



FACILITATION GUIDE FOR PROGRAM 2

CONDITION: CRITICAL HEALTH CARE IN THE UNITED STATES

A Series of Education Programs on Health Care Ethics

Ethics Program 2: A National Emergency, "Patient Safety "

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SECTION I

Narrative Video with Expert Commentary

NARRATIVE VIDEO

The 30-minute video focuses on the pervasive problem of medical error that so seriously compromises patient safety in health care. The video explores the increasing awareness of medical error as a leading cause of death in health care by considering several haunting cases. This awareness can expose a culture of litigation, fear, and cover-ups that can seriously compromise patient safety. The program discusses possible solutions to medical error by considering how health care organizations can promote corporate leadership and system based changes to enhance patient safety. The ethical debate on patient safety is presented in four sections in the video.

1. Medical error as a leading cause of death
2. The culture of litigation, fear, and cover-ups in health care
3. The need for leadership in health care to promote patient safety
4. The need to develop system based changes that enhance patient safety

EXPERT COMMENTARY

The video includes expert commentary by internationally recognized figures in the debate on medical error and patient safety, including: Rosemary Gibson; Dr. Donald Berwick; Dr. Troyen Brennan; Dr. Janet Corrigan; Dr. Lucien Leape; and Dr. Dennis O'Leary.

LEARNING OBJECTIVES

The 30-minute video enables participants to foster discussion at the end of each section as well as at the end of the program. Participants will be able to:

- understand the seriousness of the problem of medical error as a leading cause of death in health care
- understand the culture that can engender fear and cover-ups in the litigious environment of health care
- understand the urgent need for leadership in health care to promote patient safety
- understand the need for system based changes in health care to enhance patient safety

STRUCTURE OF THE EDUCATION SESSION

The facilitator should explain the learning objectives, show the video, and then engage the participants in discussion and/or assign follow-up projects.



SECTION II

Discussion Questions for the Program

I MEDICAL ERROR AS A LEADING CAUSE OF DEATH

- What is the extent of medical error as a cause of death in health care?
- Why are systems in organizations important for reducing medical error?

Answers

II THE CULTURE OF LITIGATION, FEAR, AND COVER-UPS IN HEALTH CARE

- What can be described as a culture of secrecy and fear with regard to medical error and patient safety?
- What steps could hospitals take with patients and families when medical errors occur?

Answers

III THE NEED FOR LEADERSHIP IN HEALTH CARE TO PROMOTE PATIENT SAFETY

- What need is there for executive leadership to foster patient safety?
- What role can full disclosure play as an example of executive leadership to foster patient safety?

Answers

IV THE NEED TO DEVELOP SYSTEM BASED CHANGES THAT ENHANCE PATIENT SAFETY

- Why are system based changes so important for the reduction of medical error?
- Why is a blame-free culture important for systems that support patient safety?

Answers



SECTION III

Project or Assignments for the Program

These projects or assignments could be distributed among participants for them to expand on the answers in the discussion section by further review of the video.

I MEDICAL ERROR AS A LEADING CAUSE OF DEATH

- Explain the extent of medical error as a cause of death in health care.
- Explain why systems in organizations are important for reducing medical error.

II THE CULTURE OF LITIGATION, FEAR, AND COVER-UPS IN HEALTH CARE

- Explain what can be described as a culture of secrecy and fear with regard to medical error and patient safety.
- Explain what steps hospitals could take with patients and families when medical errors occur.

III THE NEED FOR LEADERSHIP IN HEALTH CARE TO PROMOTE PATIENT SAFETY

- Explain the need for executive leadership to foster patient safety.
- Explain the role that full disclosure can play as an example of executive leadership to foster patient safety.

IV THE NEED TO DEVELOP SYSTEM BASED CHANGES THAT ENHANCE PATIENT SAFETY

- Explain why system based changes are so important for the reduction of medical error.
- Explain why a blame-free culture is important for systems that support patient safety.



SECTION IV

Individual Learning Model

The Individual Learning Model complements the Group Learning Model by providing individual students with interactive independent study. This self-learning multimedia tool contains quizzes, on-screen readings, and videos for the entire DIA Learning Ethics Series.

