

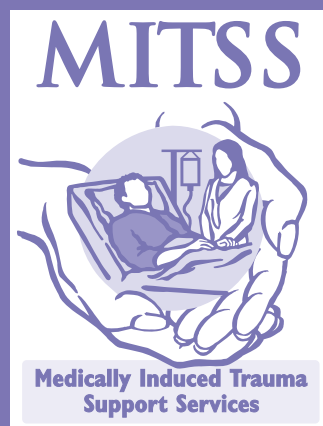
Disclosure and Apology

What's Missing?

ADVANCING PROGRAMS that SUPPORT CLINICIANS

MITSS
Medically Induced Trauma Support Services

Susan Carr



*A report based on an invitational Forum
held on March 13, 2009*

Sponsored by

MITSS
Massachusetts Medical Society
CRICO/RMF
ProMutual Group

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Speakers and Facilitators

James Conway, MS
Senior Vice President
Institute for Healthcare Improvement
Cambridge, MA

David R. DeMaso, MD
Psychiatrist-in-Chief
Coordinator, Office of Clinician Support
Children's Hospital Boston
Boston, MA

Linda K. Kenney
President, Executive Director
MITSS
Boston, MA

Paul McTague, Esq.
Partner
Martin, Magnuson, McCarthy & Kenney
Boston, MA

Jerry O'Keefe
Director, National EAP Services
Kaiser Permanente
Oakland, CA

Saul Weingart, MD, PhD
Vice President, Patient Safety
Director, Center for Patient Safety
Dana-Farber Cancer Institute
Boston, MA

Planning Committee

Susan Carr
Editor & Associate Publisher
Patient Safety & Quality Healthcare
Concord, MA

Caroline B. Carregal
Director, Continuing Education
and Certification
Massachusetts Medical Society
Waltham, MA

James Conway, MS
Senior Vice President
Institute for Healthcare
Improvement
Cambridge, MA

JJ Durham
Independent Consultant
Boston, MA

Paula Griswold, MS
Executive Director
Massachusetts Coalition for the
Prevention of Medical Errors
Burlington, MA

Mary Sue Howlett
Associate Director,
Division of Nursing
Massachusetts Nurses Association
Canton, MA

Anne Huben-Kearney RN, CPHQ,
CPHRM
Vice President, Risk Management
ProMutual Group
Boston, MA

Linda K. Kenney
President, Executive Director
MITSS
Boston, MA

Karen Nelson, MPA, RN
Senior Vice President
Clinical Affairs
Massachusetts Hospital Association
Burlington, MA

Georgia Pierce
Director of Communications
Patient Care Services
Massachusetts General Hospital
Boston, MA

Luke Sato, MD
Chief Medical Officer
and Vice President
CRICO/RMF
Cambridge, MA

Winnie Tobin
Communications Director
MITSS
Boston, MA

Saul Weingart, MD, PhD
Vice President, Patient Safety
Director, Center for Patient Safety
Dana Farber Cancer Institute
Boston, MA

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FORWARD

Supporting Clinicians, Too

Linda K. Kenney

IN NOVEMBER 1999 (the same month the Institute of Medicine released its famous report, *To Err Is Human*), I was scheduled for total ankle replacement surgery at a major medical facility in Boston, Massachusetts. Instead of waking up with a new ankle, I awoke several days later to find that the nerve block had been delivered accidentally to my heart, causing me to go into cardiac arrest. I had been rushed into a nearby operating room that had been prepared for another patient's cardiac surgery. I had received an emergency sternotomy with cardiopulmonary bypass for cardiac resuscitation. Eventually, I made a full recovery.

That incident had a profound effect on my family, my friends, and me. I also was exposed to a side of health-care most patients and families do not see: I witnessed the emotional impact the adverse event had on my orthopedic surgeon, the anesthesiologist, code team, and other health-care providers. It wasn't just business as usual for them; they suffered, too, and found themselves as unsupported as my family and I were. I knew that something needed to be done.

I founded MITSS (Medically Induced Trauma Support Services) in June 2002. Our mission is *to Support Healing and Restore Hope* to patients, families, and clinicians following adverse medical events. MITSS recognizes that everyone involved in an adverse event needs support. We have spent time raising awareness and educating health-care consumers, professionals, and organizations about the emotional impact of adverse events and the need for support services. We have been providing direct support to patients and families as well as individual clinicians from the beginning. As an organization, MITSS has advocated that healthcare institutions build their own infrastructures of support for their staff. We have served as consultants and advisors in building some of those programs.

