FROM GOOD INTENTIONS TO GOOD ACTIONS:
A STORY ABOUT PATIENT SAFETY

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Quality C:  Our hospital really is committed to promoting patient safety and quality in healthcare. I think we are working toward the ‘just culture’ approach. We don’t want to blame people; we want to do what is right. And I think that when errors happen, they should be disclosed. Sure, mistakes happen to even the best healthcare providers. We are all human. But we are ethically sensitive and want to do what is right. We document medication errors and patient falls on our incident reports. I review the charts and we are learning how to disclose errors to patients.

Nurse:  Well, what are you looking for? Do you really think people report errors? And what, exactly, are you going to disclose? I’ve read the adverse event policy and the disclosure policy. The word error never appears in either document.

Admin:  I think our ‘good catch policy’ has made a difference. I think people feel more comfortable talking about errors. We will waive costs directly related to a serious adverse event. And we've provided training on disclosure; it's a priority area. We’re training a disclosure team. So we're making steady progress. Staff gave us a 4.2, on a scale of 5, on our patient safety survey. We are making sure that our training activities involve nurses because many of the errors involve nursing care.

Nurse:  Well I don’t know what a score of 4.2 means. The good catch deal lasted about a month. And I have no idea what you are really going to disclose or to whom.

Physician:  I will sleep better if some of your safety training has an impact. Last week I ordered 10 units of insulin for a patient and he got 100. That kind of error happens more often than we think - and it shouldn't.

Nurse:  You talk about not blaming people but listening to you, it seems like the nurses are blamed. When we make a mistake, we chart it. You can't hide things like the insulin overdose - they are pretty obvious. We file incident reports and talk about what happened.

Physician:  Well that's my point. Look at the incident reports. Medication errors create most of the problems. Patient safety is important but it’s not my role. The nurses give the wrong dose, or the wrong drug. It happens a lot. Sometimes they give medication at the wrong time, or fail to give it at all. Yesterday a nurse gave my patient the medication IV instead of IM.

Quality C:  It's true – most of our errors involve medications and most involve nurses and some are serious. Most errors don't cause serious harm, but those that do, are
Admin: Medication error is a big deal. We are trying to streamline the reporting process, make it simpler if that is the problem. We are looking at various IT solutions for reporting. As you know, we don’t use those look-alike and sound-alike drugs anymore.

Nurse: It’s not that simple. The spotlight will still shine on nurses because in this hospital, doctors don’t make mistakes. It’s true. Doctors have sub-optimal outcomes or practice variances. They use their clinical judgment and have clinical discretion. How often do you recognize errors in diagnosis or treatment? When things go wrong, there is no investigation. Not really. Because there are no errors. Well, there are no errors on the official radar screen.

Physician: That's ridiculous. You are drawing precarious conclusions about clinical situations when you don’t have hard data. We have the M&M meetings. We have peer review. If there's a problem, we see it and the chief of staff deals with it.

Pharmacist: Well, some problems may be solved in M&M. But I'll be honest. Errors happen and you can't just blame nursing. I've changed a lot of prescriptions since I've been here. Actually, I have to make changes every week. If I didn't make changes, someone would die. But if the problem doesn’t reach the patient, there is no need to call attention to it.

Quality C: You must be exaggerating. I do chart reviews and I have never seen that problem. I know that pharmacy and nursing have complained about bad handwriting. But the electronic system is now in place and that will solve most of the problems.

Pharmacist: Well, the electronic approach just creates new problems. So when the orders are wrong, I have to fix them. I change conversion rates, I change doses. I change the drugs. New guidelines come out. You can't expect the physicians to remember the specifics of all of these drugs. Sure sometimes I call the physicians. But some docs say just take care of it and so I do. And some get irritated when they get so many calls. If a doc is going to get irritated, what's the point? I have to think of the patient. We'd never get all the prescriptions filled if I spent all of my time on the telephone. I make the change, put a notation in the chart, and another error is averted.

