Coping with Adverse Patient Outcomes

Stanford Ob/Gyn Department Grand Rounds
March 28th, 2011

Harise Stein, MD
harise@stanford.edu

SUMC Physician Wellness Committee
ACOG District IX Committee for Physician Work-Life Balance

in·tel·lec·tu·al·ize

1 : to give rational form or content to
2 : to avoid conscious recognition of the emotional basis of (an act or feeling) by substituting a superficially plausible explanation that is *intellectualized*

Outline

- Adverse patient outcomes
  - out of our control
  - in which we are involved
- Suboptimal coping
- Effective coping
- Litigation stress
- Institutional support

Vicarious traumatization

- Being traumatized by the trauma of others
  - AA, disasters, cancer dx, severe fetal anomalies, etc.
- Can develop secondary PTSD and/or survivor guilt
- Our reaction is more extreme to patients with whom we feel a closer connection or with whom we identify
- Ob/gyn as a specialty is particularly vulnerable

“I remember feeling horribly sad that I couldn’t do more for this child. This hit me harder than most of them. ..the child was the age of my oldest daughter and I guess that I felt that this could have been my family. They were a nice family and didn’t deserve to have this outcome. I cried a lot over this case and I guess I still cry when I think about her.” Scott 2009

You need to learn how to communicate concern without feeling every emotion of your patient.

You need to establish enough separation from your patient to maintain your ability to be effective.

To this normal compassion we add situations where we have responsibility –
by commission or omission.

Adds layers of “responsible guilt”, true guilt, and fear of litigation.

“Physicians are in a double bind of expectation: to be human, just like their patients, and to be superhuman, not like them at all, in never making a mistake and knowing everything.”

Charles 2005

“Second victim”

- Recognition that healthcare providers who face unexpected patient outcomes or acknowledged errors are also victimized by the event
- “…the darkest hour of one’s professional career”
- This may become a life and career altering event that produces permanent consequences – for good or ill

Progression after an adverse event

- No one pattern for everyone
- Some may move through certain stages, others remain “stuck” for a long time
- Previous experiences, personality, and support available are important response factors
- Involves sense of loss – of self-esteem, reputation, personal and professional stability – magnified if unresolved other losses

Initially

- Shock – stunned, dazed
- Emotional turmoil, confusion
- Trying to verify what happened
- Summoning help

"Right after the event and during the code, I was having trouble concentrating…I was in so much shock."

Scott 2009

Immediately afterwards

- Denial (temporarily disconnected or numb)
- Obsessive re-enactment
- “What ifs”
- Self-doubt
- Loss of confidence
- Overwhelmed, vulnerable
- Self-isolation

“ I started to doubt myself. There were some things that I thought maybe if I’d have done it this way, it wouldn’t have happened or been avoided…..I lost my confidence for some time.” Scott 2009

Discussion with patient/family

- Follow guidelines set up by institution as to who and how to do this
- Provider must be in good emotional balance to conduct a helpful meeting
- Information to patient needs to be honest and consistent over time and personnel
- Provider must possess all needed info, or states what isn't yet known
  - Avoid speculating or elaborating to try and comfort family
- Let family know what more is being done and when

Resident Error Disclosure

(White Acad Med 2008 83(3):250-256

- 1138 medical students and residents (78% return)
- Residents
  - 45% personal involvement with serious error
  - 34% had disclosed serious error to patient
  - 63% had disclosed minor error to patient
  - Only 33% had received training in error disclosure
  - 92% wanted new (or more) error disclosure training

The Gauntlet

- Grapevine gossip
- Institutional response
  - Questioning, review
- Insurance involvement
- Worry about the opinion of others
- Self doubts about career, job security, licensure

- Concerns of others
  - Could I make a similar error?
  - What should I say to the individual?
  - Ripples of distress through all members involved and rest of department and staff

What can a colleague say/do?

- Express sympathy
- Offer to listen if they feel like talking (about feelings)
- Ask how you can help in other ways
- Be alert for signs of distress, depression
- Ask if they have a support system, and encourage colleague to seek support for self and/or family
- Saying nothing can be misperceived as rejection, or reinforce the notion of a “code of silence”

Seeking help

- Who are you allowed to talk to?
- What resources are available?

"I didn't know what to do or who you were supposed to talk to professionally, legally. I didn't know how much I was allowed to say, where I should document things." (Scott 2009)

[Resident was supported for one week by attending]

"Then nobody wanted to talk about it. It felt like 'Well, this happens and you should be better about it and that's it.' There isn't a single day that this doesn't affect me." (Scott 2009)

Is a colleague “fit for duty?”