Early on in this work, we wanted to sponsor a forum to brainstorm ideas about supporting clinicians who have been involved in an adverse event. In January 2004, MITSS was

able to host such an event, with the gracious support of the Dana-Farber Cancer Institute (DFCI) and Jim Conway, who was then chief operating officer at DFCI. The program was entitled *Forum: Improving Clinician Support Systems for Adverse*

Medical Events. Nineteen people attended the one-day event: five were affiliated with MITSS, four of the doctors who attended had been part of my code and care teams, and others were risk managers from Brigham and Women's Hospital and DFCI. There were also representatives from nursing and pharmacy. Two psychiatrists gave sobering presentations: Dr. John Fromson from Physicians Health Services (PHS), and Dr. Miguel Liebovitz, who worked with physicians being sued for malpractice. The group discussed what could be done to support clinicians and offered some suggestions for next steps. At the time, we were not aware of any institutions that had support systems in place for clinicians following adverse medical events. We were disappointed with the small turnout for the Forum, but at least it was a beginning.

Our mission is to Support Healing and Restore Hope to patients, families, and clinicians following adverse medical events.

Best Practices

When planning the Forum that took place in March 2009, *Disclosure and Apology—What's Missing? Advancing Programs that Support Clinicians*, I envisioned that by the end of the day, we would have discovered emerging “best practices” that organizations could use to develop their own clinician support programs. That goal proved overly optimistic, in that we did not leave the Forum with a tidy list of policies to recommend. One thing we did learn is that support programs must be customized to reflect the culture of the institution; there is no “cookbook” solution

for this problem. We did, however, come away from the Forum with a set of important recommendations to help guide institutions as they develop these programs. The recommendations appear below.

Over the years, when I have had the opportunity to present at conferences, I have been overwhelmed by the stories clinicians have shared with me about the trauma they've experienced following adverse events. It appears that nearly every clinician has experienced the emotional impact of an event of one kind or another. In many cases, the event still haunts them. Early on, the response I often heard after describing the MITSS program was, "That's nice; keep up the good work." The message has shifted, and now I often hear,

"We need to do a better job supporting our staff; can you help us?"

It appears that the time is ripe for development of programs to support clinicians following adverse events. The Forum we held in 2004 provided questions and direction. At this year's Forum, although we did not discover emerging best practices, we did capture considerable information about successes, barriers, and opportunities in this developing arena. We also learned about a small number of institutions with established, successful programs, which provide several different models for clinician support. In this report, we share the information captured at the Forum and hope it will help others build their own programs.

What We Have Learned

All healthcare organizations should provide emotional support to clinicians and staff members following adverse events. This report and publications listed in the references and further readings provide guidance for establishing these programs. The following list of recommendations reflects what we have learned from the experience and expertise of early adopters—pioneering healthcare professionals who have articulated the need for support and a small number of institutions that have implemented programs.

- ◆ Programs may take many forms, but some kind of support should be made available for all clinicians and staff members. Programs should be established as soon as possible and publicized widely, so that individuals will know how to access help in the immediate aftermath of an event.
- ◆ Clinician and staff support should be part of each institution's operational response to adverse events.
- ◆ Support programs must reflect the circumstances and culture of each institution. An institution may want to develop separate programs for different elements of the workforce. The kinds of programs that have proved to be helpful include:
 - Peer support (individual or group)
 - Employee assistance programs
 - Psychological and psychiatric counseling
- ◆ Don't assume that individuals whose involvement in the event seems peripheral will not experience stress and will not need support. Similarly, don't prejudge what constitutes an "adverse" event. Managing these programs successfully means being observant and flexible about the needs of different individuals.
- ◆ Pay especially close attention to clinicians who are involved in disclosure and apology discussions following adverse events. They may have urgent needs for support and may engage with patients and families more effectively if they, too, feel supported.
- ◆ Support programs will not be successful without visible commitment from the institution's executive and medical leadership.
- ◆ Fear of legal action should not prevent someone from getting the emotional support they need following an adverse event. While clinicians should avoid discussing the details of the medical case and event outside of privileged communications with legal counsel, they may talk about their feelings without fear that those discussions will be used against them in court.
- ◆ Clinician support programs may be characterized as protecting an institution's investment in its workforce and supporting favorable return on investment. At this early stage, there is not much data available to support the business case for support programs, but a case can be made based on anecdotal evidence and common sense.

MITSS will continue to contribute to awareness and development of programs that support clinicians and staff members following adverse events. The individuals, institutions, and organizations that participated at the Forum in March 2009 helped to advance this issue with their honest and generous contributions.

Disclosure and Apology—What’s Missing?