INDIVIDUAL LEARNING MODEL

The Individual Learning Model is a chaptered, Web-based program available as Full Course or Selected Topics. It offers the following items:

- 60-minute narrative video with expert commentary
- Up to 12 chaptered curriculum topics, each including:
 - 5-minute narrative video components
 - On-screen reading components
 - On-screen quiz components
- Pre-test and post-quiz learning outcome measurement
- Real-Time Score-tracking
- Automated Certification by recognized accrediting bodies

COURSEWORK

The Catholic Version of the Individual Learning Model for Ethics Program 2 includes the following coursework:

- Chapter 1. Medical Error and The Institute of Medicine Report, To Err is Human
- Chapter 2. Breaking the Silence: Medical Error as a Leading Cause of Death and Injury
- Chapter 3. Causes of Medical Error: Why Do Errors Occur?
- Chapter 4. System Errors and Systems for Reporting Errors
- Chapter 5. Root Cause Analysis to Identify Basic Causes of Medical Error
- Chapter 6. Creating a Safety Net by Leadership that Promotes Patient Safety
- Chapter 7. Overcoming a Culture of Secrecy: Performance Standards for Patient Safety
- Chapter 8. Voluntary Error Reporting Systems: Safeguards against Legal Discovery
- Chapter 9. Fears about Medical Error: The JCAHO Initiative for Patient Safety
- Chapter 10. The Department of Veterans Affairs: National Patient Safety Goals
- Chapter 11. A Patient Safety Culture: JCAHO's "Shared Visions-New Pathways"
- Chapter 12. The Need for Systemic Change to Enhance Patient Safety



QUESTIONS & ANSWERS

Discussion Questions for the Program

The suggested “answers” simply indicate some items from the video that relate to the question. The facilitator should encourage a broad range of responses from the video and beyond.

I MEDICAL ERROR AS A LEADING CAUSE OF DEATH

- **What is the extent of medical error as a cause of death in health care?**

Reports estimate conservatively that nearly 100,000 patients a year in the United States die from medical mistakes. This number is about the equivalent of the number of people who die from breast cancer, AIDS and traffic accidents combined. Or, to use another analogy, the number is the equivalent of a 747 going down every day at Chicago O'Hare airport.

- **Why are systems in organizations important for reducing medical error?**

Safety experts around the world look to other organizations, like the U.S. Navy, to find solutions for safety issues such as those in healthcare. These experts emphasize teamwork and systems: for example, systems in the Navy permit anyone to halt an aircraft carrier's airplanes taking off or landing when safety may be impaired. But that safety mindset is not prevalent in health care.

II THE CULTURE OF LITIGATION, FEAR, AND COVER-UPS IN HEALTH CARE

- **What can be described as a culture of secrecy and fear with regard to medical error and patient safety?**

Many experts consider the climate in health care to often have a cloak of secrecy that stifles the teamwork and leadership necessary to foster patient safety. Many professionals are afraid to speak out about the defects they encounter because they are worried about what's going to happen if they talk.

- **What steps could hospitals take with patients and families when medical errors occur?**

Experts advise that hospitals could take these steps with patients when they encounter medical error. Hospitals could be honest and tell the patient and family what mistake or error occurred, hospitals could apologize to the patient and family, and if financial losses have occurred hospitals could compensate accordingly.



QUESTIONS & ANSWERS

Discussion Questions for the Program

III THE NEED FOR LEADERSHIP IN HEALTH CARE TO PROMOTE PATIENT SAFETY

- **What need is there for executive leadership to foster patient safety?**

Experts suggest that an effective program for patient safety requires direction from the top of the organization. There needs to be a culture change within organizations and the chief executive officers must take the lead.

- **What role can full disclosure play as an example of executive leadership to foster patient safety?**

One of the issues the entire health care profession is wrestling with today is the idea of full disclosure and mandatory reporting of medical errors. However, the climate in health care makes this difficult. Nonetheless, more and more hospitals are adopting a policy of full disclosure, being honest and making restitution where appropriate.

IV THE NEED TO DEVELOP SYSTEM BASED CHANGES THAT ENHANCE PATIENT SAFETY

- **Why are system-based changes so important for the reduction of medical error?**

Experts explain there is a need to change from a culture in health care, which adopts a punitive approach regarding medical error. Instead, experts encourage a new safety culture in health care that fosters safe systems to support patient safety, focusing on blameless reporting and developing knowledge, respect, confidentiality and trust. That is, we need to change systems in which health care providers work to minimize human error. This pursuit of safety should be a moral high road, a duty.

- **Why is a blame-free culture important for systems that support patient safety?**

A blame-free culture can enhance reporting of medical errors in systems that provide health care. In contrast, a culture of blame can create impediments to the improvement of patient safety. In a blame-free culture, employees or nurses or physicians or pharmacists, etc., are more likely to report a mistake if they make it, or if they see it being made. In that way, everyone can learn how to improve patient safety. The majority of medical mistakes result from errors with organizational systems and processes, and they should not be seen simply as mistakes made by individual nurses or physicians.