“The unspoken imperative of medicine is that, regardless of what happens, physicians should be able to ‘handle it’”.

-- Charles 2005

Seeking equilibrium

- Taking time off
- Going on as if nothing happened
- Changes in practice
- Depression, anxiety, PTSD
- Poor coping responses
- Seeking to improve coping
- Physical sx, including exacerbation of chronic conditions
- Waiting for the liability shoe to drop

"No matter how much you fool yourself you are over something, and maybe even though I hadn't thought of it for months, I had that woman's name seared into my memory…I still think about it. Just randomly you forget and then something will happen and it just pops into your head. You go over it again, what could I have done differently, what could I have said, what should I have done?" (Scott 2009)

Moving on

Drop out Transfer or quit	"I moved over to another service. I think a fresh start was good for me. It was devastating during that period."
Survive Coping, but sadness, intrusive thoughts, reminders	"I figured out how to cope and how to say yes, I made a mistake. And that mistake caused a bad patient outcome. But I haven't figured out how to forgive myself for that yet, or to forget it. It's impossible to let go."
Thrive Gain insight, perspective "Make something good come of it"	"…but then I thought, you know what, I've just had this experience in my life where I had to encounter this tragedy but it made me a better person. It really did, and it gave me more insight."

Emotional Changes

- Intense unpredictable feelings
- Irritability, mood swings
- Frustration
- Intrusive images/memories
- Regret, guilt, remorse
- Decreased concentration
- Anxiety, panic attacks, fear*
- Sleeping problems, nightmares
- Grief, sadness
- Depression

The natural history of recovery for the healthcare provider "second victim" after adverse patient events

S D Scott, L E Hirschinger, K R Cox, M McCoig, J Brandt, L W Hall

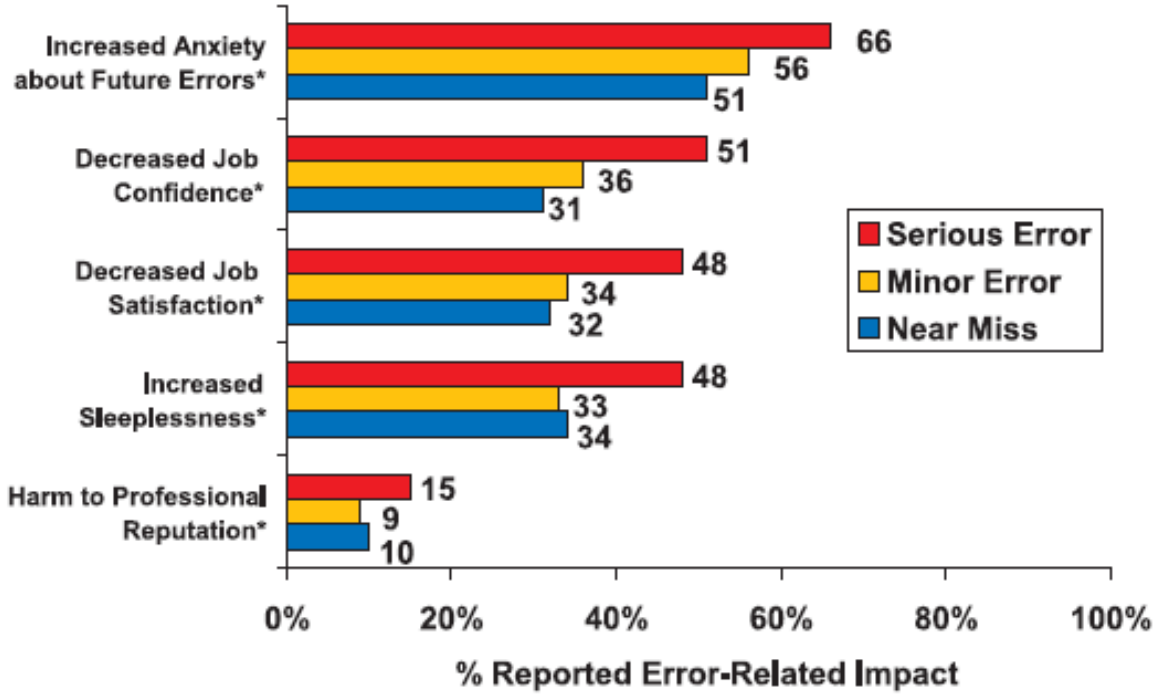
Qual Saf Health Care 2009;18:325-330

- 31 participants interviewed (MD, RN, other)
- 58% women, mean 14 months since adverse event, mean 13.5 years in practice
- Support system not in place

