

Part C: Managing Emotions after Difficult Patient Care Experiences

Discussion Guide: Dealing with Challenging Patient Care Experiences Integrating a Difficult Experience

Learning Objectives for this Section

- 3.2** Demonstrate ability to integrate one's response to a difficult experience, including acknowledgement of feelings of real or perceived guilt and discussion of medical errors.
- Acknowledge feelings of guilt, real or perceived, anger, sadness
 - Create a safe forum for discussion of medical errors and contributing factors
 - Understand and practice strategies for integration of these experiences

Relevant Milestones: PBL1, PROF3, PROF4, ICS2

Introduction

This section of the Curriculum will help trainees to integrate difficult patient care experiences regarding medical errors, disclosure of a new life-altering diagnosis, acute decompensation of a patient's condition, or the death of a patient.

"Integration" is the process of making something with disparate parts into a unified whole. For this curriculum, we define integration as the process of reconciling a challenging personal experience with one's values, beliefs and principles, in order to regain one's sense of an integrated personal and professional identity. Events that fracture one's sense of self often cause feelings of guilt, doubt, fear, anxiety, and/or dislocation from others. The healing, or integration, process helps one to regain one's sense of being a whole person.

We expect this curriculum to help trainees better understand how they respond in situations involving grief and loss, get in touch with their emotions under stress, and learn useful coping strategies, including journaling. Slides, reflective writing exercises, and cases are provided to help learners achieve the objectives shown below.

Didactic Curriculum

1. Slides

The slide set (**Section C.3**) provides a framework for leading this component of the curriculum. It begins with learning objectives and then quickly leads into a reflective writing exercise. Thereafter, the slides give background information on how providers typically deal with medical errors or experiences that evoke guilt or grief and loss. The slides are annotated for the presenter. At the end of the slides are cases that will allow the learners to reflect on and discuss strategies for dealing with difficult experiences as a care provider.

2. Reflective Writing

A reflective journaling exercise (see end of this Section) is to be used by an individual learner to think deeply about a patient care experience where he/she felt guilt related to a medical error and/or the unexpected outcome of a patient (sudden decompensation or death). The journaling exercise should be used near the beginning of the workshop, before the slides are shown.

Facilitator's Introduction: Think about a patient care experience when you felt guilt related to a medical error and/or the unexpected outcome of a patient (sudden decomposition or death). Then complete the journaling exercise sheet.

3. Debrief after Reflective Writing

Have enough members share their experiences to get saturation of feelings.

Facilitator's Role: Guilt related to errors or death

- Would anyone like to share his/her experience? If you do, you need not give details of the medical issue.
- How did it make you feel?
- What did you take away from the experience?

Facilitator's Role: Sharing experiences

- Our goal is to determine how to integrate the experience and learn from it, rather than letting it “eat away at you.”
- Allow participants to share their experiences/insights. This might include either reading the entries or summarizing the experience. It is often helpful if the facilitator is prepared to share his/her own experiences.
- It is helpful for groups to develop ground rules, e.g., what is discussed in the group stays in the group, names of colleagues are not used, etc.
- Goals of facilitation are to allow everyone to participate, with no judgments made about the reflections. Questions should help individuals to further explain or embellish on their experiences. Aim to help participants:
 - o Acknowledge and identify feelings.
 - o Recognize the fact that most of us will make an error at some point, and it may affect a patient's care.
 - o Acknowledge that sometimes we feel we have made an error, either by omission or commission, when our actions may not have affected the patient's care. However, those feelings are still real and must be acknowledged.
 - o Acknowledge that sometimes we feel guilt, even if our own actions did not lead to the event in question.
- During the discussion, issues about what to do regarding guilt, quality review, and how to help others may come up. Below is information, suggested questions and learning points to assist the facilitators.

4. Discussion regarding options for what to do with the feeling of guilt

a) During that shift, when you continue to have patient care responsibilities:

- Take a short break, if possible (strategies to refocus: cry, scream, deep breaths, meditation, eat a treat, quick walk outside of the unit, or just to the call room).
- Know your on-hand resources (e.g. trusted colleague, social work, pastoral care, faculty, program director/associates, chief residents, fellows, co- residents).

