



FIRST

Do No Harm

In this Issue

- Fond Farewell
- PCA is a Mystery
- PCA Philosophy
- The MITSS Program
- Performance

Patient Care Assessment Division, Board of Registration in Medicine

March 1, 2007, Volume 11, Issue 3

A Fond Farewell, But Not a Good-Bye

~By Charlene DeLoach, JD, CISR

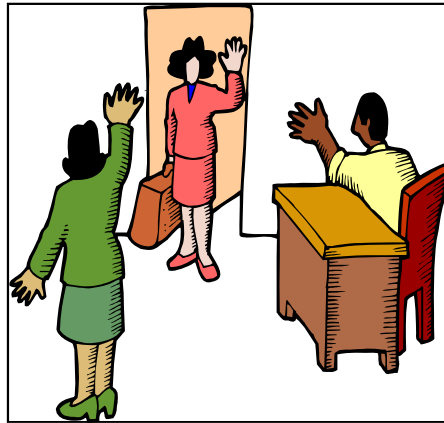
It is amazing what things you find when you pack up your office —a lost memo, a piece of gum, lip gloss, cups and an old fork (to name a few). Yet, you also have the opportunity to reflect on items that are next to you everyday: photos, awards, or other accomplishments that compelled you to come to work everyday.

But as I put my 9 to 5 life in a 2 by 4 box, the one thing that has always been with me, and will follow me to the next adventure, is a one inch piece of paper that has sat on the edge of my computer monitor for the past seven years. It states: “*the greatest error in health care is the failure of communication*”. It has been my inspiration since I first read it.

When my grandfather died in July 2000 because of a medical error, the words “patient safety” and “medical errors” had been part of the health care main stream for many years. But only had those words begun to develop meaning and focus in many of our health care institutions. I came across that quote just days after his death. While it was too late to save him, the words helped sparked my passion: to prevent other deaths due to poor health care quality and to create the words that implemented

the Betsy Lehman law and Center. It also motivated me to become the Director of the PCA Division.

Whether as an employee, as a supervisor, or as a colleague in the patient safety field, the quote is why I created, for example, this newsletter, created PCA Workshops, held facility



meetings, developed task forces and otherwise came to work everyday.

Yet, I am but one of many. While it has been my mission to improve the communication out of this office, maybe it could have been done differently or better. But I can say that there was communication where there wasn't before.

In this new age of apology and disclosure, of collaboration and transparency, it is my wish that the lines of communication continue to remain open between us and that new opportunities to improve

communication are discovered and embraced.

Everyday, in every health care-related setting, awaits an opportunity to make a new happy ending for a patient. I wish I could stay and help create more of those happy endings, but as Theodor Seuss Geisel once stated: “Don't cry because it is over. Smile because it happened.”

I am excited about my opportunity to help implement significant portions of the new landmark health care reform legislation as Assistant General Counsel for the Commonwealth Health Insurance Connector. My focus now is to help others get access to health care. But I look forward to continuing the mission of PCA, and of patient safety, in a personal capacity, and staying in touch with many of you. All in all, thank you for the opportunity to serve.

So with my 2 by 4 box, I walk out of my office and turn off the lights for the last time, and end my last PCA newsletter with a saying that also has been on my computer monitor for the past seven years....

“Experience is not what happens to a man. It is what a man does with what happens to him.” ~Aldous Leonard Huxley, *Texts and Pretexts*, 1932



PCA is a Mystery

PCA realizes that solving the mysteries of adverse events is difficult business. Before 2003, we often asked for more information than necessary concerning details of an incident and less than we should about process, deepening the mystery instead of helping solve it. Our goal going forward is a revised system, more responsive, less grating, quicker in turn-around, and better able to meet the needs of hospitals and physicians, while fulfilling our mission of protecting patients.

Recently in the *New Yorker*, Malcolm Gladwell used national-security expert Gregory Treverton's famously made distinction between puzzles and mysteries in an article about the perils of too much information. This is the differentiation: puzzles are solved by more information, another piece, until the whole picture is clear. Mysteries, on the other hand, are not solved by more information, usually there is too much, but by analysis and judgment in the assessment of uncertainty.