Table 4 Most commonly reported physical and psychosocial symptoms

Physical symptoms	n (%)	Psychosocial symptoms	n (%)
Extreme fatigue	16 (52)	Frustration	24 (77)
Sleep disturbances	14 (45)	Decreased job satisfaction	22 (71)
Rapid heart rate	13 (42)	Anger	21 (68)
Increased blood pressure	13 (42)	Extreme sadness	21 (68)
Muscle tension	12 (39)	Difficulty concentrating	20 (65)
Rapid breathing	11 (35)	Flashbacks	20 (65)
		Loss of confidence	20 (65)
		Grief	20 (65)
		Remorse	19 (61)
		Depression	17 (55)
		Repetitive/intrusive memories	16 (52)
		Self-doubt	16 (52)
		Return to work anxiety	15 (48)
		Second guessing career	12 (39)
		Fear of reputation damage	12 (39)
		Excessive excitability	11 (35)
		Avoidance of patient care area	10 (32)

Impact of Errors on Physicians' Life Domains by Level of Error Severity*



N = 3171 (64% return)
US & Canadian MDs

Waterman Jt Comm J Qual Patient Saf 2007 33(8):467-76

Resident Error (West JAMA 2006 Sep 6;296(9):1071-8)

- Prospective longitudinal cohort study internal medicine residents Mayo Clinic, quarterly eval
- N = 184 (84% return)
- 34% reported at least one major medical error
- Subsequently
  - Increased burnout scores
  - Decreased empathy scores
  - Decreased quality of life scores
  - 3.29 times more likely to become depressed

Physicians “must be able to recognize how and when their personal distress affects quality of patient care (both delivery of care and emotional support of patients and families).”

“Silence on career distress, as a strategy, simply does not work.”

-- Balch 2010
Johns Hopkins Dept. of Surgery

Lemaire, BMC Health Serv Research 2010 10:208

Canadian MDs n = 1178 (40% return)

Table 2 Physicians' coping strategies and how they relate to emotional exhaustion

Physicians' coping strategies while at work	
Coping strategies that are correlated with a lower frequency of emotional exhaustion	***Coping strategies that are correlated with a higher frequency of emotional exhaustion***
Take a time out ($r = -.18$; $p < .0001$)	Keep stress to myself ($r = .23$; $p < .0001$)
Use humor to lighten the situation ($r = -.11$; $p < .0001$)	Concentrate on what to do next ($r = .16$; $p < .0001$)
Talk it over with colleagues ($r = -.11$; $p < .0001$)	Go on as if nothing happened ($r = .07$; $p < .0001$)
Make a plan of action ($r = -.10$; $p = .001$)	
Physicians' coping strategies after leaving work	
Coping strategies that are correlated with a lower frequency of emotional exhaustion	***Coping strategies that are correlated with a higher frequency of emotional exhaustion***
Set aside quiet time outside of work ($r = -.22$; $p < .0001$)	
Find time to exercise ($r = -.21$; $p < .0001$)	
Spend time with family outside of work ($r = -.19$; $p < .0001$)	
Leave work at work ($r = -.17$; $p < .0001$)	
Talk about stress with spouse ($r = -.06$; $p = .001$)	

Maladaptive coping

- Denial; distraction with increased workload
- Obsessive rumination
- Finger pointing, blaming
- Emotional eating or worsened eating disorders
- Decreased self care
- Emotional withdrawal – marital dysfunction
- Anger
- Self medication with alcohol, rx or street drugs
- Suicidality

Coping

- Physicians who understand the long and short term effects of adverse events are better prepared to deal with them
- Recognize and self-monitor feelings – how much stress, and where is it coming from?
- Remember others are also involved – whole team was affected – be supportive
- Don’t be surprised by persistent thoughts or images – learn coping skills to deal with them

Know

- Institutional guidelines for handling adverse events
- Insurer guidelines
- Write a personal narrative of the event as soon as possible to a named attorney

Problem Focused Coping

Goldberg , Ann Emerg Med. 2002 39(3):287-92

- Accept responsibility for the mistake.
- Discuss with colleagues.
- Disclose and apologize to the patient.
- Conduct an error analysis.
- Make changes in practice setting designed to reduce future errors.
- Work at local and national levels to change the culture of the medical profession with regard to management of medical mistakes.

