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Professional Issues

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REVEALING THEIR MEDICAL ERRORS

Why three doctors went public

To err is human. To tell the world about the cases when things went wrong requires courage.

STORY BY KEVIN B. O'REILLY
PHOTO BY CJ GUNTHER

In September 2010, Kimberly Hiatt made a medical error. The critical care nurse at Seattle Children's Hospital miscalculated and gave a fragile 8-month-old baby 1.4 grams of calcium chloride, 10 times the correct dose of 140 milligrams.

The mistake contributed to the death of the child and led to Hiatt's firing and an investigation by the state's nursing commission. In April 2011, devastated by the loss of her job and an infant patient, Hiatt committed suicide.

Hiatt, who had worked as a nurse for more than two decades, was another in a long line of "second victims" of medical error, the term used in medical literature to describe physicians and other health professionals who often feel guilty and depressed after adverse events. Many physicians and other health professionals hold themselves to a standard of perfection, and when things go wrong, they feel alone.

Physician health experts estimate that 250 doctors commit suicide annually — a rate about double that of the general population. When doctors believe they have made a major medical error, they are three times likelier than other physicians to contemplate suicide, said a January *Archives of Surgery* study.

If the first instinct after an adverse event is to retreat from scrutiny into a spiral of shame and fear, sharing the ordeal publicly is probably the last thing to cross a physician's mind. But a small group of doctors has done just that. Here are three physicians who shared their stories with the world in an effort to tell their colleagues and their patients that to err is human.

"We're trying to move away from a culture of shame and blame," says David C. Ring, MD, PhD, who went public with a surgical error in 2010.

"BIGGEST MISTAKE"

It was not until he was dictating a report on the last of his six operations that hectic day that orthopedic surgeon David C. Ring, MD, PhD, realized his mistake. He had performed the wrong surgery on a patient.

A 65-year-old Spanish-speaking woman was scheduled for a trigger-finger release procedure, but Dr. Ring mistakenly performed a carpal-tunnel release. A change in the operating room's location meant a nurse who sat in on a preoperative assessment was not present to catch Dr. Ring's error. Another nurse mistook Dr. Ring's conversation in Spanish with the patient for a preoperative timeout. The marking on the site for the correct procedure — the trigger-finger release — vanished once the skin was cleaned in preparation for surgery.

Dr. Ring was distracted. Earlier in the day, he performed a carpal-tunnel release for another patient, who was upset about the injection of anesthetic for the procedure because it caused her a great deal of pain. Shortly before the wrong surgery, he visited this other, highly agitated patient in the recovery area and struggled to calm her down.

"I felt bad for her," says Dr. Ring, associate professor of orthopedic surgery at Massachusetts General Hospital in Boston. "She was really stressed out from that painful shot. I was resolved in my mind that my next surgery would be my best carpal-tunnel release ever. And it probably was — it was just on someone who was supposed to have a trigger release."

Dr. Ring alerted the patient to the error and offered to immediately perform the correct procedure, which he did. The unnecessary wound to the hand from the wrong procedure would take about a month to heal and be sensitive to the touch for several months, Dr. Ring says.

"It could have been a lot, lot, lot worse," he says. The patient got follow-up care from another physician, and the family received a prompt,

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undisclosed financial settlement from the hospital's insurer.

Dr. Ring could have let the matter quietly end there. Instead, he went public.

Shortly after the surgery, Dr. Ring and experts on wrong-site surgery held a conference at the hospital to analyze what went wrong and how preoperative protocols could have prevented the error. A transcript of the case conference was published Nov. 11, 2010, in *The New England Journal of Medicine*, and Dr. Ring's story was highlighted by ABC News.

"I knew that the biggest mistake of my life and the worst event in my life was also an opportunity," Dr. Ring says. "In my role as a teacher and mentor, if I make a mistake in diagnosis, a mistake in surgery or a mistake in judgment, it's always been a teaching opportunity. There's always been something to discuss. It's not something to sweep under the rug."