ADVANCING PROGRAMS *that* SUPPORT CLINICIANS

ON MARCH 13, 2009, 67 invited attendees, speakers, and facilitators spent the day discussing ways to offer emotional support to clinicians who have been involved in adverse medical events, including events that resulted in harm to patients and might have been prevented. Most participants represented institutions in Massachusetts, including hospitals, insurers, and medical societies, where they work as physicians, nurses, risk managers, patient safety officers, executives, claims representatives, employee assistance program (EAP) support staff, among other positions.

Professionals involved with clinician support at Children’s Hospital Boston and Kaiser Permanente in California described established programs at those institutions, an attorney whose practice concentrates on defense of malpractice cases described the legal ramifications of clinician support, and all who attended shared their experiences and ideas for advancing clinician support programs.

In the invitation, organizers characterized the Forum as a “day of learning” about a topic that for various reasons has not received the kind of attention the organizers believe it deserves. This report describes what we did and what we learned during the Forum.

The all-day event, *Disclosure and Apology—What’s Missing? Advancing Programs that Support Clinicians*, was sponsored jointly by MITSS (Medically Induced Trauma Support Services), Massachusetts Medical Society (MMS), CRICO/RMF, and ProMutual Group. It was held at the MMS offices in Waltham, Massachusetts, during National Patient Safety Awareness Week.

I. *Background and Context*

Healthcare institutions and the medical professions have been slow to acknowledge that anyone involved directly or indirectly in an adverse medical event—patients, family members, physicians, nurses, allied health professionals, administrators, housekeeping staff, and others—may experience emotional distress. Individuals may respond naturally with empathy and caring toward someone who is in crisis, but healthcare institutions generally have not responded in that way following patient safety incidents. Patients and families often are left isolated, uninformed, or even purposefully misinformed. Clinicians usually are left to process their reactions to these events on their own. There are many reasons for this dysfunctional response on the part of many institutions and individuals. Foremost among them are fear of legal action, emotional illiteracy, denial, and shame.

The Role of Culture

The elements that contribute to this inadequate response to adverse events can be attributed to underlying cultural characteristics of the medical professions, healthcare organizations, and even to personal traits considered to be typical of clinicians. Individuals in medical professions are often characterized as being idealistic, competitive, and perfectionist—traits that are reinforced through traditional medical training and by hierarchies and leadership practices in healthcare institutions.

Commenting on error and the culture of medicine, Vincent (2006) observes:

All clinicians recognize the inevitability (although perhaps not the frequency) of error. However, this seldom carries over into open recognition and discussion, still less into research on error. There is therefore, a curious, and in some ways paradoxical, clash of beliefs. On the one hand we have an enterprise fraught with uncer-

tainty, where knowledge is inadequate and errors are bound to occur. On the other hand, those working in this environment foster a culture of perfection, in which errors are not tolerated, in which a strong sense of personal responsibility both for errors and outcome is expected.... With this background it is not surprising that mistakes are hard to deal with, particularly when so much else is at stake in terms of human suffering (pg.142).

Certainly it is possible for individuals and institutions to learn new skills and habits that will improve their response to adverse events as well as the quality of patient care and collegial relationships. It should also be said that individual clinicians and healthcare organizations vary across a wide spectrum of responses to adverse events. Vincent points out that “it is hard to know how far to generalize these experiences [of adverse events],” which might be quite different from one department to the next and from large academic medical centers to small group practices. In all cases, the cultural environment within which these changes take place should be considered when designing and evaluating support programs.

Disclosure and Apology

Healthcare organizations have begun to respond to patients and families more constructively when things go wrong. These efforts have coalesced in the movement to require clinicians to promptly and honestly disclose adverse events to patients and their families and to take responsibility and apologize, when appropriate.

Some of the groups and individuals working to improve that response recognize that clinicians and others involved in adverse events are likely to need emotional support, too. In “Guilty, Afraid, and Alone—Struggling with Medical Error,” Delbanco and Bell (2007) address the personal experience of medical errors and describe clinicians, patients, and families as having some needs in common:

How can we characterize and address the human dimensions of medical error so that patients, families, and clinicians may reach some degree of closure and move toward forgiveness?...Everyone involved needs an organized structure that restores communication and supports emotional needs.

The Harvard teaching hospitals, the Harvard School of Public Health, and the Risk Management Foundation (malpractice captive for the Harvard Teaching Institutions, now known as CRICO/RMF) have developed and published principles for effective communication about errors and adverse events. That report, *When*

Things Go Wrong: Responding to Adverse Events (2006), includes guidelines for incident response; communication, support, and follow-up care of patients and families; and support, training, and education of caregivers.

