Safety and Conflict in Healthcare: A Few Messy Details

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Introduction

Let's imagine that you are over the age of 18 and have decided you would like to take the train from Winnipeg to Vancouver. You phone the reservations desk at CanRail and much to your surprise are answered promptly and courteously. There is lots of space on your preferred dates and the price seems reasonable.

Just before you hang up, the CanRail representative says that the safety record of the rail system has recently been measured and found to be fully effective more than 92% of the time. You are slightly uncertain about this and ask for details.

The friendly response you get includes the fact that one of every thirteen passengers will encounter some kind of significant mishap on the trip. After you ask innocently about lost luggage you are told that such events usually involve an injury to the passenger.

Furthermore you are told that slightly more than one in one hundred passengers will die as a result of some lapse in the safety procedures during the trip. As you are trying to digest this information, the Can Rail representative tells you that there are sometimes delays in departure, by several hours and that you may be transferred to another train in various places like Estevan and Pincher Creek.

As a word of encouragement the CanRail representative tells you that if the transfer occurs between crews that get along well, then you have a much lower risk of being involved in a significant mishap, compared to those transfers that occur when the crews definitely don't get along.

Would you be inclined to take this trip? Maybe the mosquitoes in Winnipeg aren't that bad after all and the beaches in Vancouver are probably over-rated…. If any of you are inclined to buy a ticket on this train please contact me and send your rationale (to rrobson@mediatecalm.ca).

Fantasy or Reality?

Does the situation described seem completely farfetched? A recent extensive review of the experience of Canadians admitted to acute care hospitals in the year 2000 shows that the risks are exactly what we all face as patients.

The study was reported in the Canadian Medical Association Journal of May 2005. It included 20 hospitals from five different provinces (BC, Alberta, Ontario, Quebec, and Nova Scotia) with a cross section of different kinds of facilities (one large teaching hospital or tertiary care centre, one large community hospital and two smaller community hospitals from smaller centres in each province).

More than 3700 patient records were randomly selected and examined by trained teams of physician and nurse reviewers. They concluded that 7.5% of the 2.5 million patients admitted to hospitals in Canada in 2000 experienced an adverse event. An adverse event is defined as an event that results from healthcare management, resulting in an outcome such as death, significant disability or prolonged hospitalization and specifically not related to the underlying disease process that brought the person to hospital.

It is perhaps surprising that one out of thirteen hospitalized patients (remember the train trip to Vancouver?) would experience an adverse event arising from some kind of healthcare system breakdown. More surprising and disturbing was the finding that 1.6% of the patients hospitalized in 2000 not only experienced an adverse event but subsequently died.

When adjusting the results for statistical reasons, the study suggested that somewhere between 9,000 and 24,000 Canadians died in the year 2000 in connection with an adverse event.

These results were consistent with the results of several large international studies in the preceding 15 years and highlighted the need to begin to address the patient safety situation in Canada.

The study only examined care provided to hospitalized patients, and even some of those were excluded from the study (pediatric, obstetrical and

psychiatry admissions were excluded so that the study would be comparable to many other international studies). Even so, the figures suggested that almost two Canadians die each hour of every day as a result of some kind of breakdown in the system of care.

When the care provided in outpatient settings, clinics, and physician offices, not to mention personal care homes and long-term care settings is considered, the figure is likely closer to four patients dying each hour in connection with some kind of adverse event.

What's up, doc?

Is our healthcare system really as bad as this study suggested? First of all, as good conflict resolvers do, we can always re-frame the question by saying that 92.5% of the time patients who are hospitalized receive good care. This is true. And yet the level of adverse events is much higher than is found in most other complex high risk industries (transportation, nuclear energy, chemical industry, etc.). Clearly there is room for as well as a need for improvement.

When cases are examined in detail by safety experts, almost invariably they discover stories that reflect highly technical care being provided in a complex system which has not been designed to take into account the usual abilities of normal human beings. Almost always, a series of several conditions had to be in place before any harm reached the patient.