Despite the risk to his reputation of going public with his mistake, Dr. Ring believes it was worth it to spread the idea that safety checks are needed to help prevent mistakes and that even the most accomplished physicians can err.

"I knew that if I was willing to have that difficult discussion, it would help other people," he says. "It was the right thing to do."

"THE OUTLIERS WE ALL DREAD"

Bryan E. Bledsoe, DO, was working in a small community emergency department when "this countrified, slow-talking lady" walked in.

"She said she had a subarachnoid hemorrhage," says Dr. Bledsoe, now a professor of emergency medicine at the University of Nevada School of Medicine. "I thought, 'How could she know such a thing?' "

Dr. Bledsoe discounted what the woman said, making assumptions about her intelligence and social class. She was wearing a soft neck collar, but had it on upside down and backward. The woman complained of neck pain, but not of headache, vomiting or other symptoms more typical of subarachnoid hemorrhage.

Today, Dr. Bledsoe says, he would not think twice about ordering a computed tomography scan, but then such imaging was costlier and less common. Dr. Bledsoe, then only a few years out of residency, took x-rays of the woman's neck. With the test results negative, he decided to send her home with some muscle relaxants.

The next morning, an ambulance brought in a female patient who required cardiopulmonary resuscitation but could not be revived. It was the same woman who had come the day before. Dr. Bledsoe walked into the room where the woman's children were gathered with their recently deceased mother.

"They were standing around holding her hand — she was dead on the table," Dr. Bledsoe says. "I said, 'I'm sorry. I must have missed something.' The daughter said, 'That's OK. Mama said you were a good doctor. She liked you.' That just made it worse. … They saw tears in my eyes in that trauma room."

Though no autopsy was performed, Dr. Bledsoe believes he missed the diagnosis. "From a *prima facie* standpoint, she was alive yesterday and now she's dead," he says. "That's not generally considered a good outcome. … Whether I'm right or wrong doesn't matter, it's how I feel that does. That lady's dead, and I can't bring her back.


DR. BLEDSOE

"I was just rushed," he adds. "I assumed it wasn't something too bad, and I was wrong. These are the outliers we all dread. Of every 100 patients, there's going to be one who hasn't read the book on how to present for a particular disease process. I learned that the hard way."

Wracked with guilt, Dr. Bledsoe had trouble getting the case off his mind. He attended the woman's "big Pentecostal funeral." The family wasn't upset with him. "They embraced me," he says.

He has kept the case in mind as a warning to avoid jumping to conclusions when diagnosing patients, and has used it as an example when teaching emergency medicine residents. When contacted by a reporter, he chose to go public with the story in a September 2010 article in *Reader's Digest*.

"I figured, 'What's the harm in talking about it if it helps somebody else?' " Dr. Bledsoe says. "I'm not proud of it, but any doctor who says they haven't made a mistake is a liar. Physicians are human. For anyone to expect absolute perfection in everything is a fool's errand."

TEARING DOWN "WALL OF SILENCE"

Jo Shapiro, MD, specializes in surgically repairing Zenker's diverticulum, an outpouching of the throat. The surgery involves cutting through the lining of the pouch but stopping just before getting to the outer lining. The procedure is done using a microscope that exposes a small part of the anatomy to the surgeon.

"It's a matter of millimeters," says Dr. Shapiro, chief of the division of otolaryngology at Brigham and Women's Hospital in Boston.

A known complication of this procedure is that, about 1% of the time, the surgeon will pierce the lining of the throat. Despite her best effort, that is what Dr. Shapiro did to a patient in the late 1990s. Though warned of the potential surgical complication, the patient and his family perceived the adverse event as a medical error. The man survived but developed a chest and neck infection and later sued unsuccessfully. It is emotionally trying anytime the patient's outcome is poor, Dr. Shapiro says.

