

## Open School

### Video Activity: The Patient and the Anesthesiologist

(<http://www.ihl.org/education/IHIOpenSchool/resources/Pages/Activities/PatientandAnesthesiologistPartThree.aspx>)

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#### Facilitator instructions:

- Review the learning objectives and description with your group.
- Watch the videos [on this page](#) (there are three in total) and use the discussion questions to facilitate a conversation around each video.

#### Learning Objectives

At the end of this activity, you will be able to:

- Compare different approaches clinicians can take when responding to medical errors in a health care setting.
- Discuss how mistakes can harm both patients and clinicians.
- List at least two behaviors clinicians should practice when apologizing to patients.

#### Description

Linda Kenney went into the hospital for an ankle replacement. She came out with a host of complications resulting from a mistake that no one was willing to admit. Until Rick Van Pelt, MD, her anesthesiologist, stepped forward.

In this three-part video case study, you'll find out what happened in the immediate aftermath of the surgery, watch Kenney and Van Pelt describe their first meeting after the surgery, and watch Kathy Duncan, RN, and Don Berwick, MD, analyze the case.

#### Related IHI Open School Online Courses:

- [PS 101: Fundamentals of Patient Safety](#)

- [PS 103: Teamwork and Communications](#)
- [PS 105: Communicating with Patients after Adverse Events](#)
- [PS 106: Introduction to the Culture of Safety](#)

## Key Topics

Engage patients and families in Care, engage patients and families in improvement, engage physicians in improvement, transparency, communication, satisfaction: patient and family, patient safety, adverse event, culture of safety, surgical safety.

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### Part One: The Incident

In Part one of this video case study, you'll find out what happened in the immediate aftermath of the surgery — and learn about common barriers to the open disclosure of errors in health care.

**Facilitator**, show the video in [part one of the video series on this page](#). For your group's discussion after this video, feel free to adjust these questions and/or add your own.

#### Discussion Questions:

1. Why do you think it was so important for Dr. Van Pelt to talk to Linda Kenney and her family after the surgery went wrong? Would you do the same thing if one of your actions harmed a patient?
2. Dr. Van Pelt said he was urged to leave this case to “risk management.” Why might the hospital have had reservations about his desire to talk to Linda Kenney? How reasonable do you think those reservations were?
3. What are some common fears surrounding the idea of apologizing to a patient after making a mistake?

### Part Two: The Connection

In Part two of this video case study, you'll watch Kenney and Van Pelt describe their first meeting after the surgery — an awkward but pivotal experience for both. You'll also see how they banded together to help other patients and clinicians.

**Facilitator**, show the video in [part two of the video series on this page](#). For your group's discussion after this video, feel free to adjust these questions and/or add your own.

#### Discussion Questions:

1. Linda Kenney says that Dr. Van Pelt's training had “shut him down from feeling.” Have you experienced the same thing in your training? Why or why not?
2. As a health care professional (or at least one in training), how do you keep yourself from being desensitized to human suffering?

3. At some point in your career, do you think you will commit a serious error that will harm a patient? Why?
4. Linda Kenney says patients want to be told the truth in a timely manner. How likely would you be to do this if your hospital were advising you against it? What support would you need (from colleagues or anyone else) to talk openly with a patient after making a mistake in his or her care?

### **Part Three: The Experts React**

In Part three of this video case study, you'll watch Kathy Duncan, RN, and Don Berwick, MD, analyze the case. What went wrong? What should have happened instead? What can we learn from the experience of Kenney and Van Pelt?

**Facilitator**, show the video in [part three of the video series on this page](#). For your group's discussion after this video, feel free to adjust these questions and/or add your own.

#### **Discussion Questions:**

1. Dr. Berwick says that both the patient and the provider in this case were victims. How might Dr. Van Pelt be considered a victim? What are the implications of that idea for a hospital that's trying to respond appropriately to an error?
2. Kathy Duncan says that when you're meeting with a patient who's suffered from an error, you should sit down and avoid bringing a group of administrators along. What are other steps you might take to avoid intimidating the patient?
3. Kathy Duncan identifies several important steps in the disclosure of an error: being truthful, apologizing, and promising to investigate so the error doesn't happen again. What are other steps that providers and/or hospitals can take to help all the parties involved in an error?