Emotion Focused Coping

- Anticipate this will be a difficult time – be patient with emotional changes
- Communicate in ways that feel comfortable to you
  - Talking one on one
  - Support groups
  - Religious advisor
  - Diary – personal reflection
- Keep to established routines
- Engage in healthy behaviors
  - Sleeping, eating
  - Relaxation techniques
- Hobbies, outside activities
- Avoid major life decisions
- Take time off as needed
- Enhance meaningful work

Talk about it

Talking about it helps acknowledge emotions,
and corrects dysfunctional thinking

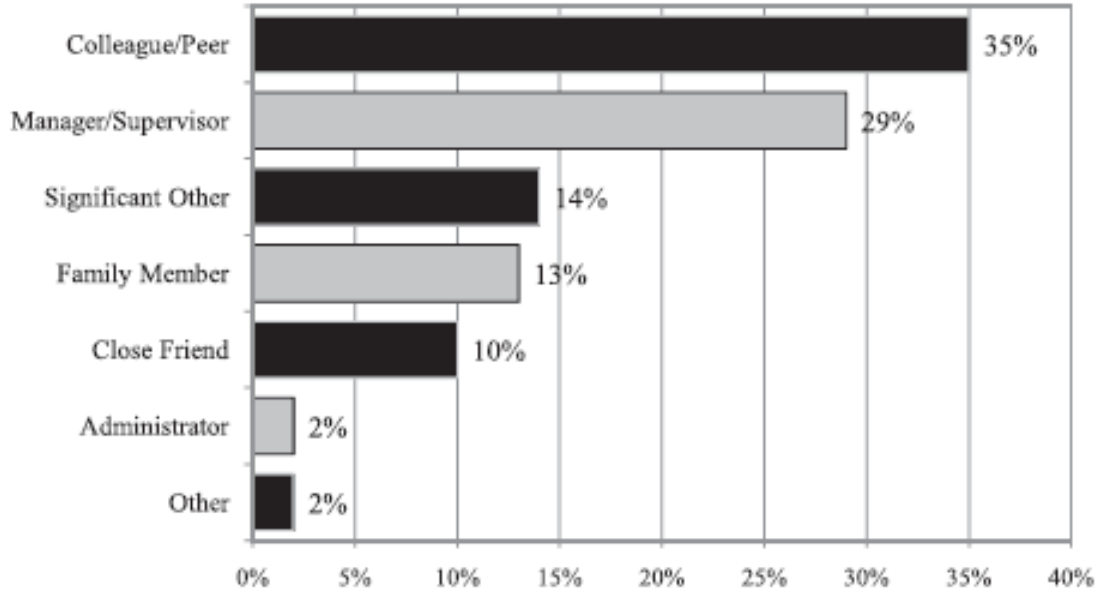
- Talk with experienced colleagues (about “feelings”)
- Talk with significant other
- Physician support groups
- Talk with personal physician (protected and confidential) who can monitor symptoms, provide support and appropriate medication
  - Decreases risky behaviors such as self-diagnosis and self-medication
  - “Consultation and treatment for reactions to malpractice suits that do not impair a physician’s ability to practice need not be reported to licensing board”

Get by with a little help from my friends

Wallace Soc Sci and Medicine 2007 64:2565–2577

- Canadian study of internal medicine faculty and residents
- N = 182 (66% return)
- Co-worker support not only increased well-being in general, but buffered negative effects of work

Source of Emotional Support After a Clinical Event When Offered



n = 989
(Prior to support program, U of Missouri)
Scott, Jt Comm J Qual Patient Saf. 2010 36(5):233-40

65% “worked it out” on their own.

<u>What clinicians most wanted was brief respite from clinical responsibilities.</u>

Mindfulness

- The two most important abilities needed to successfully get through an adverse event
  - Stop obsessing
  - Stop kicking yourself
- Two great strengths of learning mindfulness
  - Letting go of worries about things you can’t control (the past and the future)
  - Non-judgmental self-compassion

Perspective

- In one study, 87% of physicians stated that their most frequent coping strategy for dealing with (event) is “telling myself I am a good physician”. (Charles 2005)
- Realize we have a stronger memory for negative events
- Remember your strengths and accomplishments
- Remember the things you are grateful for

“What is required is a new way of thinking about one’s personal energy, that is, work is not merely a domain of energy expenditure, but also energy renewal.”

