Elite Learning by Colibri Healthcare

Podcast Transcript

Ethical Considerations in Medical Error Communication

Guest: Dr. James V. Stowe, J.D., R.N.

James is both a nurse and attorney, obtaining a nursing degree from Auburn University and a Juris Doctor from Samford University, Cumberland School of Law. He practiced in the legal field concentrating in part on medical claims before returning to hospital administration. James is currently the Director of a large Emergency Department.

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Dr. Pierce is a nurse leader committed to ensuring nurses are well prepared and offered abundant opportunities and resources to enhance their skills acquisition and confidence at the bedside. With 15 years in nursing, she has worked at the bedside, in management, and in nursing education. She has demonstrated expertise and scholarship in innovation and design thinking in healthcare and education, and collaborative efforts within and outside of healthcare. Scholarship endeavors include funded grants, publications, and presentations. As a leader, Dr. Pierce strives to empower others to create and deploy ideas and embrace their professional roles as leaders, change agents, and problem solvers. In her position as the Sr. Course Development Manager for Elite, she works as a project engineer with subject matter experts to develop evidence-based best practices in continuing education for nurses and other healthcare professionals.

Episode 1: Ethical Considerations in Medical Error Communication

Transcript

Candace Pierce: This is Dr. Candice Pierce with Elite Learning by Calibri Healthcare, and you are listening to our Elite Learning podcast where we share the most up-to-date education for healthcare professionals. Thank you for joining us for this series on ethical considerations and medical error communication. Joining me for this discussion is an expert in law and healthcare, being a nurse and lawyer, Dr. James Stowe. Thank you for joining us, Jay.

Jay Stowe: It's great to be here. Thank you.

PIERCE: Yes, we know that medical errors are an unfortunate reality in healthcare, and they come with some potentially devastating consequences for patients, for families, and for healthcare workers. So, before we really kick off this conversation, I do want to highlight that the ethical considerations surrounding

medical error communication are multifaceted, and they demand careful navigation. While transparency and accountability are crucial, we also have to prioritize the well-being and the trust of patients and families. So now Jay, this seems like a really easy question, okay? But when you break down medical errors, there's really more to it than the surface definition. So, my question, what is considered a medical error?

STOWE: You know, it all depends on who you ask. Unfortunately, that's not a very easy answer because there's, as you mentioned, there's so much built behind that word, so much fear when you say medical error and so much concern. But many institutions, and I think the National Institute of Health, have kind of summed it up a little bit better and given the definition. A medical error is a failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. So, it's pretty broad in its scope and really, does that give you any additional clarity when you do that? I don't know, you know, it's kind of broad there.

PIERCE: It is for sure. So, what causes medical errors? What is that factor behind a medical error?

STOWE: You know, first thing about this topic of medical errors, it's really something that is interesting to me as both a nurse and an attorney. I practiced with some medical lawsuits, a number of them in my career. And you look at it and looking back, there's roughly, depending on what research you look at, 200 to 400,000 plus deaths a year attributed to medical errors. It really ranks roughly, when you take COVID out of the picture, in any given kind of normal, quote unquote normal year, about the third leading cause of death. Well, that's death, right? So how many actual errors, how many missed doses or wrong doses of medication are given that caused no harm, but that's an error. How many actual errors really did occur? Uh, so it's many, many, times more than that 200,000- 400,000. So, what causes it? I think it's multifactorial. You know, there's, did get enough sleep the night before. Are you overworked? Are you stressed out? Are you worried about a loved one? Child's soccer game was this afternoon, you just worry whether or not they'll do well, and you take your mind off of what you're doing for just a second. There are so many things that can interfere with your focus when you're working that what it does is it shows us by the number that it's pretty darn easy to make a medical error.

PIERCE: Absolutely. And then it's not just human factors. You know, what about miscommunication between provider and staff and system and process deficiencies? I mean, those seem to...

STOWE: It's amazing. You know, recently there was a lawsuit out of Tennessee, Nashville, a criminal trial from a nurse that admitted the mistake. It got national attention, the Radonda Vaught case. But there were errors in the processes, right? And for example, when searching for medication in the PYXIS machine, the medication dispensing machine, only put in the first two letters versus the first three, which would have narrowed down the medication options to choose from. Well, that's simply a programming error. So how does someone in an IT department programming a computer understand the frontline necessity of a third letter versus a second one? It can get really granular, and it's difficult. There's no easy answer when trying to define everything. Because if you could define it all, you could fix it, right? But you just can't define it all because you have these really interesting one-offs that just keep popping up.

PIERCE: It seems like with medical errors, there are quite a few different types. So, we've talked about system and process errors, communication errors, treatment errors, mistakes in medications and procedures, and surgical diagnostic errors.

STOWE: Absolutely. You know, there are if you can think of healthcare, there's an error associated with it. Now, when we think of medical errors, of course, my thought process with my history and being an attorney, I kind of jumped to the most egregious examples, right? Severe bodily injury, harm, or death. But most errors are unintentional. They're not intentional. They're not a I am going to do this because I intend to harm a patient. That's really not the case. The result may be harm, but the actual practice, whether you're in an urgent care, whether you're in a dentist office, or you in a pharmacy and you've got 19 people

waiting in line in a pharmacy, are you really double checking the medications that you're dispensing as close as you need to? So medical errors can happen anywhere. I mean, it can happen in anywhere in any setting. So, errors happen every day.