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b) After the shift, when patient care responsibilities are over:

- Know your resources (e.g. support program, confidential counseling services).
- Understand the role of family and friends (the group should discuss legal and ethical issues around confidentiality, HIPAA, etc.).
- Engage in reflection, journaling.

c) In the case of a death, options that may help:

- Attend the funeral.
- Talk with the family.
- Send a sympathy card.

Facilitator's Role

- Elicit residents' ideas of options to deal with grief.
- Reflect on options that residents bring forth that can help to balance patient care and resident needs.
- Provide options that are not elicited from the group that balance patient care and resident needs.

5. Discussion of Role of Quality Reviews

- Difference between Morbidity & Mortality conference and root cause analysis.
- What needs to be reported in your state?
- What are in-hospital/self-reporting medical error systems?

Morbidity and Mortality Conference: M&M is usually a recurring, department-based review of a case or series of cases where morbidity or mortality occurred. Some states mandate M&M. The goal is to learn from the case, regardless of whether there were errors, in order to improve care for future patients. Topics for discussion may include systems-based issues and knowledge gaps. It is important to have residency leaders at M & M to ensure respectful dialogue. Attendance can be beneficial for those involved to hear the comments of peers.

Root Cause Analysis: A root cause analysis (RCA) is conducted by a hospital-appointed committee when an error has occurred that is on a hospital, state or federal list of reportable conditions, and therefore requires an in depth review. The goal is to determine what can be/should be done to prevent the error from occurring again, e.g., an educational program, a system change, or a policy change.

Facilitator's Role: Prior to session:

- Review institutional support options to be able to discuss them during the session, e.g. who is usually at an RCA, who presents the case, who are the discussants, what happens prior to and after an RCA.
- Know the routine process for review of a medical error at the institution.

6. Discussion — how can you use your experience to support others?

- Reach out to others at the time when you see their pain/guilt, either that day or in the days after. This reflects the importance of creating a community of caring with your colleagues.
- Reach out to more junior trainees, as this may be their first experience.
- Tell your story to others:
 - How did you get through it?
 - What support did you find helpful?
- Identify supports, recognize that others may need different supports than you did.

Facilitator's Role

- Discuss residents' roles as leader for students and fellow residents.
- Discuss residents' important role in supporting each other. Providing peer support is a role that continues throughout one's career.
- If other trainees are involved, ensure that the supports provided are relevant to them.

7. Cases

Four cases have been provided for discussion (below). A handout version can be found in **Section C.5**. To assist the facilitators in leading case discussions, the material below repeats each case, offers suggested questions and learning points, and describes how one might discuss with residents the specific questions that accompany each case. Facilitators may also utilize a case known to their learners or ask learners for examples relevant to them.

Facilitator's Guide to Case Discussions

Case 1: Infant with pneumothorax

You are a third year resident on call in the NICU in May. It is one of your last calls of residency, and you are looking forward to being done! It has been a very busy night; you have had multiple deliveries, including the admission of 26 week twins, and have been up all night helping your intern with the procedures and the admissions. In addition to caring for the latest admissions, you have heard from your intern on a couple of occasions about a baby who keeps desaturating. At about midnight, you and your intern decide to order a chest x-ray on this infant. After some time, you ask your intern if she followed up on this chest x-ray and she tells you that it looked okay. The infant continues to have difficulty with desaturations, and you make adjustments on the ventilator with the respiratory therapist. Finally, everything settles down, and you head to the call room for the first time all night. At about 6:00 AM, you get called by the nurses to the bedside of the baby, saying that things have suddenly worsened and they need you right away. As you arrive at the bedside, your fellow is also there. The two of you look at the chest x-ray that was taken over 6 hours before, and you see a large pneumothorax. Your fellow asks you if you had seen the pneumothorax, and you tell her that you did not review the chest x-ray with your intern. Suddenly, a wave of guilt comes over you; you realize that you have let down your intern, your fellow, and most important, your patient.

Issues for Discussion. In this situation the senior resident did not check a critical chest x-ray. This may have happened for a number of reasons. Given the fact that it was May, the senior resident may have assumed that the intern knew how to look for a pneumothorax. The night was very busy with other admissions, and the senior resident was probably very fatigued, as he had been up all night. On another occasion the decision not to look at this chest x-ray may not have had any consequences, but this time it resulted in a pneumothorax being missed for 6 hours, and an infant's condition worsening.