- Balch 2010

We often minimize our symptoms, delay getting help, and fail to take the advice we give to patients.

When to seek help

- Anxiety or distress interferes with daily work and relationships
- Remain preoccupied with event
- Self-medicate or abuse other substances
- Colleagues, friends or family observe and comment on changes in behavior
- Significantly diminished work satisfaction
- New or exacerbation of old physical symptoms

Now we add the subpoena….

"Shame is particularly difficult for physicians because its moral implications challenge their core feelings of integrity, leaving them feeling personally exposed, inferior, and diminished as persons."

--Davidoff Qual and Safety in Health Care 2002 11:2-3

“My first feelings after being charged with medical malpractice were of being utterly alone. Suddenly I felt isolated from my colleagues and patients….during the 5-year span of my own case—it swallowed up my life completely, demanded constant attention and study, multiplied tension and strain, generated a pattern of broken sleep and anxiety because I felt my integrity as a person and as a physician had been damaged and might be permanently lost.” Charles book

Why is a Liability Suit so Stressful?

(Charles 2005)

- Challenges sense of being knowledgeable and in control
- Challenges sense of being conscientious, caring, and competent
- Charges as listed assault self-esteem, sense of honor, our reputation "wounds our understanding of ourselves as admirable, well-meaning people"
- Feelings of guilt, self-accusation, shame
- Fear about short and long term repercussions
- Loss of trust - "I don't think you ever look at patients in the same way."
- Challenges our judgment and skill, causing us to question ourselves that may not dissipate for many years

Case characteristics can influence how we feel

- Our error vs. unanticipated complication
- Long-term and trusted patient vs. brief encounter in ED
- Media attention
- Sole defendant vs. multiple defendants

Different viewpoints

- MD frustrated and angry “We feel vulnerable and powerless because when we enter a process for which we are unprepared, we must depend on others to guide our steps and represent our interest.”
- Patient that expected perfection
- Administration that doesn’t want publicity
- Insurer that wants to protect their assets
- “Experts” who may have other agendas
- Must put all of these into perspective

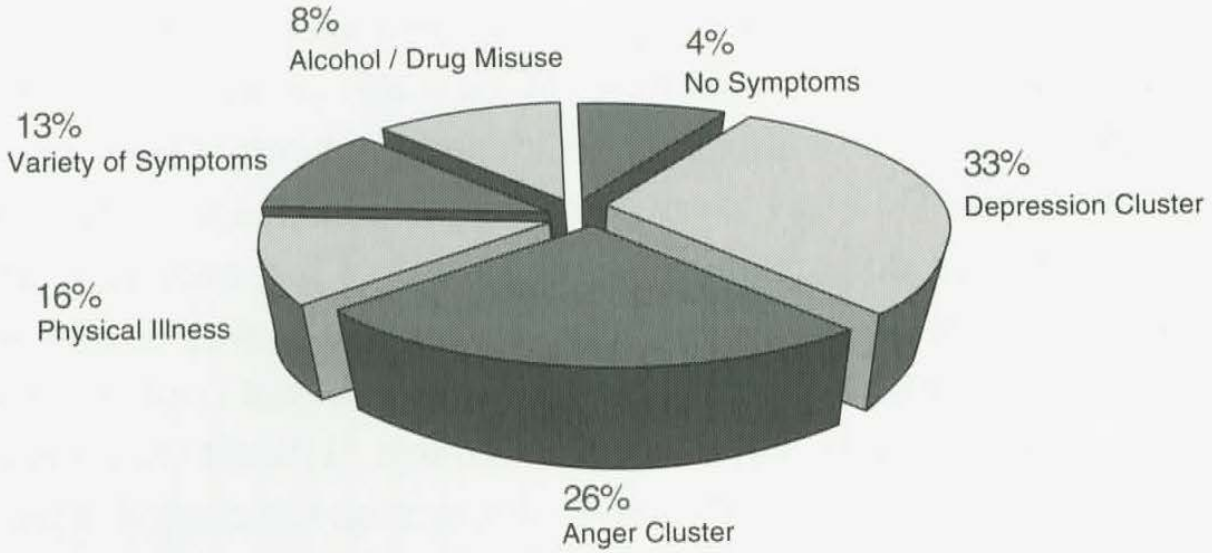


Figure 8–2. Common symptomatic responses to medical malpractice litigation. Summary statistics based on Sara C. Charles, Charlene E. Pyskoty, and Amy Nelson, "Physicians on Trial: Self-reported Reactions to Malpractice Trials," *Western Journal of Medicine* 148(1988): 358–360.