PIERCE: Well, we're human and they're going to happen. So, what are the key ethical principles that should guide the communication of medical errors to patients and families?

STOWE: This is really interesting because you get a lot of suggestions of what you should do, but no one has gone out and defined it and said, this is what you have to do. I can tell you from my experience and having sat at the boardroom table more times than I care to admit when talking with patients and patients' families about medical errors, that if you're sitting at the boardroom table talking to a patient or their family about a medical error, there was a bad outcome, right? You know, the key tenants are, you're going to have to be honest. If you've made the decision to go to the table, to sit at the table, you're going to have to be honest, and you're going to have to talk to them and tell them exactly what happened. So, honesty is at the forefront. Disclose the error. Disclose exactly what happened and exactly what you're doing. You know, this is what happened. We're doing this, our focus is on the care and wellbeing going forward. How do we optimize health? How do we get mom, dad, brother, sister out of the hospital, even though there was some harm done. What do we have to do moving forward? And I will say this, if you don't come across as sympathetic and caring, it's all for naught not, right? Don't treat it as an exercise of, well, this is just something I have to do. You have got to be sincere. If you're going to reveal that, you have got to be sincere. There are some very important and strong legal implications of sitting at the table and disclosing these errors. So sympathetic approach really is important.

PIERCE: Yes. And then do you also bring into that discussion how to prevent or how we're looking at preventing? So, if you're being transparent and honest about what happened, is it helpful to bring in, well, this is what we're doing to try to prevent it in the future?

STOWE: You know, it's really interesting that question. That can go two ways. It always depends on the receiving individuals, right? If the receiving individuals are taking in your message and you see head nods and they're following along and they truly appreciate what you're doing, and you don't want this error to your loved one to happen again, that can be a very impactful thing. And it can make a strong statement and the patient, or the family can truly enjoy that. If you're not getting a lot of warm and fuzzy from the other side of the table, what can be taken out of that is replaying those statements if they do decide to sue, replaying those statements in court of, and imagine how this goes over. Yes, the hospital told me that this has happened repeatedly, and they created a task force to change that going forward. Well, I would have a field day as an attorney. So, it has repeatedly happened, and you haven't fixed it by now? So, when we talk about standards and talk about hard-to-find rules on what you can and can't say, there aren't any because it's really up to how your conversation and how the receiving party is going to take your comments and your sincerity.

PIERCE: Right. Okay. So morally, ethically, and legally, am I obligated as a healthcare provider to disclose medical errors, even if the error does not result in say harm to the patient?

STOWE: Morally, ethically, I believe that you are. Now, again, that's coming from my morals and my moral compass, right? So, one of the issues that we have today is everybody's an individual and everybody theoretically has their own moral compass. So, what do they feel like they need to do? Well, how do you correlate that into, expectations or a standard or a rule that you must follow. When you look at a hospital, and I'll pick on hospitals, I should say healthcare institutions, whether it's a dental practice, a pharmacy, urgent care. Do you want a policy, written policy that says, hey, this is how we're going to handle medical errors? Again, as an attorney, I can get a copy of your policy and hold it up in court and say, hey, look, they have.

PIERCE: What about a guideline?

STOWE: They have so many messed up processes, they had to write a procedure about it. The optics just aren't good, right? So, what you end up finding and seeing is that the few places that there are actual written expectations are in your licensing agencies. So, your boards of nursing, your medical boards will tell you have an ethical obligation to admit errors. You know, tell it to the patient, family, whomever to receive that information, and provide care. The other way to look at that is if you've assumed care over an individual, you kind of created a fiduciary partnership, right? You've created a fiduciary duty and part of that duty is doing no harm, no malfeasance. So, if you don't do any malfeasance, don't do bad, only do good, then you have a duty to share when that bad occurs. So, there's very little teeth in laws, expectations, policies driving when you should tell somebody. When you think about it, how many communications have you had with whatever board you are certified under? The dental board, the physical board of physical therapy, you know, and I'm making this up. I don't know what they report to, you know, nursing board, medical board. We really don't have that much communication with them. So, is it up to me to report myself to them? Is it up to someone else to report me to them? And there's language in there, but what happens if you don't, right? And generally speaking, there's not a whole lot of teeth if you don't do it. So, it really rests upon the shoulders of the individual. Now, you work for somebody, or you work in a facility, what are their rules? Are they telling you that you've got to go through the quality department first? Are they telling you you've got to go through the risk manager first before you can say anything so they can protect their interest? I don't know, every hospital, every institution is different. So even if you want to say something, you feel like your moral compass is telling you, ethically, I've got to talk to the patient. I've got to tell them what happened. Can you? Will the institution that you work for allow you to do that? So, it's a very difficult thing to define. It's just this really abstract concept of when I should report a medical error. And you look at this and you think, I mentioned the fact 200,000 to 400,000 deaths a year. If you do some very just crude math, and you look at their 6,100 hospitals in the U.S. and without taking account of size and scope and the differences between the two and not counting any other facility like urgent care where someone may pass, you look at that and you go, that's roughly 40 deaths a year per institution that was caused by a medical error. And I know that's not correct math but think about the number. That is a very impactful number for institutions when they're thinking about what happens if a lawsuit is brought against each one of these cases. So really makes you think, and it really makes you wonder where to go with that. And if you should have anything in writing or set an expectation even.