Medical errors occur in any hospital, and this situation shows how easy it is to make one. The intern missed the pneumothorax, but the senior resident was ultimately responsible for the intern. When an error like this occurs, it is important to acknowledge one's feelings of guilt. Since multiple people were involved in the error, discussing it with your fellow and your intern is important. The intern probably feels guilty that she missed the pneumothorax. The discussion regarding the error may allow everyone to learn something from the situation.

Residents are in a learning environment where mistakes are made. Discussion of this situation will help everyone learn to avoid this type of error in the future. The fellow plays a critical role in helping to teach the intern how to identify the pneumothorax, and teaching the senior resident to supervise safely. If this lesson is taught in a safe non-threatening environment, the discussion may help all learners focus less on their guilt and more on how to provide safe, high quality care in the future.

1. How would you (as the senior resident) reflect on this situation?

In this situation, the senior resident did not check a critical chest x-ray. This may have happened for a number of reasons. Given the fact that it was May, the senior resident may have assumed that the intern knew how to look for a pneumothorax. The night was very busy with other admissions, and the senior resident was probably very fatigued, as he had been up all night. On another occasion the decision not to look at this chest x-ray may not have had any consequences, but this time it resulted in a pneumothorax being missed for 6 hours, and an infant's condition worsening.

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2. How would you discuss this situation with your intern?

The intern probably feels guilty that she missed the pneumothorax. As the senior resident, it will be important to take responsibility for not checking the chest x-ray with the intern. The senior will want to review with the intern how to look for a pneumothorax. In addition, it may be helpful to reflect on the night as a whole to discuss other resources available to you and the intern. As you were very busy caring for ill infants all night, it would have been appropriate to ask the fellow to look at the chest x-ray with the intern, if you did not have time and to emphasize the importance to the intern of double checking results if he/she was not sure.

3. If you were the fellow, how would you discuss this situation with the senior resident?

Residents are in a learning environment where mistakes are made. Discussion of this situation will help everyone learn to avoid this type of error in the future. The fellow plays a critical role in helping to teach the intern how to identify the pneumothorax, and teaching the senior resident to supervise safely. If this lesson is taught in a safe non-threatening environment, the discussion may help all learners focus less on their guilt and more on how to provide safe, high quality care. The discussion regarding the error may allow everyone to learn something from the situation.

4. How would you discuss this with the parents of the child?

As the senior resident, it is appropriate to disclose this with the family of the child. In this discussion, the senior resident could discuss the chest x-ray that was obtained, and the fact that the pneumothorax was not identified for several hours, and the importance of now acting on that result. If the senior resident does not feel comfortable disclosing this to the family by him/herself, the fellow, or the faculty could assist the resident in disclosure. At many institutions, the Office of Risk Management can also assist with disclosure. It will be important to tell the family what happened, and make sure that they understand the next steps.

Case 2: Six month old baby with congenital heart disease

Caleb is a 6 month old male with complex cyanotic congenital heart disease s/p surgery who is in the PICU during your first PICU month as a second year resident.

You had worked the night before and Caleb was your patient. You had been up all night reviewing blood gases, labs, and adjusting his multiple drips and fluids. Caleb had a rocky postoperative course, was fluid overloaded, edematous, and had electrolyte abnormalities. You were caring for 7 other patients—most were more stable, but others took a lot of your time.

Caleb's family had been at the bedside all night and asked a lot of questions. Each time you went in the room the family wanted to talk. You had a lot of other patient issues and what was going on with their baby was very complicated; you weren't sure you understood it all. When they asked you questions you gave short answers to their immediate questions and then stated multiple times that you would come back. Each time you came back you didn't have the time to sit down with them and explain what was going on, or to understand it fully yourself.

You come in the next night and the baby and family are no longer on the unit. Caleb developed an arrhythmia soon after you left the hospital and died shortly thereafter. When you hear the news, you feel incredibly guilty that you didn't take time with the family while the baby was alive.

You walk in to sign out and a lot is going on. You know that because you were so busy, you ignored some of the nurses requests for you to come in to talk to the family, or at the least you put it off to have more time for the other patients. Now you wonder if the family understands what happened and whether you could have done more to support them and get their questions answered. You never got to tell the fellow or the attending that the family had questions, you were just too busy.

