiting how others felt based on their tone of voice, their expressions and other nonverbal cues.

“Conversational turn-taking,” “Average social sensitivity,” enhances psychological safety.
“Conversational turn-taking,” “Average social sensitivity,” and psychological safety.

“shared belief held by members of a team that the team is safe for interpersonal risk-taking” Amy Edmonson
“Conversational turn-taking,” “Average social sensitivity,” and **psychological safety**.

“shared belief held by members of a team that the team is safe for interpersonal risk-taking” Amy Edmonson

places “where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning how to learn together.” Peter Senge

learning organization
The #1 characteristic of leaders of highly functioning teams at google was . . . ?
“Vulnerability is not about fear and grief and disappointment; it is the birthplace of everything we’re hungry for.”

— Brené Brown
“Vulnerability is not about fear and grief and disappointment; it is the birthplace of everything we’re hungry for.”

— Brené Brown

How have you applied this in your leadership journey since we discussed?
The Human Experience of Giving and Receiving Care
What is it that you desire most in your work?
What is it that patients desire most in their care?
If that’s what we desire most, and that’s what patients desire most, how is it that we don’t deliver on that all of the time?
What do we experience when we fall short of getting what we desire most for ourselves, our co-workers, and our patients?
Burnout: Frameworks

Christina Maslach
- Emotional Exhaustion
- Depersonalization
- Personal Accomplishment

Bryan Sexton,
National Taskforce for Humanity in Healthcare
- Emotional Thriving
- Emotional Recovery

Bohman, Dyrbye, Sinsky et al.
- Culture Of Wellness
- Personal Resilience
- Efficiency of Practice

Burnout at its core as the impaired ability to experience positive emotion.
What emotions are we talking about?

Joy
Hope
Gratitude
Inspiration
Awe
Interest
Amusement
Pride
Serenity
Love

Tiny Engines

Undoing Effect

Bryan Sexton and Barbara Fredrickson
26% of your individual burnout score is predicted by the burnout of the people around you.

The organizational template becomes collective accessibility to positive emotion.
Domains of a High-Performance Culture

- (A) Meaningful work
- (B) Workflow Autonomy
- (C) Professional Development
- (D) Logistical Support to Do Work Well
- (E) Physical and Mental Health
- (F) Ability for Meaningful Activities and Fulfillment Outside of Work
- (G) Collegial Work Environment
- (H) Organizational Learning
How do the skills and frameworks we have talked about to this point in the course relate to experiencing positive emotions, and/or to the domains of a high performing culture?
Domains of a High-Performance Culture

Culture Optimization

(A) Meaningful work

(B) Workflow Autonomy

(C) Professional Development

(D) Logistic Support to Do Work Well

(E) Physical and Mental Health

(F) Ability for Meaningful Activities and Fulfillment Outside of Work

(G) Collegial Work Environment

(H) Organizational Learning

Patrick Kneeland, updated 2.2014
“The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes.”  

Lucian Leape
Balancing “No Blame” with Accountability in Patient Safety

Robert M. Wachter, M.D., and Peter J. Pronovost, M.D., Ph.D.

To Err is Human
(99%)

To Drift is Human
(Speed Limit)

Reckless Behavior is Rare
But Important to Identify
And Distinguish from Human
Error And Drift
<table>
<thead>
<tr>
<th>Human Error</th>
<th>At-risk Behavior</th>
<th>Reckless Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadvertent action,</td>
<td>A choice. Risk not recognized or believed to</td>
<td>Conscious disregard</td>
</tr>
<tr>
<td>slip, lapse, mistake</td>
<td>be justified. Drift.</td>
<td>of unreasonable risk.</td>
</tr>
<tr>
<td>Improve through:</td>
<td>Improve through:</td>
<td>Improve through:</td>
</tr>
<tr>
<td>✦ Processes</td>
<td>✦ Removing incentives for at-risk behavior</td>
<td>✦ Remedial action</td>
</tr>
<tr>
<td>✦ Procedures</td>
<td>✦ Creating incentives for healthy behaviors</td>
<td>✦ Punitive action</td>
</tr>
<tr>
<td>✦ Design</td>
<td>✦ Build systems that support ideal behavior</td>
<td></td>
</tr>
<tr>
<td>✦ Environment</td>
<td></td>
<td></td>
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<tr>
<td>✦ Training</td>
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</tbody>
</table>