PIERCE: Well, and while you're talking, my brain is definitely over here turning because I'm thinking, okay, I've worked in quite a few different hospitals, due to moving around, and I don't know that I've ever had a hospital tell their expectation of what I should do if a medical error occurs. I don't recall that in my orientation at all.

STOWE: You're right. And what you see is you see little things, right? Like the pharmacy department may put out an extravasation policy. If a wrong medication is given or if, not to say wrong information, but let's say a highly viscous medication is given in a peripheral vein and it gets inflamed, it clots off, it gets inflamed.

PIERCE: I've seen those, yes.

STOWE: What do you do? How do you treat it? That's an error, right? Because it probably shouldn't have gone in that line. Not that the medication was necessarily incorrect, could be, but for this instance, or this example, it was put in a place where probably shouldn't have been put in, right? And you're trying to mitigate the damage on the back end. So, you'll see things like that and what it does is it normalizes that occurrence. It provides a remedy, but by seeing those policies and seeing that, it also normalizes that occurrence as common and acceptable when the truth is we should fix things on the front end and correct the expectations and the practice and not necessarily on the back end and fix the damage.

PIERCE: So, talking about legal a little bit there was, and I can't remember this hasn't been that long ago. There's a lawsuit. I believe it was in Georgia and a baby was born, and the family was not informed until later what had actually happened to the baby. Now I saw that there were some lawsuits. So that's a legal obligation or that's a someone saying well I thought you should have told me. I think that moral versus ethical versus legal obligation in that scenario.

STOWE: So, anything with kids is a very highly charged area, right? We love our kids; we protect our kids. It's biological, it's human. You have heightened, as my kid says it, my spidey senses, and so you're just automatically, papa bear mode, mama bear mode, walking over your kid. Unfortunately, when something happens to a child, regardless of their age, and this happens to be at birth, regardless of the age, we're super sensitive to it and overly sensitive, right? So, it gets scrutinized more often than not. Lawsuits are in abundance against OBGYNs, OB practitioners. It's one of the most highly litigated fields, because we want to blame someone, okay? As individuals, I have found through years of legal work, we want to blame someone, right? We don't necessarily have a lot of feelings one way or the other about a lot of different factors involved in the suit. We just want to know; I didn't harm my child. I didn't do that, someone else did. And it's a coping mechanism, right? It's a coping mechanism that we have, but we have it. We're human, that's part of how we're made. So that's a very litigious area. And so, knowing that it's a highly litigious area, this is where your moral compass comes in, as far as the practitioner, maybe OB-GYN that delivered the child or was the primary physician for the pregnancy prior to birth, what have you. Is it your responsibility to go and tell them?

PIERCE: As a nurse.

STOWE: Well, as a nurse, you fall under the guise and the direction of wherever you're practicing. So that's a little bit different than a practitioner, but as a nurse, you have to fall under that. So, it's difficult because, the studies today will tell you that if there's a medical error, and you go and you own that error and you're sympathetic in your conversations, you talk about or you explain to the patient and family how you got there, what you're going to do to take care of them post-event, that you actually mitigate or reduce the risk of lawsuits, greatly reduce them. Again, people are looking for an answer, right? That's why when you don't apologize and you may find out years down the road and someone else knew and didn't tell you, you're just inflamed, right? You want answers and you want accountability. They have found that, so we're moving today more towards talking to people and explaining that there are errors. But legally, there are some huge risks in doing that from a legal standpoint. In Alabama, we have a statute of limitations of two years from the injuring event. You must file a lawsuit within two years. Some people will say, I'll tell them, but I'll wait for my two years to be up before I tell them. It's not a complete get-out-of-jail-free card, right? So also in the law, there is part of the statute of limitations is there's two years from the date of injury or two years from discovery of the of the injuring event, or two years from the date you should have discovered it. This came into play years ago and there's been a number of examples of that have a surgical procedure, run the mill, what have you, abdominal surgical procedure. Used to leave gauze in the abdominal cavity, right? They were put in there during the procedure, you get sewn up, they thought they had the count right. This is before generally there's a, what you call a magnetic tip on them now that you can take an x -ray and it actually highlights before you close them up and you can make sure you get them all out. I don't know if everybody knows that, but they do that. They just want to be sure, I mean, you can, please don't leave anything in there. But gauze actually will migrate through your intestines, and you can pass it. And so, people years later, five years, eight years, ten years later, there's a rag in their toilet and they're like, what the heck happened? You know, and they've been having it, they've been having pain for years. And so, they go back, and they sue. Hey, you left something in there.