One benefit of effective response, disclosure, and apology is the healing that all parties—patients, families, and clinicians—may experience when loss is acknowledged, responsibility taken, apology and forgiveness offered, and trust restored. It should not be assumed, however, that having a policy for disclosure and apology insures effective communication. These are difficult conversations for even the most skilled communicators. The good that comes from apology and disclosure may be limited if clinicians are left to their own devices, without training or support, when they themselves are experiencing guilt, fear, and grief. Clinicians who are offered emotional support following adverse events are more likely to communicate sincerely and effectively with the patients and families involved.

Additional Concerns

At least two more factors further complicate the challenge of addressing the need for support following adverse events. Clinicians and patients who were directly involved are not the only ones who may need help. Staff members and clinicians who had peripheral involvement with the event may still experience emotional distress and benefit from support. Certainly, it is best to err on the side of caution when thinking about who may need help. Make sure that all staff members are familiar with support programs that are available to them.

It also can be difficult to anticipate which events will be troubling for any particular individual. What constitutes an adverse event can range from having a patient suffer serious, preventable harm clearly caused by medical error to having a patient unexpectedly and rapidly decline for no obvious reason. Events with ambiguous outcomes and contributing causes may cause clinicians and staff just as much stress and emotional turmoil as unfortunate events that are clearly understood. In general, it is a mistake to rely on assumptions about who may need emotional support and when it may be needed. Each individual’s needs will be different.

Adding further complexity to the responses to adverse events, there is tension in our current understanding of medical error, which underlies clinicians’ emotional experience of adverse events. On the one hand, it is now commonly accepted—per James Reason’s “Swiss cheese model” (2000)—that most preventable adverse medical events are caused by deficiencies of systems, not individuals. Latent errors and unreliable processes

Understanding intellectually that a system failure may have caused error and harm does not prevent clinicians from experiencing the emotional toll of an adverse event.

often contribute to harm at the “sharp end” of patient care. On the other hand, medical training continues to emphasize individual achievement and perfection, and most clinicians bring a strong sense of personal responsibility to their practice of medicine. Understanding intellectually that a system failure may have caused error and harm does not prevent clinicians from experiencing the emotional toll of an adverse event. Our medical and legal system has done very little until recently to help them process difficult events and restore their sense of personal and professional worth and balance.

Clinician Support in Published Literature

At first glance, awareness in published literature of the need for clinician support appears to loosely parallel the history of the patient safety movement, with roughly 20 years’ worth of published reports and pivotal works published in 1999 and 2000. A closer look reveals that the relatively small number of reports published about clinicians’ personal and emotional experiences following adverse events have prompted little organized response or change.

In 1999, the Institute of Medicine (IOM) released *To Err Is Human: Building a Safer Health System*, which attracted vigorous concern and interest from healthcare consumers and professionals alike. The report is often credited for launching the patient safety movement, and many other published reports and reflections quickly followed. A few months later, in March 2000, the BMJ published “Medical Error: The Second Victim. The Doctor Who Makes the Mistake Needs Help, Too” by Dr. Albert Wu. Wu’s editorial had modest impact compared with *To Err Is Human*, but it is now the most frequently cited article about the clinician’s experience of error. Wu coined the term “second victim,” which is used frequently to refer to clinicians who experience emotional distress following adverse events.

In the decade preceding publication of *To Err Is Human*, articles about medical error, such as Parts I and II of the “Results of the Harvard Medical Practice Study” (Brennan et al., 1991; Leape et al., 1991), “Error in Medicine” (Leape, 1994), appeared in medical jour-

nals, setting the stage for the IOM report in 1999.

On a smaller scale, articles about the effect of medical error on clinicians appeared sporadically in journals through the 1990s. One of the most dramatic stories, however, had appeared more than 10 years earlier. In January 1984, *The New England Journal of Medicine (NEJM)* published an essay by David Hilfiker, MD, in which he recounted an experience he’d had six years earlier, as a family physician with a busy practice in a small town in Minnesota. In “Facing Our Mistakes,” Hilfiker describes in searing detail an error he committed in 1978 that resulted in the mistaken termination of a 13-week pregnancy. The pregnant wife and her husband were friends as well as patients of Dr. Hilfiker. As soon as he understood the tragic error he had committed, he explained it to the couple, took full responsibility, and apologized. Hilfiker talked with colleagues and investigated what he had done wrong so as never to repeat the error. Despite having responded appropriately under dreadful circumstances, Hilfiker was unable to resolve the emotional, personal, and spiritual crisis brought on by this event. His distress was deepened by subsequent errors that, although less dramatic, reinforced his feelings of inadequacy, fear, and dread. In plain language, Hilfiker describes the dual effect of perfectionism and lack of emotional support in his practice of medicine:

...although I told them [the couple whose pregnancy was lost] everything they wanted to know and described to them as completely as I could what had happened, I never shared with them the agony that I underwent trying to deal with the reality of events. I never did ask their forgiveness.... Somehow, I felt it was my responsibility to deal with my guilt alone.