"Intellectually, you say that something might go wrong with the care you're giving. But when it actually does, at that moment you realize you've made the person worse rather than better," she says. "You feel terrible for the patient, and you feel like you've let them down. You feel that you should have done better. Somehow you call into question all of your competence."


DR. SHAPIRO

Dr. Shapiro spoke about her experience for the first time publicly before 3,000 physicians, nurses and health care administrators at a patient safety conference in 2006. At the time, she says, pressure on physicians to disclose adverse events was mounting, but health care organizations were doing little to help them deal with the emotional hurdles that make disclosure a difficult thing for doctors.

"We have to understand that, despite our best efforts, things will not always go well," Dr. Shapiro says. "The public needs to understand that, and health care providers need to really integrate that into their way of thinking. … I'm just one of many people to say, 'We're going to tear down the wall of silence, and let's just talk about it.' "

Before the big speech, Dr. Shapiro was uncertain about her colleagues' reaction, but afterward received "an amazing amount of warm and wonderful" responses from other health professionals. Additional doctors interviewed for this article also reported receiving many supportive comments from colleagues, and even letters from patients who said they wished they had such caring and compassionate physicians.

Peter J. Pronovost, MD, PhD, also publicly has told the story of a mistake he made early in his career that could have resulted in permanent brain damage to a patient but luckily did not.

Going public about the times when things go wrong "shows that just because you have an MD after your name doesn't mean you can't make a mistake," says Dr. Pronovost, a noted patient safety researcher who directs the Division of Adult Critical Care Medicine at Johns Hopkins Hospital in Baltimore.

"If it's OK that I make a mistake because I'm human, that also means there is an approach to make this better that doesn't just require my personal vigilance. There's a system and a science of safety here that can help." ◆

Supporting physicians when things go wrong

Few physicians talk publicly about their medical errors, but a growing number are benefiting from programs dedicated to helping doctors deal with the emotional turmoil that often comes in the wake of adverse events.

Jo Shapiro, MD, helped start the Center for Professionalism & Peer Support at Boston's Brigham and Women's Hospital in October 2008. There are 55 physicians and other health professionals at the hospital trained to offer emotional support to peers involved in cases of patient harm.

"When there's any kind of adverse event that we hear about, one of us will make an outreach call to the physician involved," Dr. Shapiro says. "We ask them simple questions like, 'How are you doing? How are you feeling? Is there anything I can do to help you?' "

A call from another doctor means a lot, she says. "'They say, 'The fact that people care about this just made me feel so much better,' " Dr. Shapiro says. The encounter gives doctors a chance to talk in confidence with a peer about the guilt, fear and shame that often accompany adverse events.

"We point out how unrealistic it is that we're trained to think that we should never make a mistake," she says. "We also validate what they are feeling. We tell them that the suffering they're feeling means that they care. We wouldn't want people not to care. It is very hard when someone comes to harm."

Other health care organizations such as Children's Hospital Boston, Johns Hopkins Hospital in Baltimore, the University of Illinois Medical Center in Chicago and the University of Missouri Health System have peer support programs, says Linda K. Kenney, president and executive director of Medically Induced Trauma Support Services in Chestnut Hill, Mass.

Kenney, who was nearly killed by a medical error in November 1999, now advises hospitals on how to disclose adverse events and support the patients, families, physicians and other health professionals involved. Nearly 400 people have requested her organization's tool kit on setting up peer support systems.

"I feel like we've reached the tipping point," Kenney says. "Several years ago, people in health care were patting me on the head saying, 'You're doing a good thing, but we're really OK.' Now, they're saying, 'We really need to do something. We're now acknowledging that things go wrong in health care.' "

Dr. Shapiro also sees momentum. She has spoken to 10 groups about peer support programs. "The interest level is off the charts. This resonates so well with the idea that we've got to do something to help each other." ◆

— Kevin B. O'Reilly