Professional emotional changes

- Disengagement
- Decreased commitment, dedication
- Hostility towards patients
- Cynicism
- Difficult relationships with co-workers
- This all may increase risk of another adverse event

Important to start coping right away

- Study using Oregon databases of 1,903 MDs
- Physicians who had a claim producing event, compared to those who did not, had twice the risk (7 to 14%) of an additional claim during the 12 months following the initial incident.

Frisch Western Journal of Medicine 1995 163:346-350

Stress of a lawsuit can have a negative effect on your ability to defend yourself.

Prepare like an athlete.

Preparing for litigation

- Balance time to prepare as needed with other responsibilities
- Re-evaluate practice patterns to decrease stress
- Re-evaluate other commitments and priorities - decrease responsibilities for the trial period so you can focus
- Recognize the compounded effect of concurrent family or other life stresses and strategize ways to manage them
- Foster important relationships

Leading up to trial, prepare yourself

- Have a personal physician
- Self care – exercise, sleep, etc.
- Awareness of personal vulnerabilities
- Learn relaxation or cognitive/behavioral techniques to strengthen your vulnerabilities (anger, fear) so you can present a calm, professional demeanor

"…personality traits in ordinary, normal physicians that makes them vulnerable to doubt, guilt feelings, and an exaggerated sense of responsibility…Such a state of mind is exactly what the plaintiff attorneys hope for and depend on: they want us to doubt our competence and to feel guilty and personally responsible, even if we are not, for whatever happened." Charles 2005

Leading up to trial get ready mentally

Manage anxiety by controlling what is controllable, and being proactive

- Learn about the legal system
- Review the parameters and limitations of your insurance policy
- Consult an expert about financial asset protection
- Know your deposition - read all of the depositions and comment for your attorney, especially errors or omissions
- Know the literature – bring articles to the attention of your attorney
- Help with visual aids
- Become a devil's advocate – help your attorney understand alternative medical approaches
- Suggest names of expert witnesses and help formulate questions for them
- Ask attorney to summarize their understanding of what you said and clear up any misinterpretations

The Legal System

- We like feeling in control, and the legal system is an unknown area where we have to depend on someone else
- Medicine collegial, law adversarial
- Lawyers not involved personally, “unable to relate to our outrage”
- Very drawn out process that moves at its own pace, with a casual view of our time
- Truth ≠ Justice
- “The tort system is about compensation, not competence”
- Expect delays, unanticipated or surprising testimony, lengthy legal arguments that don’t seem to apply to what’s going on

During the trial

- Need to be in court – flexible work schedule
  - Minimal if any work obligations recommended
- Maintain composure
- Pay attention to your attorney
- Cross examination intent on rattling us to present a confused or inaccurate testimony (use various techniques) “They are not interested in uncovering facts as much as revealing our vulnerability”
- Be patient and wait turn to present your side
- Must prepare for two things: to testify and to lose

“I’d wake up in the middle of the night in a murderous rage, which is absolutely the worst. And you can’t get back to sleep and there’s nothing you can do about it.”

Charles 2005

Remember family (Charles 2005)

- Lowering our guard at home “can result in our being moody, irritable, and short-fused with those closest to us……Being sued affects and changes family dynamics.”
- “We may be too preoccupied at the time to notice the generosity and graciousness with which they support us and maintain a balanced environment around us.”
- Also don’t forget staff – to prepare and appreciate them

After the Trial

- “Winners” and “losers” look the same – same symptoms and behaviors as the result of their experience – angry, disappointed, bitter
- “I wrestle with every decision I make on every patient, knowing how it can be misinterpreted and distorted and manipulated for greed” Charles 2005

Impact on career satisfaction

Xu Womens Health Issues 2008 18(4):229-237

- Survey of 800 Michigan ob/gyn providers (48.2% response)
- Decreased career satisfaction if malpractice insurance costs >=$50,000
- No association with satisfaction and total number of malpractice claims, or recent claims

A lawsuit, like war, is not one but rather a series of events…..As at the end of a war, we may try to follow everybody's advice to go on with life, but we are, in fact, changed at levels and in ways that we do not fully grasp and cannot easily measure and that others may not understand at all." Charles 2005

Make Lemonade

- Emotional insight, growth
- Appreciation for family and friends
- Clarify life priorities
- Seek better self care, life balance
- Improved patient care processes
- Seek counseling if retained negative attitudes toward patient care
- Strive to be “better” rather than “bitter”

“I treated it like an adventure. I would not let it interfere with my love of medicine and my patients. I would be a better doctor. I would meet amazing people. It was a terrific challenge. Not allowing the negative distractions associated with the case to interfere with my focus and taking time away from patient care during the trial were important lessons. After my trial, I had one regret, I should have had a week’s vacation.”