PIERCE: Here it is, I found it!

STOWER: So, yes, you don't want to have to bring it to them, but there's some statute of limitations there that do come into play and do affect the way people think about it. You can roll the dice. Hey, should I say

anything at all if it's never discovered? So it's very difficult, but ultimately the disclosing of medical errors no matter what type of practitioner you are, runs afoul generally of what most attorneys would tell you of defending a lawsuit of this nature. So, it's a complicated process.

PIERCE: Okay, so an error occurs. Is there role that patients and families may play in investigating and analyzing these medical errors?

STOWE: I will tell you that after 25 years in healthcare system, I will start with, if a family member, loved one goes to the hospital, I or someone I trust are with them from the moment they step foot in the hospital to the moment they leave. The reason is healthcare is complicated, right? It's not easy, it's a science, it's not an art. An art can be defined. Science is still a work in progress many times. So, it's fair if it is a science and there's hypotheticals and there's testing things out for you to ask questions and poke holes into theoretical theories of, I'm going to prescribe this medication. Okay. So, I think it's very fair to ask those difficult questions and be with people and make sure things are done correctly the whole way. Because there is such fear about repercussions, either fear for loss of your job, if you work in a healthcare setting if you were to say something or fear of a lawsuit, many people don't speak up. So as a family member, I want to be there to prevent errors, if at all possible. But two, I want to be there to be able to ask questions. And I think that's where patients and families really can impact things. You need to be able to get in, ask the questions, and figure out what went wrong. Now, there's a way to do it. Don't come in like a bull in the China shop and I won't answer. But truly when you think long-term, now could it impact care down the road, your decisions, healthcare decisions? It could. So, I think there's a very valid argument for families to be involved and try to get to the bottom of what happened to provide the best care possible or ensure that the best care is provided down the road for their level.

PIERCE: Well, you were talking a little bit about fear of repercussions. So, we're scared to admit when something happens. So how can a healthcare organization really help to create this just culture? That's the hot topic word that really supports reporting errors while also holding professionals accountable when they do make mistakes.

STOWE: Hospitals, institutions really have to structure their processes, right? When I say structure their processes, the court system has generally deemed quality reporting as undiscoverable, meaning as a plaintiff's attorney, I could request that you hand me every document under the world, but I don't have to hand over certain ones. And the quality reports and process improvement documents don't have to be handed over, right? Because it's kind of like the hospital secrets of everything wrong. And we don't want to just give it to you, because you just will show that to everybody. So, you have to have a reporting structure. And this is why if you've ever been involved in, say, a root cause analysis or a process improvement situation, it's generally led through the quality department. And the reason is all those documents in your research and investigation and findings can be held privately within the institution. That's not necessarily a bad thing, right? We want to encourage improvement. We want to encourage fixing issues. So, we have to provide institutions a route to do it so that won't bankrupt them through lawsuits. That's kind of the bottom line. So, hospitals can start this process and the biggest issue for a hospital system or any healthcare institution is, okay, you've established a system, you have an event reporting system, you educate, you want your frontline staff to report these things, you want them to do this, it's all private, right, it's secure. Post-COVID, healthcare is really, is still topsy-turvy. Hospitals, y on average, have between a 1-3% profit margin, which is very, very low for any business. And yes, people have to understand these are businesses. We want to think they're just altruistic and that's why they're there to help us no matter what, but they are businesses, and they have to make money to pay the light bills and pay their staff. We’re in a national nursing crisis. We're short in other disciplines too. So, all of these things add on layers and layers of complexity. We have a nursing issue. We want to do a root cause analysis and we say, we want to get together for one week, map out the process, figure out options, and educate. How many nurses can you take away from the bedside for a week?

PIERCE: None!

STOWE: Right. So how do you perform these improvements? Right. So, it's just a very complicated issue that you think topically, oh, this is easy. The roadmap's out there. We'll get these people together. We know exactly which fishbone diagram and all these different things we can complete and how to change and improve. But theory versus practice is very different today. So, it can be done. It absolutely can be done. Hospital systems, to pick on them, structure things correctly, be proactive, monitor for change, but at the end of the day, you've got to dedicate resources that allow for a just culture to exist. If a just culture exists, we all think about just culture as it's just, it's, we're not going to, we're not penalizing people. And that's really not what just culture means. Just culture means that, to me, if there's no intent, to do harm, no intentional bad act, then it's essentially a learning opportunity. If there's an intentional act or a mission that caused harm, well that's still subject to discipline, right? Not only from your institution but maybe the licensing board or even criminally. But if it's not, are we capitalizing on those unintentional acts that can make us have better performance and reduce down the road, well, we don't have to worry about disclosing errors. We're just providing better care. And so, there is a pathway to do that. It's just resource heavy and it's difficult and it's very difficult in today's healthcare and economic environment.