Adapted from James Reason, David Marx, Michael Leonard, Allen Frankel
Step 1. What are the systems contributors to this event?

Step 2. What were the care provider behaviors, decisions, actions that contributed to this event?

Step 3. Event response.

3.1 What steps can be taken to improve faulty systems that contributed to this event? How would these steps be implemented practically?

3.2 What steps can be taken to provide direct and timely feedback to the involved provider(s)/staff?

3.3 How will we support the involved provider(s)?

3.4 Disclosure to the patient

What will we do to prevent the next patient from being harmed?
Transparency around Unanticipated Medical Outcomes
A Man With Pneumonia

- Hx: Atrial fib, admitted for pneumonia
- Meds: Rocephin, Coumadin (2.5 mg/day)
- Early AM on Hospital Day 5: RN calls doctor after finding neuro deficit
- INR=6; C-T ordered
- Record review shows no previous coag studies this admit; doctor can’t believe hadn’t ordered one on admission
O2 Monitor at bedside
1 gm Rocephin IV g 12 hr.
Convadine 12.5 mg PO q.d.
Repeat CXR in A.M.
The family asks the (RN, MD, PT): “Why did Dad have a stroke?” How would you recommend the medical team answer?
Why Did Dad Have A Stroke?

1. **No disclosure**: "pneumonia serious... bad heart condition... just happens sometimes."

2. **Facts, more later**: "INR was high, which might have contributed ... we need to review events ... to find out the cause of the stroke"

3. **Disclose error**: “INR high...Dad got too much coumadin (+ “I didn’t check INR since admission ...”); may have contributed, need to review“

4. **Disclose error, assign responsibility**: “INR high, Nurses misread my order (or bad handwriting)”; “I am so sorry that this probably caused stroke..."
What keeps us from being transparent to patients around unanticipated medical outcomes?
## Simulated Error Case

<table>
<thead>
<tr>
<th>Response</th>
<th>US Medicine</th>
<th>Canadian Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would definitely not disclose this error</td>
<td>0.8%</td>
<td>1.2%</td>
</tr>
<tr>
<td>I would disclose this error only if asked by the patient</td>
<td>12.5%</td>
<td>6.5%</td>
</tr>
<tr>
<td>I would probably disclose this error</td>
<td>52.7%</td>
<td>47.8%</td>
</tr>
<tr>
<td>I would definitely disclose this error</td>
<td>34.1%</td>
<td>44.4%</td>
</tr>
</tbody>
</table>
Barriers to Disclosure

- Shame, fear
- Loss of patient trust
- Medical-legal concerns
- Lack of framework, skills, and institutional support
What do patients/families want to know?
Table 2. Comparison of Patient and Physician Attitudes About Medical Error Disclosure

