Abstracts

Thursday, 20 October 2016

9.45 Hans Schoo: 'The role of the Inspectorate in promoting open disclosure'
Introduction

10.00 Arno Akkermans: 'Incident disclosure in the Netherlands: where do we stand?'

Recent broadly-supported guidelines stipulate that physicians and other care providers should be open and honest about medical adverse events and errors. Stakeholders in Dutch health care cooperated to draft the code of conduct 'GOMA', which contains directives to caretakers, hospital management, legal representatives and liability insurers. The standard of being open has been reinforced by recent decisions of the medical disciplinary board and - last but not least - has been incorporated in formal legislationin January. Nevertheless, practice still falls short of the ideal. To gain insight in how being open can be realised, researchers and hospitals collaborate in the learning network OPEN. Through commitment to OPEN, the participating hospitals share their experiences and give insight in their procedures and practices in handling adverse medical events and complaints. The researchers of OPEN translate, compare and analyse this information so that more aggregated knowledge is developed. In this presentation new legislation, the main principles of the code of conduct GOMA and the newest insights from the OPEN network will be discussed.

11.15 Robert Slappendel: 'Including the patient perspective in incident analysis in the Netherlands'

Patients and related families are extremely useful in malfunctioning of doctors or research of severe incidents. Especially patients have an excellent view how doctors work. In case of malfunctioning 50% of the CanMED's criteria are directly visible for patients. In research of any incident patients or related family can easily help to find the truth corridor. In our practice it was one of the first reasons for patients participate in research of severe incidents. Several other benefits for patients came out quickly when using this method. If patients are really informed about what went wrong and what the doctor/ hospital is going to avoid in future in similar cases you will reach a change of mind. It will help them handle disappointment and they will understand that their story is valuable. Last but not least it will lower the usual amount of claims if transparency about errors is given. Real clinical cases will be presented to support this view.

12.00 Josje Kok: 'Engaging patients and learning from patient perspectives: a status report'

We wish to present the (preliminary) findings from an ongoing PhD research project, investigating how and by what mechanisms the governmental regulation of adverse events (AE) works and which consequences occur. We draw from quantitative data collected at the Dutch Health Care Inspectorate (IGZ) as well as in-depth qualitative interviews held with Quality & Safety managers, members from AE research committees and AE researchers in thirteen Dutch hospitals. We will demonstrate that since the IGZ has

requested hospitals to involve patients/families in the investigation process of an AE (leidraad meldingen 2013; Wkkgz 2015), in an attempt to stimulate hospitals to learn from patient perspectives, the IGZ has documented a dramatic increase in the engagement of patients/families. Likewise, the IGZ has recorded a rise in the number of hospitals disclosing the results of an AE investigation report to patients/families; another leidraad/Wkkgz request. The qualitative data collected inside hospitals foreground the backstage practices represented in these figures, revealing some interesting insights. For instance: although patients/families are frequently consulted during the AE research process, AE researchers often find it difficult to learn from patient perspectives. Our data suggests that there are other, more prominent, motives to involve patients/families in the AE research process. With regards to the disclosure of the findings of AE investigation reports, it is indeed done more often but executed in many diverse ways. During our presentation we would like to discuss these differences; opening the floor to share ideas and ventilate experiences.

14.14 Stef Verhoeven & Jos Bus (www.zorgveilig.nl) 'Tell me! How telling stories can make care safer'.

Telling story's is an important instrument in making care safer. At storytelling website, both the experiences of patients and caretakers are gathered. Stef Verhoeven en Jos Bus will explain how storytelling can make care safer, and share some of the story's they have gathered from the patient perspective.

14.45 Catherine Poorthuis: 'Okay, open disclosure, but how?'

An unexpected adverse clinical event clearly has a major impact on the patient, but also on the doctor involved. In this respect, the literature refers to the doctor as 'the second victim'.

Second victims may be plagued with concerns as to whether they will be fired, what their colleagues think, whether they can regain the trust of their team or whether there will be legal consequences. The impact is even larger when the relationship between the doctor and the patient deteriorates. In that case, for the patient as well as for the doctor, it is even more difficult to cope with the incident and there is a greater chance that legal steps will be taken by the patient or his relatives. Therefore, sharing the information of how things went wrong, the 'open disclosure' is an important step for the doctor to take in the process following the incident.

At the same time, the way the incident disclosure takes place should not be underestimated. Empathy is the keyword, only when a doctor is apologetic, will there be a chance for forgiveness by the patient or his relatives. The problem is, it is almost undoable for a doctor to show empathy at that particular moment, given his own feelings of guilt, fear and shame: Self-absorption kills empathy.

15.45 Stuart McLennan: 'Incident disclosure and the prevention of second victims'

Medical errors, even minor errors and near misses, can have a serious effect on clinicians. Health-care organisations need to do more to support clinicians in coping with the stress associated with medical errors. Strategies to develop support systems will need to address a number of considerations which will be discussed in the presentation.