PIERCE: Absolutely. I mean, I talk to my students a lot, because we are talking about interviewing people and they'll say, well, we'll bring some bedside nurses in and like, well, how are you going to how are you going to cover their shift? What is your plan for being able to let them come down and not stressing them out? Because then they are thinking the whole time they're there. I got to do this, this, this, and this when I get back and I only have four hours left in my shift. And, you know, so, I mean, that's definitely something to think about in all aspects of leadership in any organization. Well, we have come to the end of this episode. Thank you, Jay, for shedding so much light on the core ethical tensions at play in healthcare and really just highlighting the need for the sensitivity, compassion, and of course, commitment to continuous improvement in healthcare. Join us for episode two where Jay and I will discuss best practices and practical strategies for fostering an environment of transparency, accountability, and trust in the face of medical errors.

Episode 2: Ethical Considerations in Medical Error Communication

Transcript

Candace Pierce: Thank you for joining us for episode two of our two-part series on ethical consideration and medical error communication. We're going to continue this discussion building on the foundation laid in our previous episode to take a deeper look into the nuances, limitations, processes, and stakeholder perspectives involved in upholding ethics around medical error communication. So, if you have not, make sure you take some time to listen to episode one. Dr. Jane Stowe is here to continue this discussion with me. So, we're going to hop right into it. How can healthcare educators better prepare future providers on the ethical and communication skills needed to handle medical errors?

STOWE: Hey, great question. And that's really where you need to focus this, the future of the discussion of medical errors is how do we make a true impact? And I think it really is focused on the group of individuals that you're talking to. And by that, I mean, look, if you're talking to a bunch of nurses in a hospital, explain the fact that, hey, look, let me tell you about our structure. Never have I sat in a hospital where the structure and legal liability are discussed when reporting. Those fears from the frontline personnel are not

alleviated. So, if I were to come to you and say, look, hey Candace, here's what we've got going on. We've got a great new reporting structure, an event reporting system. So, we want you to report errors, near misses, things that just didn't go well, right? May have ended poorly, were wrong. And do you know what, we're going to establish a culture and an environment where if you need to enter one, your charge nurse is going to come to relieve you so that you have the time to enter it, okay? Don't try to squeeze in another action in you're already busy day. We want to make sure you do this. And while we're doing it is to prevent errors going forward. Does that sound like a good idea? Yes, it sounds like a good idea. I said, well, let me tell you what, we're going to do this through the quality department where everything you report is private. You're not going to get in trouble for reporting these actions as long as there's nothing intentional, right? Like if you intentionally did something, well then, we got to have a sit-down real talk. But again, if it's an error, let's report it, okay? This is not something that's going out to our attorney. This is something that's going to stay in the hospital. It's in the quality department. And we're going to discuss these things to try to prevent errors in the future. I think if you have a real conversation about things and how it's reported and how you're protected yourself, how you're given time to do this and not have to add just one more thing. You know, if you talk to a nurse in a hospital and say, oh, you want me to document one more thing? One more thing? Well, it's one more thing every day. Right? And they don't do it. They're out of time. They're out of time, and there's fear of repercussion. From a physician's standpoint, or maybe a nurse practitioner or some of these other entities that take more direct care of patients as far as writing orders and directions, I think you have to change, kind of change the switch a little bit, right? Because they don't necessarily work for the hospital. They may be a contract employee or given rights to work in or privileges to work within the hospital. So they're a little bit different setup, but I think that's where you change things and say, we do talk about the structure through the quality department and protection, but we also talk about, and I think what's impactful is you bring someone like myself in as an attorney with experience and you say, well guys, let me just tell you. Ladies, this is the reality, and this is the fact. If you go in there and you do X, Y, and Z, you're going to mitigate your risk for lawsuits. Now, can a lawsuit still be brought? Sure, it can. People ask me all the time, hey, can I file a lawsuit for something? You can always file a lawsuit for anything you want. As long as you pay the fee to file a suit, you can file it. It doesn't mean it's legitimate, doesn't mean it's not going to get thrown out the first time the judge reads the first letter, doesn't mean any of that. But you can always file something. So, I think you have to gear the conversation a different way for the groups that you're talking about, but you've got to set a standard. And then you have to actually have quote unquote governing bodies within the hospital back you up, like back that standard and expectation up. So, here's the medical director, chief medical director of the hospital, chief medical officer, CMO, are they going to go to a surgeon and say, hey, look, you didn't enter this. You didn't tell me about it, right? Probably not. However, you've got to get to that point where people are comfortable with reporting in order to truly effectuate change, right? If you're a nurse in the operating room and that doctor makes a mistake, one, do you have the same knowledge base as the physician? Did you know that an error occurred? You may not have, right? Or two, are you under such influence, or have you been influenced by the doctor to not report anything? So, there are a lot of levels, hypothetical levels that you have to consider when doing it, but I will tell you, what if 20 % more people comply with the just culture and reporting than did previously? Did you capture everybody? No, but think about the 20% of errors that you can address and potentially prevent going forward. So, I would argue that any increase in reporting and addressing of those things and changing processes and procedures is better for patient care. There are better outcomes. So, it doesn't have to be 100% to be effective.

PIERCE: So, entering, I want to go back to where you're talking about disclosing. So, you're entering it. The severity is it, according to the severity of the error say a near miss, a minor harm, a major harm. What factors should guide how much detail you actually provide?