<table>
<thead>
<tr>
<th>Focus Group Themes</th>
<th>Patients’ Attitudes</th>
<th>Physicians’ Attitudes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition of error</td>
<td>Broad; includes deviations from standard of care, some nonpreventable adverse events, poor service quality, and deficient interpersonal skills of practitioners</td>
<td>Narrow; deviations from accepted standard of care only</td>
</tr>
<tr>
<td>What errors to disclose</td>
<td>All errors that cause harm</td>
<td>Errors that cause harm, except when harm is trivial, patient cannot understand error, or patient does not want to know about error</td>
</tr>
<tr>
<td>Disclose near misses?</td>
<td>Mixed</td>
<td>No</td>
</tr>
<tr>
<td>What information to disclose about error</td>
<td>Tell everything</td>
<td>Choose words carefully</td>
</tr>
<tr>
<td>How to disclose error</td>
<td>Truthfully and compassionately</td>
<td>Truthfully, objectively, professionally</td>
</tr>
<tr>
<td>Role of apology</td>
<td>Desirable</td>
<td>Concerned that apology creates a legal liability</td>
</tr>
<tr>
<td>Emotional impact of error</td>
<td>Upset, angry, scared</td>
<td>Upset that patient was harmed and about how error could impact career</td>
</tr>
</tbody>
</table>
Rationale for Disclosure to Patients

Error disclosure as informed consent
  Positive obligation to inform patients of errors

Error disclosure as truth-telling

Regulatory requirements
  JCAHO standards, state laws

Disclosure gap
  Blendon study: 30% disclosure rate
To the patient, an unexpected outcome is unexpected

Care Reasonable

Natural progression of medical condition
Inherent risk of investigations or treatments

Care Unreasonable

System failure(s)
Clinician performance/errors
Equipment malfunctions

Unanticipated outcome

Harm not preventable

Harm preventable
The family asks the (RN, MD, PT): “Why did Dad have a stroke?” How would you recommend the medical team answer?
Key Elements of Disclosing Unanticipated Outcomes

Content

Known facts including results of event analysis

Regret for unanticipated outcome

Formal apology if caused by error or system failure

What will be done to prevent the error from happening again

Key Elements of Disclosing Unanticipated Outcomes

Institutional support

Integrated disclosure, patient-safety, and risk activities – and link to improvement efforts

Disclosure support system including training, real-time coaching, and emotional support – “Care for the Caregiver”

Elements of an Effective Resolution When Things Go Wrong

Effective Resolution

- Ethics
- Rapport and Trust
- Legal
- Economics
National Models of Disclosure

University of Michigan

University of Illinois – Seven Pillars

COPIC and 3Rs
Table 2. Key Elements of COPIE’s 3Rs Program.

<table>
<thead>
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<th>Key features</th>
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<tbody>
<tr>
<td>Disclosure linked to no-fault compensation for patient’s out-of-pocket expenses (up to $30,000)</td>
</tr>
<tr>
<td>Disclosure training for physicians</td>
</tr>
<tr>
<td>Exclusion criteria: death, clear negligence, attorney involvement, complaint to state board, written demand for payment</td>
</tr>
<tr>
<td>Disclosure coaching for physician and case management for patient provided by 3Rs administrators</td>
</tr>
<tr>
<td>Payments not reportable to National Practitioner Data Bank</td>
</tr>
</tbody>
</table>

**Key outcomes (January 2000–October 2006)**

- 2853 Colorado physicians enrolled
- 3200 events handled in program
- 25% of patients received payments; average, $5,400 per case
- Seven paid cases subsequently litigated, two of which resulted in tort compensation
- 16 unpaid cases subsequently litigated, 6 of which resulted in tort compensation

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Guiding principles of the comprehensive process for responding to patient safety incidents at the UIMCC</th>
</tr>
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<tbody>
<tr>
<td>1.</td>
<td>“We will seek to provide effective and honest communication to patients and families following patient safety incidents involving patient harm.”</td>
</tr>
<tr>
<td>2.</td>
<td>“We will apologise and provide rapid compensation when inappropriate or unreasonable medical care causes patient harm and defend vigorously care that we believe was appropriate.”</td>
</tr>
<tr>
<td>3.</td>
<td>“We will learn from our mistakes.”</td>
</tr>
<tr>
<td>4.</td>
<td>“Reckless behaviour will be subject to corrective action.”</td>
</tr>
<tr>
<td>5.</td>
<td>“We will provide support services for providers involved in patient safety incidents (the “second patient”(13)).”</td>
</tr>
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