In other words, it was very rarely a problem of a careless nurse, a lazy pharmacist or a negligent doctor – it was almost always a situation involving a complex system that could not anticipate all the rapid changes that might occur with sick patients – basically the system had many weaknesses that were like traps that would lead any normal care provider to eventually make a mistake. Sometimes these mistakes caused harm to patients.

The understanding that the problem was largely related to system design issues was a powerful tool to start to address the patient safety challenge. Still, significant cultural issues continue to make it difficult to make progress. The tendency to blame the individual, especially those working

closest to the patient (often called the "sharp end" of healthcare) remains ingrained not only in healthcare but also in society.

Room for a mediator

Why would this situation be of interest to conflict resolvers (except as they may need to enter the healthcare system)? In fact, there are many reasons why mediators should be interested and many ways in which their knowledge and skills can advance patient safety initiatives.

First, one of the most difficult conversations for healthcare providers can face is talking to a patient or family members when an injury or death has occurred in association with a breakdown in the system of care. These **disclosure discussions** are now mandated in most parts of the country and it is clear that mediators can provide useful guidance and training about how to conduct such discussions.

Secondly, healthcare, as a complex system is typically one in which there are many "silos" of professional activity with very little meaningful communication across the continuum of care, with the result that the patient suffers. There are many reasons for these communication breakdowns, often related to the training and other cultural influences that have evolved over time.

Conflict resolvers have the skills that can facilitate meaningful discussion between various professional groups all of whom are caring for a patient. Ideally our skills should be brought to bear before something bad happens to the patient. After an adverse event, it is extremely important to understand, as much as possible, all the factors that contributed to the particular event so changes can be made to reduce the likelihood of similar problems in the future.

Perhaps most important is the recent realization that conflict actually causes errors and significantly increases the risk of poor patient outcomes. Think back to the train trip from Winnipeg to Vancouver and the reference to sometimes having to transfer to another train along the way.

In healthcare, those transition points are common. A recent study showed exactly how powerful the level of conflict between various units could be in predicting the outcome for patients. The extent of collaboration between the physicians and nurses in an ICU and the medical or surgical unit receiving a patient in transfer was assessed by a comprehensive questionnaire. The degree of collaboration was directly correlated with patient outcome. When the relationships were considered to be non-collaborative there was a **three fold increase in the risk of patient death** or re-admission to the ICU when compared to those units where the level of collaboration was considered to be positive. This is a powerful indication of the direct impact of conflict on patient outcome.

What happened to the patients?

One of the paradoxes of the young patient safety movement in Canada is the relative absence of patients and family members as active participants in finding solutions to the challenges described above. There are many reasons for this. An important one is the large gap in perspective between many professional care providers and those who are the recipients of care. In short, patients often look at a situation in a very different way than do doctors, nurses, and other professionals. These differing frames lead to significant communication gaps and challenges that in turn lead to adverse events and bad outcomes.

Many professionals have little training in how to actively interact with patients on a variety of projects and initiatives. And yet patients provide an enormous reservoir of energy and good will to help us "fix things" that are not working in the system. After all, it is the patients who truly have the strongest interest in improving the system. And yet it seems such a challenge to tap into this source of experience, energy and ideas.

Who is better trained to understand how to re-frame perspectives and help the parties balance apparently divergent interests than conflict resolvers and mediators? That's what we do for a living. Using our skills to help promote the integration of patients and families into the heart of the patient safety movement is an important contribution that can be made.

What are we waiting for?

Adopting a systems analysis and using human factors tools has helped the patient safety movement to begin to move forward in Canada. The physicians, nurses, pharmacists, risk managers and most importantly patients and family members who are the engine in this movement are often unaware of the particular skills and knowledge of mediators and how such a perspective can help them further improve patient safety initiatives and outcomes. We have a golden opportunity to use our skills in ways that will help our fellow citizens as well as our own loved ones and family members. Let's get on with it and start learning about patient safety and offering our skills to help facilitate the efforts to improve the way our healthcare system provides care.

Published in;
Conflict Resolution Today: Special HealthCare edition,
Vol. 18, No. 1&2 March 2006