Charles 2005

“We are better off in every way if we remain human during this demanding and deeply traumatizing experience (Charles 2005) -

- Talk to others
- Participate actively in a process whose every detail we should understand thoroughly
- Reject passively being overwhelmed and victimized
- Take on two challenges – informing ourselves about the law and defending our integrity
- Take an active role in our defense no matter at what stage or for how long
- Realize that nobody is going to fight in our place

“All of us have had bad outcomes, have made judgments we regret, and have made choices we would now reconsider. Nonetheless, most of our patients have done well and benefited from our care…Viewing this lawsuit in the context of our entire career keeps it, and us, in healthy perspective.” Charles 2005

How can we better care for our own?

- Shift focus from finding someone to blame to find ways to limit the recurrence of this event
- Understanding that errors are a function of a system, and the MD is only one link in a chain
- Institutional awareness promotes open dialogue

Changes required for a Culture of Safety:

Leape Clin Chim Acta. 2009 404(1):2-5 Harvard School of Public Health

- Move from looking at errors as individual failures to system failures
- Move from a punitive environment to a just culture
- Move from secrecy to transparency
- Change from being provider (doctor) centered to being patient-centered
- Move from reliance on independent, individual performance excellence to interdependent, collaborative, interprofessional teamwork
- Accountability is universal and reciprocal, not top-down

Organizational support important

- An entire team has been distressed
- Lack of support
  - Increased staff stress
  - Decreased morale
  - Increased turnover
  - Diminished organizational culture
- “Clinical support must become a predictable, expected part of a healthcare organization’s operational response to unanticipated clinical events.” (Scott 2010)

Support systems

- Dept level support
- Institution
  - Risk management help with patient notification, documentation, litigation
- Insurance company – educational materials, claims manager
- Specialty society – AMA, ACOG many resources

Education

(Frisch PR Western Journal of Medicine 1995 163:346-350)

- After a series of educational seminars, ob/gyn claims incidence dropped from 23.3% to 15.2% and in payout from 11.6% to 4.2%
- ACOG has a series of online resident quizzes on liability issues, with director handbook
- SUMIT has a series of online educational modules

Brigham Model

(van Pelt Qual Saf Health Care. 2008 Aug;17(4):249-52)

- Adverse incident with anesthesiologist and patient who interacted “off the grid”
- Patient began a nonprofit “Medically Induced Trauma Support Services” for both patients and providers who have been affected by adverse events
- System of provider support groups, one-on-one, and a hotline
- Peers trained in manner similar to first responders (fire, police) “emotional first aid”
- Confidential, no records kept
- Excellent resource website www.mitss.org