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We need to find healthy ways to deal with our emotional responses to those errors. Our profession is difficult enough without our having to wear the yoke of perfection... The medical profession simply seems to have no place for its mistakes.¹

In an interview in 1989 (*Second Opinion*), Hilfiker reported that his essay drew responses from individuals and the medical profession as a whole. A limited number of harsh letters were published in the *NEJM*, but

¹ Hilfiker left Minnesota 1985 for Washington, DC, where he worked at an inner-city clinic and helped found a home for homeless men with AIDS. No longer actively practicing medicine, Hilfiker promotes social justice through his writings and speaking engagements (www.davidhilfiker.com).

Hilfiker reports that he personally received “about 150 letters,” most expressing thanks for his having told his story and some relating their own experiences of error and preventable harm. In the 1989 interview, Hilfiker commented that the medical profession’s response, in general, had been to ignore his article. Although Hilfiker and others have articulated the need for support of clinicians, there has been little institutional recognition of that need until recently.

Recent research supports Hilfiker’s experience that the unresolved emotional aftermath of an error may increase the likelihood of further errors. In 2008, Schwappach and Boluarte reviewed the medical literature for evidence of the emotional impact of medical errors on physicians and their need for support. In addition to finding in West et al. (2006) a “reciprocal cycle of error involvement, emotional distress, and future errors,” the authors found apparent connections between caregiver support, positive learning environments, and incident reporting.

While not directly aimed to provide support to affected physicians, positive incident reporting behavior and attitudes towards communicating errors is a necessary condition for providing counseling and support to individuals touched by medical events....Some studies suggest that combining error reporting systems with emotional support systems increases reporting, but whether they also mitigate physicians’ emotional distress remains unclear.

Patient safety experts at the University of Missouri Healthcare (UMHC) also performed a literature review when they began to recognize “predictable patterns of behavior” that signaled distress among their nursing staff following adverse events. In “Sharing the Load of a Nurse ‘Second Victim,’” Scott, Hirschinger, and Cox (2008) describe their growing awareness of the problem and what they found (and didn’t find) in the literature.

Many professionals who make errors face this career-threatening phenomenon. However, we could find no nursing-specific studies to address interventions that would mitigate this personal trauma.

Following the literature review, they interviewed 31 nurses about their experiences and feelings following adverse events, including what if any steps they had taken to find help and support. The authors went on to develop a plan for institutional event response at UMHHC, including three levels of support for nurses: colleagues, department leaders, and other institutional resources. They have found that nurses at UMHHC prefer to talk about an adverse event with “a peer of similar training

and experience” and estimate that will be sufficient support for 60% of nurses.

The published literature about clinicians’ experiences following adverse events is rich in emotional observation and reflection. A handful of authors, such as Vincent, Delbanco, Bell, and Wu, have heightened our understanding of institutional and professional cultures that contribute to this problem.

A few articles, such as “Sharing the Load of a Nurse ‘Second Victim,’” describe the design and implementation of programs, but in general, there is a limited amount of published guidance, with very little data, for institutions in the process of creating support programs. Dr. Rick van Pelt has described one institution’s program of clinician support, including how and why that program was developed. van Pelt was the anesthesiologist involved in Linda Kenney’s ankle surgery and adverse event in 1999. Following his experience of the hospital’s dysfunctional response and lack of support (for Linda and himself), he was instrumental in developing the Peer Support Service at Brigham and Women’s Hospital in Boston and served as a founding Board member for MITSS. In “Peer Support: Healthcare Professionals Supporting Each Other After Adverse Medical Events,” van Pelt (2008) describes the program, the adverse event, and his emotional experience in its aftermath:

I was now forced to confront my own emotional distress and I realised my complete lack of training in how to manage this situation. In an instant, the years of clinical training, my board certification and the respect of my colleagues as a competent anaesthesiologist had become irrelevant and meaningless. I felt lost and alone.

Part II: Successes, Barriers, and Opportunities

Following introductory remarks, attendees of the MITSS Forum in March heard presentations given by directors of two established and successful programs, which represent different approaches to providing clinician support.

Kaiser Permanente has a well-developed program of support for employees following adverse events, which was launched in 2004 under the auspices of an existing employee assistance program (EAP). Jerry O’Keefe, national director of the EAP, described Kaiser’s dedication to supporting its workforce, its operational response to adverse events, and the rationale or return-on-investment that supports Kaiser’s significant commitment to

the program. (O’Keefe’s presentation is summarized in Appendix I, page 13.)