10.00 Michelle Mello: 'Meeting patients' needs in disclosure conversations: lessons learned in the US and New Zealand'

Although health care institutions are keenly interested in improving their response to patients injured by medical care, patients' experiences with disclosure and reconciliation processes are not well understood. This presentation will provide practical advice to healthcare providers and hospitals about what is important to injured patients during these challenging communications. It draws on more than 120 in-depth interviews with patients, family members, and others in two countries: the United States, where medical malpractice litigation is widespread, and New Zealand, which compensates medical injuries using a no-fault, administrative scheme.

The aims of the study were to better understand aspects of institutional responses to medical injury that, in patients' and family members' view, promoted and impeded reconciliation; and to make recommendations about how health care institutions can better meet injured patients' needs through the use of communication and compensation. The study found that listening to patients suggests several concrete strategies. Among these are to (1) bring into the disclosure discussions those people the patient wants involved, even when involved physicians are reluctant; (2) encourage patients to involve lawyers and/or other support persons; (3) ask, do not assume, what patients and families need from the process; (4) recognize that for many patients, "being heard" is critically important, but often does not occur; (5) ensure that apologies are authentic and culturally appropriate; and (6) always communicate efforts to prevent recurrences of the event.

11.15 Kris Vanhaecht: 'Taking care of the second victim in health care'

The Institute of Medicine's report "To Err is Human" estimated that errors cause 44,000 to 98,000 deaths annually in the United States, with a total cost of between $17 and $29 billion each year. Recent studies show that serious adverse events occur in one out of seven patients. Respectful management of adverse events should therefore be a high priority for hospital management.

When a patient safety incident occurs, a white paper of the Institute for Healthcare Improvement states that the organization has three specific priorities. The first priority is to care for the patient and his or her family members who are the direct victims of the adverse event. The second priority is to care for front-line health care workers involved in or exposed to the event. These individuals can be referred to as "second victims", a term first introduced by professor Albert Wu in 2000. The third priority is to address the needs of the organization, which can also suffer a potential loss from the incident, becoming a third victim.

Every health care worker can become a second victim: nurses, physicians, pharmacists, social services, physiotherapists,... It is estimated that almost 50% of all healthcare providers are a second victim at least once in their career! Second victims need emotional and professional support from colleagues and supervisors, so that the occurrence of patient safety incidents results in constructive changes in practice.

During this presentation Prof. Kris Vanhaecht will provide an overview of some recent studies his team has been involved in out of Belgium, Italy and The Netherlands and will discuss his view on the pro's and con's of Peer Support Teams and the challenge for Open Disclosure.

13.30 Stuart McLennan: The Law as a Barrier to Error Disclosure: A Misguided Focus?

Internationally organisations' and clinicians' legal fears are consistently identified as one of the most important barriers to error communication. However, this presentation will suggest that far too much focus has been put on the role of the law as a barrier to error disclosure.

While legal fears are undoubtedly a factor in some clinicians' reluctance to disclose errors, the true reasons are more complex. A range of factors that contribute to errors not being disclosed have been identified, including a professional and organisational culture of secrecy and blame, professionals lacking confidence in their communication skills and the shame and humiliation associated with acknowledging an error — to oneself, one's patient, and one's peers. Indeed, international research suggests that the legal environment may have a more limited impact on physicians' communication attitudes and practices regarding medical errors than often believed.

While law reform may be desirable for other reasons, it seems unlikely that changes in the law would lead to major changes in error communication practice. The assumption that law reform will increase error communication falsely assumes that we are primarily dealing with a legal matter rather than one grounded in human relationships. While it is important to address unnecessary legal barriers to such open communication, changing the law to remove real or perceived barriers is not a magic bullet. To see this one only needs to look at the experience of New Zealand where cultural barriers to openness and honesty persist despite the implementation of a no-fault compensation system since the 1970s.

Research suggests that a more important determinant of error communication practice than legal issues is the culture of organisations and the medical profession in general. This presentation concludes that efforts to promote error disclosure should be focused on changing culture and the training and support of clinicians.

14.00 Jo Shapiro: 'Incident disclosure and professionalism in health care'

Grappling with a medical error that causes patient harm is one of the most challenging moments of any clinician's career. In addition to the sadness at seeing your patient experience suffering, there are professional, personal, and societal expectations of perfection that, although we may know intellectually are unrealistic, we feel deeply on an emotional level. Furthermore, most clinicians do not have a great deal of experience in this arena, because the incidence of an individual clinician's making a clinically significant error is not likely to be high, even over many years of practice. Therefore, it is important for all clinicians to understand some basic principles underlying effective conversations to use when faced with the need to disclose information to patients.

14.45 Janine McIllwraith: 'From hindrance to help: plaintiff lawyers and open disclosure'

In Australia in the last year we have seen a number of incidents in public hospitals in which disclosure to the individuals concerned has been delayed and in some cases seemingly occurred only after the threat of media attention. This short presentation will look at each of the incidents or group of incidents and the subsequent disclosure timeline with a view to identifying any common issues in these examples of sub-optimal incident disclosure. Finally the presentation will hypothesise as to whether there is a way for plaintiff law firms to move away from being seen as a hindrance to open disclosure and instead move towards supporting enhanced and effective disclosure of incidents in a timely manner.