STOWE: I think when you're reporting within the system, reporting your error, if it's structured properly, you can give every last detail. If you're talking about disclosing to the patient or family member, that's when it gets a bit hairy. The degree of disclosure, and disclosure in and of itself is risky. I say that when I say I want everybody to disclose things for improvement. But think about it this way. I'm a physician, okay? I've

practiced for 20 years. I've built up a nice practice. I have a nice lifestyle. I have expenses larger than most. I've got a couple of kids in college maybe. I've got a lot of bills to pay. Everybody's got a lot of bills to pay, but maybe a little bit more expensive. Something went wrong in childbirth. Okay, I'm an OB-GYN. Somebody went wrong, and I'm going to go tell the family that, do you know what, I failed to monitor something that could have prevented the poor outcome. If I go and sit at the boardroom table with them and I say, hey, I should have monitored this, and I didn't, okay? When you talk about a medical negligence claim and it's the claim of action that you would sue for is negligence, okay? We all call it medical malpractice. That's kind of what we call it. But negligence has five elements. It's kind of roughly in four. There's a duty to care for the patient, breaching that duty, causation, and there's a couple different steps to causation, and then the actual breach caused damage. So, if I go to the boardroom table and say, hey, I failed to monitor this aspect, I admitted I had a duty, I failed to do it, I breached that duty. I'm admitting to you because I breached that duty, X, Y, and Z poor outcomes happened. So, my failure is the causal link to the damage that resulted. So, I have at that table now made your entire lawsuit. I have met every element to be able to file a malpractice plan. And so, this is really, so when you take that, you can go straight to court and all you're now talking about is how many zeros are on that check. Not a matter of having to prove those things. That's why some attorneys will say, don't say anything, because then they have to prove that you breached the duty. They have to prove that you caused the damage, and then they have to prove that there were damages. Proving a lot of things versus just handing that proof over on a silver platter is quite difficult. So, at what stage? I think there's just simply a fear and the fear grows and the disclosure decreases in direct correlation with the degree of harm that resulted. If there's death, there are very few people to disclose things. If there's a permanent injury, some will disclose some, but it's a smaller amount. If there were, hey, wrong medication was given, no harm, no foul, disclose it all day long. Because even if you sue, if there's no harm, no foul, you haven't proved any damages. You've proved there was a duty to care for the patient. You proved there was a breach, but you didn't prove there was any damage, so you may not win the lawsuit. So, I think it's in direct correlation with the degree of harm that is caused.

PIERCE: So also, in disclosing to say the risk management department quality department, I can disclose all of that there with them, because I don't have to turn that over. It's not discoverable. Correct?

STOWE: Correct, correct. And so that is why you want to structure things, and you want to tell your people that, there's two different things. Reporting the error within your organization is not the same thing as sitting down at the table and talking and reporting it to the patient or patient's family. That's two different things. So, reporting it within your institution allows for process improvement. Those individuals over the heads of that department get to powwow with the administration and they will decide whether or not you get to step two and that is sitting down at the table with the patient and family and disclosing it. So, there are two very different things. So, I would encourage people the reporting within your system is 100% plus, right? Because you can address those things. And you can find ways to improve and prevent errors going forward. That kind of takes a lot of that fear off the table. As far as sitting down with the patient and family, especially from a nursing standpoint, you really don't have to worry about that. Others are going to be involved and they'll sit down.

PIERCE: Okay, so wait, I have a question now. I have a question. Okay, so we know that lawyers can be involved, risk management's involved, you know, healthcare system administrators can be involved, and they play a role in this. Okay, I want to take just a case study. I don't know all the details in the Georgia case with what happened with the baby. I mean, I know what happened to the baby, and I know that nurses were sued. So, I just want to take, okay, if I was a nurse, which I don't really go to the end of the hospital if I was a nurse down there and that happened, and I went to the quality department or risk manager, and I sat down, and I talked to them about what happened, then they technically would guide what would happen next. So then as a nurse, I get sued because maybe I was told not to talk to the family. Am I covered? What happens there? Because I know nurses were named in the lawsuit for not being forthcoming about what happened.

STOWE: Right. So that's interesting, and that can come up in trial. So, a lot of difficult decisions have to be made, right, from those nurses and the hospital. The hospital more than likely dictated what was disclosed to the patient and family, which more than likely, and again, I haven't read it, but more than likely said, we're not going to talk about this, or we will talk about it, not y 'all. That's generally the case. Nurses haven't practiced in a quality department as a whole, haven't practiced in risk management, haven't had a lot of interactions with attorneys. They may know an attorney, their parents may be an attorney, and they may also be an attorney, but you haven't actually had interactions during a lawsuit when you're an individual, right? So, there's a lot of unknowns and you don't know what to say, what not to say. So, the hospital will generally guide that and guide the direction there. Now, if you felt like you should have told something, you felt like you should have disclosed it, those things unfortunately can come out in court through testimony. And the unfortunate part is you generally have to wait till court to get that out there. But then there's also, you run the risk of a believability standard at that point, right? Like, oh sure, you can tell me now. Why didn't you tell me then? Or you wanted to, I'm sure. Yes, you wanted to so bad you didn't do it, right? So, it's, you know, it is scrutinized more so. There are ways around it. There's questioning with a hospital representative that's put up and all kinds of stuff. But yes, generally speaking, the hospital that you work for is going to direct that narrative, because again, while the nurses are sued, the nurses worked for the hospital, and the hospital is the one that has the big insurance. Nurses generally are a path, nurses, LPNs, pharmacy techs, and pharmacists. All these people within the hospital are generally avenues to attach the lawsuit to the actual institution that has a much bigger insurance. Sad state, but that's the truth of a legal action, right? And they work for them. And so that link can easily be made.

