

Open School

Case Study: On Being Transparent

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Learning Objectives

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

- Contrast different styles of leadership in regards to reporting adverse events.
- Explain several benefits of transparency after a medical error or adverse event.
- Identify problems associated with concealing medical errors or adverse events.

Description

You are the CEO and a patient in your hospital dies from a medication error. What do you do next? The University of Rochester's Dr. Paul Griner presents this case.

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Key Topics

Transparency, crisis management, leadership, engage patients and families in improvement, adverse event, systems thinking, and medication safety.

One of the first things I learned after being appointed president of Strong Memorial Hospital in Rochester, NY, was to deal openly with patients and families (and the community) when we made mistakes. Here's one example that has always stuck with me:

A 6-year-old patient with a defect in bowel function was hospitalized for severe constipation. He was given a dose of neostigmine (a drug that helps muscles contract and relax to move food through the

system) that was 10 times the normal amount because of a decimal point error made by the resident who ordered the drug. Instead of 0.4 mg, the patient received 4.0 mg.

Tragically, the patient died the same day from the overdose.

My human resources director advised me to immediately hold a press conference to announce our mistake. I did. The conference lasted for two hours and centered on reporter questions about why the resident and nurse had not been fired. I explained that both were highly regarded and that the problem was a “system” problem, not a problem of an incompetent physician or nurse. I explained that we should have a fail-safe system in place to prevent such a mistake. (Today, hospitals have electronic medication error avoidance systems. We didn’t have that in 1984.)

I indicated to the reporters that we would be examining the medication administration procedures in place from the point the medicine is ordered to the time it was given, and would put in place a procedure or procedures to ensure that such an error would not happen again.

This story contrasted sharply with an experience I had with a wealthy patient from Geneva, Switzerland, who came over to the states each year for a comprehensive examination.

Before coming to Rochester after his overseas flight, his routine was to spend a few days in New York City and visit friends. On one such annual trip, he fell while walking along a street in New York, fracturing his pelvis. He was admitted to a well-known hospital and spent three weeks recovering in bed.

After three weeks, I received a call from him asking to be transferred to Strong Memorial Hospital in Rochester. He was unhappy with his care, indicating that no one seemed to be attending to him. We arranged the transfer and, when I saw him that afternoon, I was astounded to find that he had a pressure ulcer on his heel that was an inch deep. The ulcer wouldn’t heal, so I secured a vascular surgeon to perform arterial bypass surgery. The surgery, which improved circulation in the patient’s leg, was successful and, after a period of weeks, the ulcer healed completely.

I wrote a letter to the president of the New York hospital to discuss the patient’s care. Some weeks later, after not receiving a response, I called his office. I was transferred to the hospital lawyer. I indicated the reason for the call and asked why I had not received a response. He said, “Oh, we would never acknowledge a mistake. We might get sued.”

Discussion Questions

1. What is the difference between the two stories? Why do you think they were handled differently?
2. Pretend you were a reporter at the first press conference. What question would you ask the CEO? Why?
3. How would you respond to the lawyer in the second story?
4. Why is transparency important after a medical error?

5. Have you ever made or observed an error involving a patient? Was the patient harmed? How did you handle the error?