Health care facilities would prefer to approach quality reviews as puzzles. Physicians serving on hospital Patient Care Assessment Committees prefer puzzles as well. Most likely that is because of the general thought of risk-benefit: the greatest good for the most patients. Gather the clinical details, understand the event, devise a plan for correction or justify the care which was delivered: problem solved, case

closed, move on. A tidy package of puzzle pieces. But more often than not, the package isn't so tidy and the pieces of the solution do not fit in the box exactly. Yet, the plan is good enough, or at least good enough to move on to the next problem.



On the other hand, reporting to PCA very often requires that lots of information be included about an event. And devising corrective actions requires the art of medicine, making judgments about events that committee members didn't actually observe and their thinking, in the back of their heads, is that they have done the same things themselves, luckily with better results. So instead of sending a report solved by information, another type of report gets sent, one bursting at the seams with details and speculation.

The PCA is then faced with helping the hospital solve a mystery instead of a puzzle, requiring several iterations of questions and replies by health care facilities. The hospital's hope of

enduring and responding to several health care reviews and being done with them turns into an unending interchange, and not infrequently, resentments. After all, it would be much easier to solve the puzzle and be done with it, than to search for clues that might solve the mystery both now and for the future.

Malcolm Gladwell's thoughts seem perfect for the PCA-Health Care Facility interaction about unexpected occurrences. He writes: "If things go wrong with a puzzle, identifying the culprit is easy: it's the person who withheld information. Mysteries, though, are a lot murkier: sometimes the information we've been given is inadequate, and sometimes we aren't smart enough about making sense of what we've been given, and sometimes the question itself cannot be answered. Puzzles come to satisfying conclusions. Mysteries often do not." But, "the complex, uncertain issues that the modern world throws at us require the mystery paradigm."

Reporting quality reviews about untoward events in the hope of improving patient safety is also an uncertain template for progress. Although deemed a necessary activity in *To Err is Human*, whether reporting would work for medicine, like it has for the manufacturing and service industries, is not yet confirmed. Some have characterized progress in patient

(Continued on page 6)



PCA Philosophy



Our dedicated staff has been laboring hard and producing excellent Health Care Facility Reviews despite a work load which stretches them to the limit. I speak for the Committee when I express our enormous gratitude and appreciation for those efforts: in the name of patient safety, Hurrah!

In several internal staff meetings and discussions, and reflecting upon my many outside visits to hospital based PCA committees, a pattern has emerged. With some exceptions, Massachusetts hospitals are dedicating resources and have established sophisticated internal processes for noticing medical errors and near-misses, reporting them, triaging them for investigation of the more serious or frequent events and, wonderfully, designing, implementing and tracking safety improvement systems. This has been an impressive and eye-opening experience. This state is on the move!

In their work, these local champions for safety often attract loyal, but significant concern and resistance from their clinical staff, administrators, attorneys and hospital trustees. Medicine is a cautious and conservative profession. Liability is a serious concern; the risk of financial, legal and reputation damage to individuals and institutions is considerable, and bad news, whether

accurate or not, can be devastating.

Fearful of this, I believe hospitals often do not share with us dangerous discoveries and the practices, processes, and improvements they have discovered and implemented. This data, if aggregated and widely distributed across our state (and nation) could fulfill the vision and charge of our Committee.

We on the BORIM's PCA are 'The Converted'. As up-close-and-personal witnesses to the exquisite attention our staff pays to maintaining anonymity and confidentiality, we see directly



what those outside our meetings do not: Despite the absence of a single example of a PCA report leaking or leading to the disciplinary investigation of an individual physician, a healthy and understandable suspicion remains widespread among our Massachusetts colleagues.

As our hospital-based PCA partners across the Commonwealth labor to reassure and improve their local culture these groups have told me of commonly encountered

problems. Hospitals struggle to differentiate and accommodate complex, competing and sometimes closely overlapping laws, regulations and authorities. This honest worry and confusion is compounded as various and multiple state and federal agencies (and 3rd party health plans) are themselves rapidly adopting safety-focused policies and consequently often change their requirements, all in the good spirit of safe, effective and affordable healthcare.