PIERCE: So, is there a time when it's ethically justified not to disclose an error to a patient like maybe concerns over their like a patient's mental health?

STOWE: I think that's a very valid question. And I think the easy answer is yes, I think there are those situations. But I immediately follow that up with, when do you disclose it and who gets to decide those answers? Because if you start down that slope of qualifying when someone should be told something, when they shouldn't for reason A or reason B or reason C, all of a sudden you create a scenario where you can abuse a system and use that as a withholding mechanism of disclosing errors. Now, that's a pretty cynical view, but I will tell you after 25 years of seeing this. We run all of our error reporting through our quality department now so that it's not disclosable, right, not discoverable in court. So, it's not farfetched to consider the same ideological concept that we're going to use these excuses not to disclose. So, I think that at the end of the day, this should just be disclosed. It is what it is, an error. If I'm truly supposed to have autonomy over myself or my loved ones as far as directing their medical care, I want to know. Now that's my personal belief. And not everybody's going to agree with that. And again, what happens when you tell somebody something and they have a physiological response to it when in theory you should have waited to tell them, and their personal outcome is poor. Then you can argue for the alternative or the other side. So, it's a very difficult concept. I personally don't see any sort of middle ground in it. I think you've got to decide one of the other.

PIERCE: So, what about some, are there different standards or processes when it comes to disclosing errors where maybe the patient can't make decisions? They don't have the capacity, you know, maybe with minors or cognitively impaired adults.

STOWE: We have most minors list a power of attorney, a parent, a guardian. If you're an older individual with a cognitive impairment, institutions can easily get a guardian enlightenment court as a representative. So again, that's one of those resting your hats arguably on a reason not to disclose potentially when we have avenues to provide for appropriate representation of the patient that we can then disclose, and that person is then legally obligated to provide direction as to which what medical pathway we want to choose. So, I think, you know, in that case, we do have options as far as adult representation, legal representation to direct care, even post -error which way should you go now that the error has occurred.

PIERCE: Right. You know, through the majority of our conversation over these last over these two episodes, I hear fear a lot. And I think we all have the fear of number one, making mistakes. However, we are human, and mistakes happen. We're not computers. They're going to happen. We talked a little bit about just culture in our last episode as well. So how can we really work to ensure, especially leaders, how can they work to ensure that error disclosures are going to focus on learning and improvement, And it's not about excessive self-protection and blame?

STOWE: Well, that's the million-dollar question.

PIERCE: Isn’t though, isn't it though?

STOWE: That's a great question. You know, you've got to establish a strong culture, just culture. And really you can call it what you like. But you have to have a strong reporting culture. And what I have found over the years is many, many institutions have a very sincere desire to start this, to implement this, and to really effectuate change, right? For the good, let's help patients, let's do good. And all of a sudden, six months later, someone’s spouses in the military get transferred, they leave to another city, right? So, all of a sudden, you're a reporting person that's evaluating this in the quality department, there's no longer there. Financial times are tight, hey, okay, well, we're going to combine that with somebody else. You now have a point person. And what you see over time is this slow erosion of priority in this area. And over the years, over the months, years, all of a sudden, it's, oh yes, we do have that, don't we versus, hey, this is something we champion. And so, if we don't keep this as a champion-focused error prevention, then you're really not going to effectuate change. Because at the end of the day, those individuals you're bringing in as staff, into your organization, are learning the culture and the ways and the policies and procedures of those that are currently there. So those coming in are going to learn the bad ways if we don't fix those bad ways to begin with. And so, it's kind of fighting an uphill battle. It can be won, but you have to keep it at the forefront as far as organization. And do you know what? At the end of the day, what you see from these types of focuses is it's a drain on resources, staffing, supplemental staffing, and cost. But what you don't see is three years down the road, the errors that it prevents, and the money that you saved. So, you know, your CFOs, while they understand the concept, have a hard time swallowing it generally because it's money coming out and I don't really see anything coming in.

PIERCE: Yes, kind of like the education department.

STOWE: That's right. That's right. You know, it's a tough pill to swallow, you know, it's a, but if you concentrate and just like education, if you provide education, education, education, not only do you have better staff, you have better healthcare than that's being delivered. Your length of stay goes down. Your errors go down. All these things go down, which equates to very hard dollars. So, conceptually it's a tough pill to swallow for some.