Issues for Discussion. Discuss supports available both at night and the next day. The fellow and/or attending are available to answer the resident's questions and/or the parent's questions. Discussing the case with them and getting his questions answered may have made him feel more comfortable talking to the family and not avoiding them. If the resident was still too busy to speak with the family, he could have informed the fellow/attending that the family had questions. The family needed someone to talk to, and the next day he would not have felt that he hadn't done all he could. Residents need to learn that sometimes doing what you can means getting the right other people to support the family. That is why they are part of a team.

The next day, the resident needs help in focusing. Consider with whom he can discuss his role and feelings. Have the residents identify resources, e.g., social work, faculty, peers, other team members. Emphasize reaching out—others will not necessarily know you need help if you don't tell them. Help him decide what needs to be done when: signout, patient care, self-care. Self-care needs to be on everyone's list, so it is not forgotten.

1. Should you, could you have done anything differently when you were on call?

During the night on call, there are support systems available to help the resident. As a resident, you always have your fellows or your faculty that are available to answer the resident's questions and/or the parent's questions. As the resident, if you discuss the case with your faculty or fellow, you may feel more comfortable talking to the family and not avoiding them.

2. Is there anything that you could have done to support the family better?

If the resident was still too busy to speak with the family, he could have informed the fellow/attending that the family had questions. The family needed someone to talk to, and the next day the resident would not have felt as much guilt for avoiding the parents' questions. It is important to remember that sometimes doing what you can means getting the right other people to support the family. That is why we are all part of team. In addition, sometimes the family needs additional support. You can offer to have social work come to speak with a family, as well as pastoral care.

3. Is there anything that you can do now at the beginning of your next shift to help you to focus on the duties that you have ahead of yourself for the night?

The next night, the resident needs help in focusing. The resident has a lot of tasks ahead of him for the night, getting sign-out, taking care of patients, and self-care. Self-care is critically important to long term physician mental health. There are a lot resources available in the hospital, such as faculty, peers, chief residents, and the residency program director. Often, residents who have faced a difficult situation can reach out to social work or the employee assistance program, which can be a good place to reach out to for assistance in dealing with guilt that a resident feels regarding a specific outcome. Residents should reach out for assistance - others will not necessarily know you need help if you don't tell them.

Case 3: 2-year old in the ED with respiratory symptoms

It is 9am and you are busy working in the pediatric emergency department. A 2 year old fully immunized, circumcised male patient comes to the emergency department with a fever of 38.7 degrees. He is quite active, looks good, has some minimal rhinorrhea, and your review of systems is otherwise negative. His physical exam reveals no focal findings and you discharge him home with a diagnosis of probable viral URI. You instruct the family to return if he appears sicker.

At 8:30pm (30 minutes before your shift is to end), a 2 year old male patient comes in by ambulance. The parents of this child had called EMS after they went to wake him from a 2 hour nap and found him to be difficult to wake up and "not acting himself". At triage he is noted to be febrile, hypotensive, tachycardic, with poor perfusion, and is very difficult to arouse. As you are called to the bedside to assist with the care of the patient, you realize he is the patient you had discharged earlier. He is noted to have a petechial rash over his body. In the ED he is given multiple fluid boluses, IV antibiotics, requires intubation and dopamine to maintain adequate blood pressure. He is transferred to the PICU with the tentative diagnosis of meningococcal sepsis.

Issues for Discussion. Sudden unexpected bad outcomes in patients are always difficult, and they often lead to the strongest emotions of sadness, anger and guilt. It is common that we, as health care providers, will second guess our decision-making and analyze the situation to identify our mistakes.

Important strategies here are to provide support to the family and also to care for oneself. This case allows a dialogue among participants, so they can reflect on what they would be most likely to have done themselves, and why. Should they speak with the family, apologize, and/or follow them up to the PICU? Other strategies would be to debrief with a valued colleague, or perhaps go home and pursue active coping strategies such as exercise, or a quiet time reflecting, or going to sleep. It is important to emphasize that strategies should be individualized and no one size fits all. However, it is imperative for the wellbeing of this resident to have some venue to integrate the experience. You may also want to discuss resources available at your institution.

1. What would be your dialogue with the family?

It is important, if this hasn't already been done by someone else, to retake a complete history including prior to the first ED visit to determine if there was any information that may have led to the diagnosis. Pay particular attention to what happened after the first ED visit: how was the child and what occurred when the family got home.