Nurse: That's my point. Would you call that an error? You don't. Do you file an incident report? No. Sometimes when you make the changes you tell us to let the doctor know. And then we are right in the middle. If I'm an hour late with a dose of Tylenol, that's an error. I wish I could just have someone catch my error or say “clinical judgment” and the problem would magically disappear.
Quality C: You're making me quite nervous. I think we have a good reporting system and I think we provide good and safe care. We're on top of the new JCAHO guidelines. We encourage you to alert us to any potential problems. And I think we're being fair in our approach to errors.

Admin: I agree. We've got a number of new systems in place. I think our plan to waive costs directly related to serious events shows that our concern for patient safety is very genuine. But some of this stuff you mention, well it gets to the politics of nursing versus physicians and nurses trying to practice medicine. Some physicians, depending on their mood, appreciate advice and some don't.

Nurse: Well I don't think those systems would have helped Mr. Brown. And I sure got burned when I was taking care of him. He has really poor circulation and we were treating his foot wound with dry dressings, just as his cardiac surgeon had prescribed. We were on top of the problem and following current wound care guidelines. But when Mr. Brown's primary care physician took over, there was no coordination of care. You know who I am talking about; that doctor never even called the cardiologist. He said he didn't have to. Instead, he used the treatment he learned in medical school 30 years ago. Now Mr. Brown is back in the hospital and is going to lose his toes, maybe even his foot. I think that is pretty serious. When I complained to my supervisor, I was accused of nitpicking and practicing medicine without a license. She told me not to question the physician's clinical judgment. I even asked the ethics committee to look at this issue but I was so ashamed by their response that I will never make that mistake again.

Physician: That's not a fair example. The primary care physician is under no obligation to call the cardiologist. What’s more, the procedures he used may have been entirely appropriate. A physician does have to use his clinical judgment. You can't go snooping around in charts and guess what you would have done in that circumstance. You don’t do that to your colleagues. That’s exactly why it is so important to use the right definitions when we talk about error.

Admin: We're getting a little off-center here. You have to be reasonable. We can't control what the physicians do in their offices.

Nurse: Right. But now Mr. Brown is back in the hospital to have his toes amputated. When and how can you question clinical judgment? When do you call a bad outcome a treatment error? That primary care doc didn't do any doppler studies. He didn't know if there was any circulation in those toes. I thought that the failure to use the right tests or ignoring new clinical guidelines was an error. You tell me I’m wrong, I will go away. If I'm right, you have to deal with physicians.

Physician: Personally, I hate practicing by recipe. Intuition is an important characteristic of the art of medicine. There is no substitute for our clinical judgment - it is rooted in our experiences. We'd be wasting our time if we tried to implement all the
things suggested by these patient safety advocates. And I’m not sure why we’re having all these discussions about errors. We don’t have wrong site surgeries here. We know our patients and so don’t do surgery on the wrong patient.

Pharmacist: You know, the nurse has a point. We had that case last week when the 83 year-old patient came to the ER with a hematoma. He was hospitalized and put on Coumadin. When discharged, the physician ordered a blood test in three weeks. Just shy of 3 weeks, he came to the ER and his INR was 14. The hematoma was serious; we’re lucky he didn't have an even more serious bleed; we’re lucky he lived. I think that's an error and frankly it's one we see all too often.

Quality C: That was an unfortunate case but I think you’re exaggerating when you say it happens often. I’m sure that doesn’t happen often. I can guarantee you that I do the chart reviews and I haven't seen very many cases like that one.

Nurse: Of course not. Who is going to put something like that in the chart? You can’t expect to see a flashing blue light when a problem occurs. That kind of case gets buried. It happens a lot. Point A, he got coumadin. Point C, he was back at the hospital. No one is going to look at Point B.

Physician: That's my point about all of this “error” talk. That coumadin case does not involve an error. Period. It would be an error if the doctor had ordered the blood tests and they were not done. I’m not casting blame, but the burden here is really on the hospital. The hospital should have some policies if they want to avoid this kind of ahhhhh, problem. If you get right down to it, it's the discharge planner’s fault. And patients have to be empowered to take responsibility for their care.

Nurse: Empowered? That patient was 83 years old. Like I said, this stuff happens. Stuff like this never goes in the chart. It just gets buried. And then I have no idea what we are really supposed to tell the patient. Like, “I’m sorry you are going to lose your toes, Mr. Brown. It’s too bad your doctor didn’t know about the current treatment practices.” And what do I say to the family when they ask about the hematoma? Even if I had access to the clinical guidelines, what am I supposed to do with them? Wave them in the doctor's face? Show them to the family?