It isn't easy. As in other areas of medicine, adult learning often lags behind scientific discoveries in the burgeoning science of safety. Despite the persistent, tireless and creative outreach efforts of our staff to educate our stakeholders, a number of recurrent questions have emerged in my hospital visits, reflecting these worries. Many of these can be answered, but the questions should be asked so they can be answered, rather than lambasting in speculation, misinformation or confusion.

However, it can be said that hospital and professional staff anonymity is far better protected after a report of a given event to PCA than other state agencies which are not constrained from naming names in their public revelations. And valuable information can be generated as the result of such report, to a confidential

(Continued on page 6)



Beyond Disclosure and Apology—The MITSS Program

Open and honest communication is now recognized as an essential component in systems improvements for patient safety.

Patients are clear about what they want following an adverse event: They want the truth (in real time); an apology or acknowledgement that things hadn't gone as planned; they want to know what's being done so it doesn't happen to anyone else; and, they want *support*. Support may be in the form of monetary compensation, it may include some type of counseling, or both.

Healthcare providers are not routinely trained to deal with the emotional aftermath of an adverse event. Their emotional needs may also be going unmet, and clinicians are often left feeling isolated and with a sense of shame, guilt, and incompetence. The fear of medical malpractice may discourage open and honest communication with patients and their families; communication with colleagues is also frequently discouraged. Clinicians are usually expected to return to their routine patient care as though the event never happened.

The healthcare culture is slowly changing, however, and disclosure and apology are moving forward despite some resistance. But, the gaping hole remains – where is the emotional support? Medically Induced Trauma Support Services (MITSS) has made it its mission over the past five years to

see that support is made available for patients, families, and clinicians following adverse medical events. MITSS believes that support is crucial to facilitating the healing process for all involved in unanticipated medical outcomes.

MITSS is a non-profit organization headquartered in Chestnut Hill, MA, whose mission is “*To Support Healing and Restore Hope*” to patients, families, and clinicians who have been affected by an adverse medical event or medical error. Medically induced trauma is defined as an unexpected outcome that occurs during medical and/or surgical care that affects the emotional well being of the patient, family member, or clinician.

The organization's vision is for all those involved in a medically induced trauma to have access to support services. MITSS envisions a more compassionate, patient-centered healthcare system. MITSS achieves its mission by:

- **Creating Awareness and Education.** Since 2002, MITSS has been educating the healthcare community on the uniqueness of medical trauma, the broad scope of its impact, and the crucial need for support services through participation in forums, local and national conferences, and through the media.
- **Direct Support Services to Patients, Families, and Clinicians** --

MITSS provides educational support groups for patients and their families who have been affected by medical error or unanticipated outcomes led by a clinical psychologist. MITSS also provides support groups for nursing professionals finding themselves at the “sharp end” of an adverse medical event. The toll free number is **(1-888-36MITSS)**.

- **Advocacy for Action** -- MITSS encourages and consults with healthcare institutions in developing infrastructures for clinician peer support systems. Assistance in developing a referral process to the MITSS program for patients and families is also provided.

MITSS' long-term strategy is to develop accessible support services for clinicians such that they are utilized and meaningful. One of the ways they are doing this is by building a confidential peer support hotline where clinicians can call and be put in touch with trained clinical peers with similar clinical experience who can identify with the situation. The plan is to identify clinicians who are willing to be trained in peer support and available to serve their clinical colleagues. For more information, call (617) 232-0090 or visit the MITSS website at www.mitss.org.

[Thank you to Winnie Tobin, Communications Director, MITSS, for this article]



One Hospital's Multi-Disciplinary Performance Improvement

In 2000, the Berkshire Medical Center Department of Medicine established a process called "Multi-Disciplinary Rounds". This process systematically reviews the care of all inpatients, ensuring compliance with evidence-based treatments and guidelines to make certain that patients receive timely multi-disciplinary care and assessment.

As part of the evolution of this process, the hospital's PCA Coordinator began to challenge all Hospital Departments to develop methods to review departmental occurrence and incidents to develop departmental and hospital improvement efforts and corrective measures. Subsequently, the facility held monthly Morbidity and Mortality conferences, but while it provided educational value, it did not provide an opportunity to critically evaluate the care provided to a patient.