PIERCE: Absolutely. So, I know we've talked a little bit about what's discoverable, and what's not discoverable if a lawsuit comes about. When you're developing policies in your facility, I know some people like to use the term guidelines now. That was really big in a facility that I was in where they were like, no, no, no, no more policies, all guidelines. So, what policies, guidelines, or legislation would you recommend to better support the ethical disclosure of medical errors in our system?

STOWE: I think you really have to jump towards kind of the end argument of this. And then I'll explain that when I say, are we going to provide legal protection to those that disclose errors, regardless of the harm that is caused or not? If we are going to provide that protection, then now we are able to open up the world of disclosures, right? So, you take that fear off the table. So, once you take the fear off the table, then you've got to educate on your processes, and you just report, and then you do process improvement, and you truly change the way that you look and conduct business. If you don't provide that legal protection, then the fear is always there. It remains because you're serving up all of those elements for a lawsuit. You're

just giving it across the table and saying, please don't sue me. That's really kind of what you're doing, but you're doing it nicely. So, the reality of it is, you can't just indemnify a profession, right? So how do you say, hey, just because you're in the healthcare field, you're indemnified from any wrongdoing. That just, that in it itself, I don't believe is ethical. So now you're in a kind of conundrum of what do you do? How do you take that threat of a lawsuit off the table? And I don't think you can. I don't think you can. So, when someone comes up with the miracle answer of how to take that fear and that threat of a lawsuit off the table, then I think you'll see much more robust error reporting and process improvement where just is really kind of hampered by that fear right now.

PIERCE: Absolutely. So, as we kind of wrap up episode two, what are some resources or training that you might recommend for providers on ethical disclosures and having these difficult conversations?

STOWE: You know, time is a premium for everyone today. I mean, it really is. I would encourage something very simple. Take five minutes and just Google, whatever your search engine is, whatever your preference is, I say Google just because it's big and it's out there. Whatever your search engine is, type in there and just say, hey, medical error disclosures, risk mitigation lawsuits, and talking to families about messing up, okay? It's going to give you some data, and you can read it for yourself that says, hey, look, you know what, it is a better thing. Talking to patients, it really is. The patients, you establish a better patient relationship because you came to them, you talked to them. You told them what happened, and you told them what you're going to do going forward to help fix it or do the best you can. You'll be surprised people actually stay with those doctors that come and talk to them, because they know they're going to tell me the truth now. It's kind of a strange concept. I'm going to stay with you, and you messed up, but it's true, you know, and you reduce litigation. So, I would encourage you to look at those things. And if you're not really sure how to have that conversation, talk to your risk department. If you're a provider looking at this, if you're a nurse looking at this, dental assistant, pharmacy tech, whomever in the healthcare field, you know, Google, quick Google, understand the reasoning and then talk to some people that have been involved in risk management, quality department on how to have those conversations. You know, I'll tell you a quick side note is, when I was in my early career in nursing, I worked at a trauma burn intensive care unit, and it was staffed by a second- and third-year surgical resident. Okay, every day fourth and fifth years we go to an OR what have you they would care for the 12 patients in that ICU. Patients would pass, and these individuals, these doctors would have to go and talk to them and their families about that. It was very quickly that I realized from my own sanity that I was going to go with the doctor, and I was going to do the talking and let them answer the big medical questions because we don't train people how to have those difficult conversations. This is a difficult conversation. You've got to learn it. So, if you don't know it, don't be afraid of it. Reach out for help. Grab those individuals that have been there that know how to do it and let them guide you. Okay. It's okay to ask for help even in this situation. Your patients, and the patient's families will greatly appreciate it and you'll be surprised that even through an error, what sort of difference you can make in their life, a positive one.

PIERCE: One of the things that I remember from the RaDonda Vaught trial was that the family is not the one that took them to court. The family was appreciative of her admitting and really saw her as a sincere apology. And that's always really stuck with me through that whole trial with her and all that she's been through.

STOWE: I think that's a great example of you disclose, you show your sincerity, your true sincerity, and it doesn't bring a lawsuit. That's an example of the exact fear mitigation that we need.

PIERCE: Absolutely. This is such a great conversation. Thank you so much, Dr. Stowe. We have come to the end of our time for this series. And one of the statements that I made at the very beginning of the series in episode one was that ethical considerations surrounding medical error communication are multifaceted. And I think that this conversation today really shed light on the need for a multifaceted approach from robust processes and training to open dialogue and empathy. And every stakeholder is going to play a

crucial role in fostering an environment of trust and accountability. Challenges exist and of course, they're going to continue to exist. And so, as healthcare providers, we have to stay committed to ethical communication that lies at the heart of everything that we do to include patient safety, healing, and the preservation of the sacred trust between healthcare providers and those they serve. Thank you, Jay, for always bringing so much insight into our discussions. It's always such a joy to have a discussion with you.

STOWE: I really enjoyed it, Candice. It's been an honor to be here. Thank you so much.

PIERCE: Absolutely. And to our listeners, I encourage you to explore many of the courses that we have available on EliteLearning .com to help you grow in your careers and earn CEs.