Children’s Hospital Boston has had an Office of Clinician Support (OCS) also since 2004. David DeMaso, MD, is psychiatrist-in-chief at Children’s and director of the OCS, which helps clinicians with emotional problems related to their professional or personal lives. The OCS operates on a mental health model and collaborates with Children’s EAP and peer support programs, as well as the patient safety and quality departments. (DeMaso’s presentation is summarized in Appendix II, page 15.)

Reports from the Front Lines

Following the presentations, attendees gathered in small groups to discuss the current state of clinician support in their own institutions and to identify successes, barriers, and opportunities for further development of these programs. Comments from the small groups were recorded and reported to the Forum for discussion.

Successes

The groups found successes to celebrate, though awareness of the need for clinician support is nascent, and there are not many fully developed programs. The groups acknowledged that there is evidence of support for these programs from some institutions, including insurers. There are some “early adopters” that offer successful examples, such as Brigham & Women’s Hospital in Boston, University of Missouri Healthcare, as well as Children’s Hospital Boston and Kaiser Permanente in California. Jim Conway, senior vice president at the Institute for Healthcare Improvement, MITSS Board member, and facilitator of this session, estimated that there are currently no more than 10 programs of clinician support in the United States. These examples offer very different models and show a high level of innovation in responding to the needs of staff.

MITSS was identified as a non-provider organization that offers a model for successful programs. The response to MITSS’s invitation to participate in the Forum and the dedication and enthusiasm of participants was seen as a hopeful sign of the relevance and timeliness of the topic. The Forum itself is evidence of the potential for different stakeholders—in this case, an advocacy and support group (MITSS), a state medical society (MSS), and two medical-malpractice insurers (CRICO/RMF and ProMutual Group)—to work together to advance clinician support programs.

Institutional acceptance and implementation of disclosure and apology policies indicate leadership buy-in for programs that many see as related to clinician support.

Current literature offers some evidence documenting the need for emotional support of clinicians and others following adverse events.

Barriers

Forum attendees identified many current barriers to advancing support programs for clinicians. Education and professional training of nurses and especially physicians fosters perfectionism, which makes it difficult to admit mistakes and ask for help. That dynamic contributes to a common view that use of EAP services is a sign of weakness.

Clinicians who are isolated from their peers by the tradition of “siloes” medical practice and dysfunctional dynamics within clinical teams will also find it difficult to engage with their peers to offer or receive emotional support.

There are still more barriers to overcome for clinicians who do recognize that they need help and want to reach out: fear of litigation and discovery, lack of clarity about what is appropriate to discuss and with whom, and persistent cultures of “shame and blame” around adverse events.

Clinicians often feel pressured to continue to produce at the highest level possible and hesitate to devote time to their own needs. At many institutions, executive leaders emphasize financial success, with priority given to hard-money return on investment (ROI). It takes some creativity to articulate the ROI of clinician support programs. If this can be seen as a movement, it is at an early stage of development, without clear best practices or supporting data.

Fear of legal action is the most commonly cited barrier in discussions of response to adverse medical events. Paul McTague, Esq., partner at Martin, Magnuson, McCarthy & Kenney in Boston, gave a presentation at the Forum about the legal ramifications of clinician support programs, which included a lively question-and-answer period with participants. His remarks are summarized in the sidebar on page 8.

Clinicians often feel pressured to continue to produce at the highest level possible and hesitate to devote time to their own needs.

Legal Ramifications of Clinician Support Programs

Fear of legal action and our malpractice system are the most frequently cited barriers to offering clinicians support following adverse events. Paul M. McTague, Esq., a partner at Martin, Magnuson, McCarthy & Kenney in Boston, told the group that, historically, clinicians were advised not to talk with anyone except their attorneys following adverse events. McTague referred to that belief and to the impression that the legal system is a formidable barrier as “myths.” He went on to describe circumstances in which clinicians can turn to colleagues and others for support without fear of disclosure and concern for liability. Understanding the context and intent of the conversation is important. Clinicians may talk with anyone, including colleagues, about their *feel-*

Clinicians may talk with anyone, including colleagues, about their feelings following an event or during the course of defending lawsuits.

ings following an event or during the course of defending lawsuits. It’s fine for a clinician to discuss the effect the event is having on him or her, what it feels like to be sued, and other emotional aspects of the experience, which would be central to offering or receiving support.