Admin: Good grief. Tell the patient? There’s no need to start alarming patients. We have to be very clear about what we are going to talk about. Thankfully we don’t have many errors. There’s no need to use words like errors.

Quality C: I think times are changing. I went to a meeting last year and they said that when errors occur, you should tell patients and apologize. They even showed a video about how to do it. It was good except that really, the doctor didn’t actually say that an error occurred and didn’t really apologize.
Pharmacist: You know last year I suggested that we should start a warfarin clinic. Think about it – we’ve got a bad combination – old patients, warfarin and nasty side effects. We pharmacists understand the complications and we could be managing these cases.

Physician: Everybody thinks they should take over. Physicians are perfectly competent and able to manage these cases. We do it all the time. I am rigorous about ordering blood tests.

Quality C: Of course you are. But what about some of the others? Do you ever talk to them about their practices? What do you do when your peers do things that really aren’t quite right? Do you mention it? And really, would you chart something like this?

Physician: You don’t go looking in someone else’s charts. We just don’t do that. It could cause all kinds of chaos. You’d probably lose referrals, real fast. We all live in glass houses. And you have to realize there is always someone out there who wants to sue us. There are lawyers under every bed. I’m a good doc but you’d cover this up. Problems happen and you can't avoid all of them. You just do the best you can.

Nurse: So when problems occur, we never really hear about it. It’s all behind locked doors. We don't know if a mistake was made. We don’t know if there is any follow-up. It’s really hard to get feedback. When I saw what his doctor was going to do, should I have told Mr. Brown to get a second opinion? His toes were at stake. If it was my mother I’d want someone to tell her. But if my supervisor says don’t ask/don't tell - get real. I don't. I’m certain that 99.9% of close calls don't get reported. And I don't think that most errors get reported either.

Pharmacist: Gosh. These things get really sticky. Dr. Peters did a wound debridement with no pain medication; the poor old woman was just screaming. Dr. Smith always seems to have surgical problems of one kind or another. And Dr. Wright gets so mad if you question him. Or what about the Jehovah Witness patient who got the albumin to prevent shock after her surgery? It’s not something she’d ever know about and it absolutely prevented harm. Good grief. Are you calling those things errors? What do we do with things like that? What kinds of errors do you think we should be telling patients about? These could be really hard conversations.

Physician: Well those may not be good practices but they aren’t exactly errors. And there is no need to give a lot of detail to anyone when no lasting harm has been caused. I think you have to disclose only when there are really, really serious problems, when an error is really apparent.
Nurse: And that is exactly why patients aren't told. Not really. We might tell them that we gave them the wrong medicine. But we wouldn't tell them what really happened. We wouldn't tell them that the 12-hour shifts are too long or we forgot to trade information at the shift change or that Dr. Anderson gets mad when we ask too many questions. And we never, ever really talk about diagnosis or treatment errors.

Quality C: It doesn't sound like we're on the same page at all. We did the culture survey and now we are supposed to implement some patient safety initiatives. We are supposed to implement a new disclosure policy. But I feel like I am on a scavenger hunt. I am not sure what we should do at this point. We don't have time to do the root cause analysis for every little thing. And anyway, whenever we do the root cause analysis, someone quits. My confidence in our ability to make things safer is shrinking a little.

Admin: I don't like this conversation. There seems little that I can do about it. You'd think the leader could effect change but the rubber meets the road on the lowest level. Plus, the quickest route to the unemployment line for an administrator is to get cross-wise with the medical staff.

Nurse: Well, there are many things that go wrong and for every one you notice, there are 10 you don't. When it comes to errors, it's not just being worried about legal issues; it's a face saving issue. Sometimes I hear about things and I just think helloooo. I wonder if anything will ever change.

Quality C: No-one is sure what to do. I don't know if we ignore these things or if we think they're not important or we just don’t know who to turn to for help. We still run on the premise that we know best and patients should be happy with what they get. Until someone comes to review and we think, oh my…