Thus, the Berkshire Medical Center established a weekly Morbidity and Mortality conferences. Yet this time, the house staff and the Attendings also reviewed patients in whom a member of the Department or another service noted care issues, which were deficient or required improvement. The Chief Residents in medicine began to review the medical records of all patients who died on the medical service. The Chief Residents completed the reviews of all deaths within days of occurrence and also sought out cases to discuss involving

patients who were still inpatients in the facility, but new issues arose.

After the first few meetings, the housestaff was willing to bring issues to the conference and many of the issues brought or disclosed through the review process required the attention of other hospital personnel to resolve. So new groups were invited to join the conference, such as nurses from nursing units on which



the patients being discussed were admitted. Then Departmental Attendings and Hospitalists began to attend. Because of the Department's commitment to systems improvement and personal improvement, members soon realized that to have all of the providers at the table at the time of discussion lead to more accurate 'problem diagnosis' and far more robust 'treatment plans'.

The conference has now grown to include representatives from Pharmacy, Nursing Administration, Case Management, Information Technology, the Performance Improvement Department, the COO and the PCA Coordinator.

Given the intention of the conference and its attendees, the Chair has re-named the conference as the "Department of Medicine Multi-Disciplinary Performance Improvement Conference" and has established the following goals:

1. To improve process of care and therefore patient outcomes
2. To involve all members of the health care team in developing robust solutions to patient care problems
3. To have an open and frank dialogue about all cases and minimize or eliminate finger pointing and personalization of cases which may have had a poor outcome
4. To be an educational forum in which all members of the health care team can learn to improve performance, how other departments work, and how we may better work together to improve patient care.

This new initiative by Berkshire Medical Center is quite different from traditional physician-led and -managed morbidity and mortality conferences focused on the individual physician and ways physicians could improve performance. Now it is a process that is multi-disciplinary and focused on total performance improvement. ☺

[Thank you to Dr. Robert Cella, MD, Vice President of Medical Affairs, Berkshire Medical Center, for his contributions to this article.]



PCA Philosophy (continued)

(Continued from page 3)

group designed to provide an overview of the system and a method of learning.

We can learn so much from each other and can save lives doing so. And an interdisciplinary review is a model which must be employed without exception, sine quo non.

I look forward to having this discussion with all of you as I meet with you at various meetings and

functions across the state. We all have a specific and vital job to do, but working together is the key. I am optimistic that what we have learned of the challenges will be met and overcome.

The PCA Division will once again be hosting workshops that can help you understand why we ask for what we do and how to report to our staff. These will take place later in the spring and summer. These will be

offered at no cost. However, please know that we are always available (confidentially) by phone. If you need information, or a resource, we are happy to provide that for you.

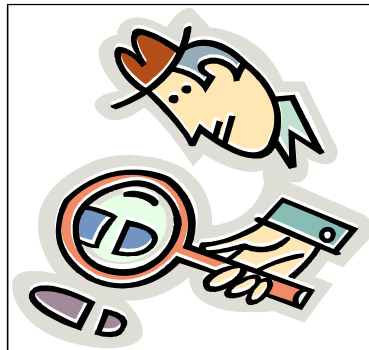
Again, thank you for your contributions. Each of you are extraordinarily vital ambassadors for PCA and its mission. We look forward to the great work ahead. Spread the word! ☺

PCA is a Mystery (continued)

(Continued from page 2)

safety as “slow and arduous” over the past 6 years. Mysteries, not puzzles.

During that time period several states have adopted statutes for reporting unexpected events; the total now is twenty-five. Measuring the effect of these reporting requirements is an ongoing learning process. States are looking for outcomes of the statutes. Several process measures have been proposed by national quality



organizations like JCAHO, NQF, and CMS, but if process measures in reporting lack the correlation clinical

measures do with outcomes; it may be some time before we can report on the effectiveness and efficiency of mandated reporting

Our plea for hospital PCA Committees then is patience and understanding. After all, we are all trying to solve the same mystery—how to make patients safe. ☺

[Thank you to Dr. Stancel Riley, Consultant, BORIM, for his contributions to this article]

To directly receive an e-copy of this newsletter, please send an email with your name and organization to First@dph.state.ma.us, with the words “Add me to the email list” in the subject line.

Thank you to Charlene DeLoach, JD, CISR, Director of the Patient Care Assessment Division, for her vision for the newsletter and for making it happen since September 2005.