McTague advises clinicians, however, to avoid discussion of the details of the medical case and the event, with special care taken to avoid offering or soliciting opinions and judgments about the

particulars of what happened. Discussion of those details should take place only in circumstances that are “privileged,” which is to say that the content of the discussion will not be “discoverable” (revealed to the plaintiff and used in court) by the plaintiff’s attorneys. Peer Review and Morbidity and Mortality Conferences of adverse events are privileged by statute. Any conversation that takes place between a clinician and his or her attorney is privileged. Other conversations enjoy protection from discovery: for example, with members of the clergy and licensed mental health professionals. Conversation with the institution’s risk management staff is protected to a great degree by the Commonwealth (of Massachusetts) Peer Review Statute, and conversations with the insurer’s claims representatives enjoy protection, although there is no definitive case law in this Commonwealth. Further, conversations with your spouse are “protected.” Technically, in Massachusetts, these conversations are “disqualified,” which is less protected than “privileged,” with legal details varying from state to state. McTague reported that he has never seen the discoverability of a disqualified conversation challenged in court.

Discussion following McTague’s presentation revealed the level of care that must be taken in navigating legal liability, especially by colleagues who offer peer support. For example, a physician who is currently in charge of a program that trains clinicians to coach each other through disclosure conversations wanted to know how to handle a particular question that patients and families sometimes ask physicians following an adverse event: “Could you have done anything differently?” After saying that this “hindsight” question is often unfair, McTague explained that circumstances indicate different possible answers. If the outcome was undesirable but within the range of possibilities discussed with the patient during informed consent, the conversation may be challenging but straightforward. If the outcome was not anticipated or possibly the result of an error, it is crucial to be honest and forthcoming with the patient and family without taking responsibility for more than is known at the time. In addition to mental clarity about events that frequently are complex, being truthful and compassionate in these conversations requires emotional sophistication and fortitude, which is further evidence of the need for clinician support programs.

McTague commented that lawyers have a unique opportunity to witness the impact of adverse events and legal action on clinicians. He has seen the emotional and physical toll taken on his clients and the damage to professional confidence and self-image that may also result from extended periods of stress.

Opportunities

Working with examples of successful programs and clearly identified barriers, participants were able to identify numerous opportunities to advance support programs. Because not much work has been done in this area, there is great opportunity for creative, innovative solutions with participation from diverse stakeholders including non-clinical staff members and patients. Clinician support programs have potential to improve communication and collegiality in general, not just in times of crisis, and to contribute significantly to improving the culture within an institution.

Participants identified opportune moments for introducing support programs, such as during medical school and clinical training, as well as orientation for new employees. Change can also be leveraged by regulation, accreditation, and licensure requirements, though some warned against diluting the importance of clinician support by having it become just “one more thing” on an ever-growing list of regulatory requirements.

Current successes and resources offer opportunities to contribute by sharing stories through publication and presentations. Other opportunities include dissemination of the video about clinician support that CRICO/RMF currently has in production and the development of research programs, for example, at the Lucian Leape Institute of the National Patient Safety Foundation. There is need and opportunity for development of a toolkit (for which the Massachusetts Coalition for the Prevention of Medical Errors offers a model) that would help institutions create their own programs.

The challenge of implementation was identified as an additional barrier: presentations about successful programs don't necessarily equip the audience with practical guidance for the design and implementation of new programs in their own institutions. This need for local solutions—not standardized, “one size fits all” programs for clinician support—appeared on all three lists, as a success, barrier, and opportunity. The programs at Children's Hospital Boston and Kaiser Permanente are very different examples of successful programs that developed organically, reflecting the needs, resources, and cultures of each institution. Other institutions may find those examples and stories inspiring and helpful. Where there is opportunity for success, however, there is also opportunity for failure. The challenge involved in creating an original, authentic program to address a complex problem should not be underestimated. And finally, because these are uncharted waters, there is an opportunity for innovative institutions to lead on this issue, to set a course, establish an agenda, and accelerate the rate of change.

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Part III: Questions and Conclusions

The discussion of successes, barriers, and opportunities revealed a number of questions to be addressed as this work continues, which were identified in closing by Saul Weingart, MD, vice president of patient safety at Dana-Farber Cancer Institute in Boston. He commented that most if not all of these questions require answers based on local conditions at each institution.

What are the triggers for clinician support?

There are many possible entry points to support programs, in terms of personnel and timing. As they develop, programs will have to decide how reactive or proactive to be. Do you wait for clinicians to self-initiate and present themselves at the EAP door? That's the traditional model. It's a shift of mindset to offer services—to go looking for cases—as opposed to being invited in. Also, when is peer support appropriate versus professional mental health support? How is that choice evaluated? Who decides?

Do you target the individual or the team?

Does targeting both make sense?