In addition, you should discuss with the family that often diseases progress with time with new information, i.e. signs and symptoms, declaring themselves. While we look for hallmarks of more serious disease they are not always present. In addition, when a child represents to the ED we routinely review the first visit information again to see if we could have avoided the second presentation.

2. How would you try to comfort and support the family?

The family will often be nervous, scared and/or fearful. You should offer to answer any questions they have and if you cannot answer them, find others who can. In addition, it may be comforting to them if you explain what is happening, who is in charge and who will be caring for the child, and the next steps for treatment. Also tell them about available support for them, such as a social worker or chaplain. You may also express your feelings; e.g, you regret that you were not able to predict what would happen, you are frustrated that we don't always have tests that give us the answers we need, or you feel guilty that you cared for a child who is now sicker than you expected.

3. What might you do to reflect on this experience?

As health care providers, we often try to second guess our decision-making and analyze the situation to identify our mistakes.

- You may want to review the original medical record.
- You may want to discuss the case with a colleague or supervisor to get another's point of view. As physicians, we are not always the best judge of when we have made an error or what we could have done differently. Discussing the situation with a colleague can help you to verbalize your concerns as well as get another perspective.
- You may want to write about the experience, but to avoid legal complications, don't use a public forum, such as Facebook or a blog.

4. How would you comfort yourself?

Strategies might include debriefing with a valued colleague, or perhaps going home to pursue active coping strategies such as exercise, a quiet time reflecting, or going to sleep. Strategies should be individualized, because what helps one person may not help another. However, it is critical for the resident's well-being and healthy identity as a physician to find an approach that works, in order to integrate this experience, and prepare for similar situations that may occur in the future.

Case 4: 5-year old with morphine overdose

You are working in the inpatient unit and caring for a 5 year old patient, Marvin, who has hemoglobin SS disease. Marvin is admitted frequently with pain crises. He is your sixth admission within the past 3 hours. You evaluate him quickly and write an order for a morphine dose in order to try to alleviate some of his pain while waiting for the PCA to be initiated. You are anxious to help him and provide him some relief, but plan to return to do a more complete history and physical once you have attended to some of your other patients. About an hour later the nursing staff calls you because Marvin is acting very sleepy and difficult to arouse. You worry at first that perhaps he may have had some type of neurological event, like a stroke. The nurse working with him checks your orders, and notes that the dose of morphine which you ordered was 10 times the dose for his weight.

Issues for Discussion. This case represents a clear-cut medical error. Discussion with participants should focus on why the error may have happened, in addition to the emotions engendered by the incident. Review with the group the guiding principles and protocol for disclosure of medical errors, including informing the family/parents as soon as you are aware that error occurred, apologizing for the error, explaining next steps to remedy the error, and disclosing the impact of the error. If all of the steps above cannot be done immediately, then it is important to find another time to speak with the family without delay. In this case the medication can be reversed, resulting in no long-term harm.

Next, the group should evaluate the impact of the error on the resident as provider. What are strategies that the resident might use to integrate this experience: debriefing, journaling, taking time for reflection, understanding why the error may have occurred. An important goal to include is finding ways to “forgive oneself.”

1. How would you explain this to the family?

The error should be discussed clearly and succinctly. In addition to what you have done, i.e. do you need to give naloxone, do you need to increase monitoring and what are the possible risks, i.e. more sleep, the need to give naloxone, need for oxygen or other support. Who you have informed, i.e. supervising resident and faculty. Parents also benefit from strategies of how this can be prevented from happening again or to other patients. The power of stating “I am sorry that this occurred” is also important.

2. How would you discuss this with your medical colleagues?

You may want to think about this in 2 components. First component is to discuss it to get another person’s perspective on the error, as this can often help with you processing it and getting a sense of severity. Secondly, discussing ways to prevent this error from occurring in the future, either for you as an individual or the systems in place (or that should/could be in place) to prevent this type of error, including alerts in EHR, checks by pharmacy and nursing, etc.

3. What might you need to do to reflect on this experience?

As mentioned above, discussing it with a colleague can often help you reflect on it. Writing about it may also help you reflect. In addition, it may be helpful to think through the situation, with someone else, or in writing, or quietly by yourself, the factors that led to the error, the possible ways to have prevented the error, and the possible outcomes of the error. In addition, what you will do in the future to reduce the chance of this or other types of errors occurring in the future.