Restoring Healing in Health Care

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Code of Conduct (From *****)

- **Respect** the dignity of all individuals by practicing in a non-discriminatory manner;

- • Recognize that patients and their families are **partners** in the healthcare delivery process entitled to fair and respectful treatment;

- • **Communicate** honestly and factually with patients and their families, as well as colleagues and others;

- • **Share** confidential information or protected health information only in circumstances where appropriately authorized or required by law;

- • Investigate and analyze events so that steps can be taken to reduce the likelihood of similar injury to others;

- • Promote cultural **change** that encourages the reporting of events that may result in actual or potential harm to patients or others; and

- • Advocate for patient safety.

What is the number of deaths from preventable medical errors in U.S. hospitals every year?

- Approximately 98,000
- An amount equal to the number of deaths from one jumbo jet crash a day in which all aboard die.
- 200,000

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~Institute of Medicine Reports 1999, 2008

On average, how many medication errors will hospitalized patients be subjected to in the U.S.?

~ At least one per day per patient.

~ Less than ten.

~ One a day per hospital.

On average, how many medication errors will hospitalized patients be subjected to in the U.S.?

~ At least one per day per patient.

~Institute of Medicine 2006

What is transparency?

- A clear plastic film with writing on it used twenty years ago in schools.
- A term used by wine connoisseurs
- The practice of full, open, honest dialogue in medical care.

What is the leading cause of medical malpractice litigation?

- Ambulance chasing lawyers
- Gamblers looking for a jackpot.
- Communication lapses & breakdowns within healthcare.

(Activity)

Transparent Learning in HealthCare

The Story of Lewis Blackman Trailer

★ ★ ★ ★ ★

○ *"Conflict is taken away, given away, melts away, or is made invisible."*

– Nils Christie, 1977. "Conflict As Property."

What is the leading cause of medical malpractice litigation?

- Communication lapses & breakdowns within healthcare.

  "Experts agree that communication breakdowns are also a leading cause of medical malpractice claims and lawsuits."

  ~ Health Care Risk Control – Communication", ECRI Institute, July 2006

The Provider's Role

- Answer finder
- Healer
- Life Saver
- Empathizer
- Teacher
- Meaning Giver

- Do you have an Informed Patient?

Compass of Shame (Nathanson)

Withdrawal:
- isolating oneself
- running and hiding

Attack Other:
- "turning the tables"
- blaming the victim
- lashing out verbally or physically

Attack Self:
- self put-down
- masochism

Avoidance:
- denial
- abusing drugs and alcohol
- distraction through thrill-seeking

Withdrawal

Attack Other

Attack Self

Avoidance

Surgeon's Story

"Courage and strength of character are required to advocate for Patient Safety despite the myriad of conflicts of interest."

~ Cardiothoracic surgeon

(From Medical Errors Real or Perceived, Krukenkamp & Mannix, Harvard & ECCA 2008)

Confidential Letter to the CEO

- Moral, Ethical, Professional Duty
- Issues of Patient Safety & Quality of Care
- Fundamental Conflicts of Interest
  - Head of Program was Baby's Doctor
  - Head of Program Directed its QA
  - Head of Program was Head of Hospital QA
  - Head of Program was Hospital CMO
  - Head of Program Reported to the CEO
- (From Medical Errors Real or Perceived, Krukenkamp & Mannix, 2008)

Evidence Based Best Practices

"Economists assume people focus solely on outcomes. People want to know that they had their say – that their point of view was considered even if it was rejected."

~Kim &Mauborgne, "Fair Process: Managing in the Knowledge

Economy", Harvard Business Review, 2003.

Healing the Scars

- What did you think when you realized what happened?

- What impact has this care or care outcome had on you and others?

- What has been the hardest thing for you?

- What do you think needs to happen to foster healing?

For addressing challenging behaviors:

- What happened?
- What were you thinking at the time?
- What have you thought about since?
- Who has been affected by the care outcome? In what way?
- What do you think needs to be done to foster healing?

Walls

"Community is the antidote to institutional toxicity."
~Parker Palmer

1- How good a job did I do today?

2- How good did I do in telling the truth?

3- How did I do today in putting what's good first?

4- Did I do anything creative today?

Circles & Conferences

- Proactive and Reactive
- Tools in Trans-disciplinary Best Communication practices
- Focuses on repairing harms not punishing
- Builds relationships
- Stimulates cooperative action
- Fosters mutual understanding

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What you can do –

- Wash Your Hands
- Wash before you eat and after toileting
- Sneeze in your bent elbow
- Stay home when you are sick
- Ask for more time if you don't understand instructions
- Ask for a Patient Advocate
- Look for VOICE ™ pin
- Visit: http://www.voice4patients.com/other_content/Living_Memorial%20Garden_Medical_Harm.pdf

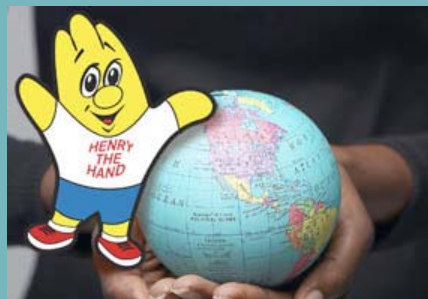# Healing Collaborative for Pediatric Safety at SplittheBaby.com

○ **Alex's Lemonade Stand Foundation**

Resources:

THE LOST ART OF HEALING

SPLIT the baby
by Mary Ellen Mannix

WALK ON WATER
Inside an Elite Pediatric Surgical Unit

How Doctors Think
JEROME GROOPMAN, M.D.

WALL OF SILENCE
ROSEMARY GIBSON and JANARDAN PRASAD SINGH
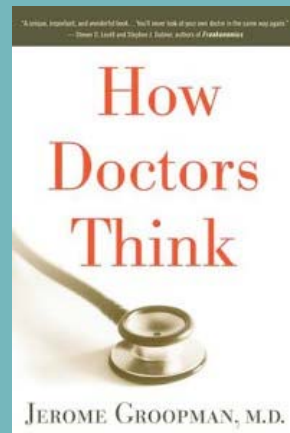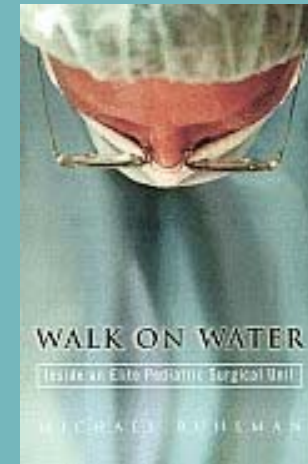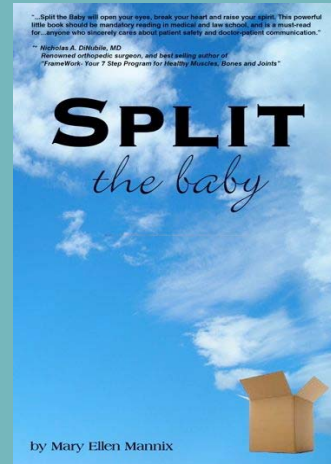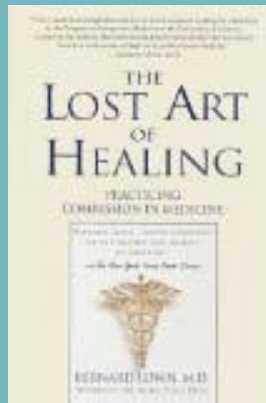
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Take gentle care of you.

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