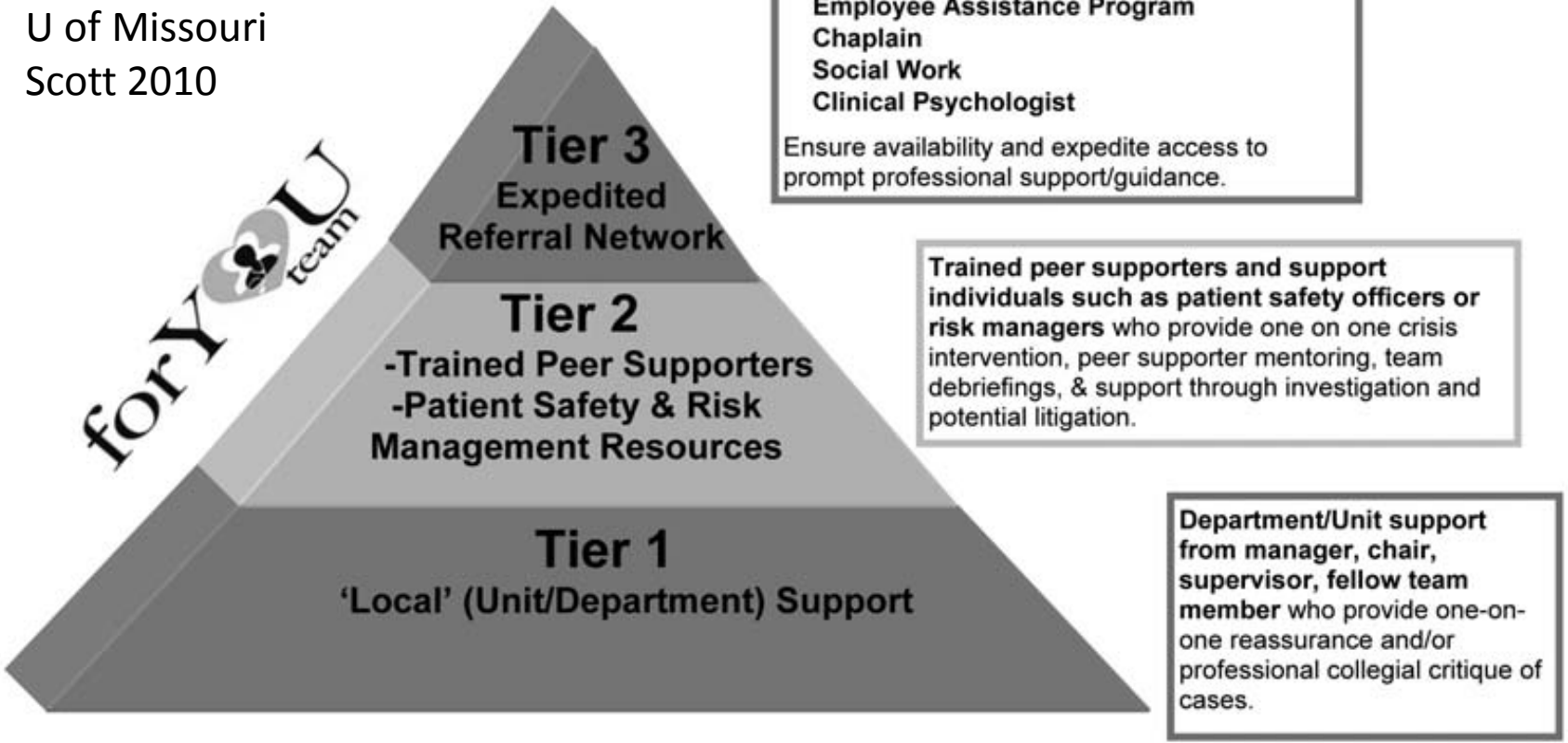
Box 1 Hallmarks of the peer support team model

- Credibility of peers
- Immediate availability
- Voluntary access
- Confidential
- Emotional "first aid" (not therapy!)
- Facilitated access to next level of support (eg, Employee Assistance Program)

Group debrief (Everly Brief Treat Crisis Interv 2006 6:130-136)

- Providing a structure
- Fostering symptom management
- Validating the traumatic experience
- Providing an opportunity to rebuild trust
- Decreasing isolation
- Fostering ventilation and grief in a safe environment
- Learning about one's own beliefs and worldviews as they may have been affected by the traumatic experience

U of Missouri
Scott 2010



Kaiser Adverse Outcome Response Model

(Devencenzi 2006)

- Request for EAP support can be initiated by anyone
- Processes provided (each has different indications):
  - Defusing (within 12 hrs)
  - Crisis Management Briefing (24-48 hrs)
  - Debriefing (48-72 hrs)
  - Individual emotional support
- Follow-up
  - EAP assesses ongoing needs of dept.
  - Staff evaluation of effectiveness of EAP intervention

“All doctors deal with stressful times in their personal and professional lives and must cultivate habits of personal renewal, emotional self-awareness, connection with colleagues, adequate support systems, and the ability to find meaning in work to combat these challenges. We also need to set an example of good health to our patients and future generations of doctors.” Balch 2010

The Five Rights of a Second Victim

(Denham J Patient Saf 2007 3:107-119)

1. Treatment that is just - no presumption of guilt or negligence
2. Respect - no name-blame-shame
3. Understanding and compassion
4. Supportive care

   "We must take a systematic approach to delivering this care in as professional and organized way as we would in treating any other patient."
5. Transparency and the opportunity to contribute

   Provide an opportunity to heal by contributing to the prevention of future events