Many physicians are reluctant to use services that are offered broadly to staff in the institution. Should institutions therefore provide physician-specific programs? On the other hand, support staff, including housekeepers, may experience emotional turmoil brought on by adverse events but may be overlooked by those offering emotional support for clinical staff.

Should support programs be selective about the circumstances they address?

Should institutions provide emotional support services for family crises, substance abuse, and general work-related stress in the same program that addresses patient safety events? Is there overlap for these services? Developing a comprehensive program may draw additional

resources, but may also dilute the focus on patient safety incidents, which require a targeted response.

Suffering leads to learning, but how much is too much?

Albert Wu, MD, has observed that clinicians who experience emotional stress after adverse events learn from them and change their behavior accordingly. Is some distress good? How much? We want clinicians to take responsibility and feel some pain in some circumstances, but often the pain is disproportionate to the learning. How do we learn to balance personal responsibility and provide healing interventions so clinicians can perform most effectively?

How do you make a business case for clinician support?

It's important to find ways to make this need "real" to the C-suite in each institution, through the use of storytelling, testimonials, and data whenever possible. Effects of emotional distress on clinicians may include absenteeism, team dysfunction, increased medical errors, and increased turnover. In short, the business case is that an institution's workforce is its most valuable asset and is worth supporting with services. There is growing interest in the connection between patient and physician satisfaction and profitability, which may offer data to support the business case.

Moving Forward

Although the Forum did not discover existing best practices for clinician support, a number of important take-aways emerged:

- **Local solutions.** Clinician support requires local solutions tailored to an institution's prevailing culture. Following the presentations by Jerry O'Keefe and David DeMaso, Jim Conway commented that the programs at Kaiser and Children's represent "different models, what IHI would call 'test of change.'" He went on to say that this work "engages both the heart and the mind. At the end of the day, we need to know how to take what we have learned and apply it 'back at the ranch.' In early times of change, situation and context are unbelievably important."

- **Peer support.** Anecdotal reports and published literature indicate that peer support is crucial when things go wrong. Clinicians who have personal experience coping with an adverse event, good communication skills, and are liked and respected by their peers, are valuable resources. They will benefit from training, but should be part of all clinician support programs.

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- **Collateral benefits.** The benefits of providing clinicians and other staff members with emotional support following adverse events extend beyond immediate circumstances. Collateral benefits include better communication with colleagues, patients, and families; improved staff satisfaction; and increased willingness to report errors.

- **The business case.** An institution that tends to the emotional needs of clinicians and staff members following adverse events is protecting its most valuable investment, its workforce, comprising all the men and women who provide direct patient care and other important services.

Turning Point

MITSS believes that the experience of clinicians and staff following adverse events is an issue that has been simmering beneath the surface of other discussions for many years. The success of the Forum seems to be a turning point, indicating increasing resolve among institutions and individuals to address this problem and create solutions.

Looking forward to continuing to support clinicians as well as patients and families, MITSS President Linda Kenney comments,

Given the current level of interest and number of institutions we see entering the discussion, we believe that progress on this issue is accelerating. Best practices will begin to emerge but may not be established for five years or more. In the meantime, institutions need to assess their readiness for this work and begin to develop programs. MITSS has the expertise, tools, and resources to help. We are proud of our strategic leadership on this issue, beginning with the Forum in 2004, continuing with the Forum in March, and look forward to helping institutions and individuals make real progress in the near future.

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APPENDIX I

The Program for Clinician Support at Kaiser Permanente

Kaiser Permanente, the nation's largest integrated health system, has had a program in place since 2004 for support of clinicians and staff following adverse events. Jerry O'Keefe, national director of Kaiser's employee assistance program (EAP), describes how the support program is woven into Kaiser's culture, saying, "We can't afford not to do it; it's the right thing to do; it's expected; we've created a culture that believes in it." In addition to critical event response, the program encompasses outreach, training, and pre-event simulation and is supported by a strong business case.

Kaiser initiated the program as part of its response to the Institute of Medicine's report about medical error, *To Err Is Human: Building a Safer Health System* (2000). Kaiser recognized that supporting its most valuable resource—providers and staff members—would potentially help reduce medial errors, improve the quality of care, increase productivity, and foster goodwill, trust, and appreciation. The program is aligned with Kaiser's commitment to sustaining a healthy workforce and helps fulfill a state mandate in California to attend to physician well-being. Receiving support for their emotional needs helps providers and staff members restore their professional confidence following a crisis and return to productive work more quickly and effectively than if they were left to suffer on their own.

Teams and departments also work better in a culture that includes this kind of employee assistance. O'Keefe observes that the aftermath of critical incidents and adverse outcomes can "shine a bright light on pre-existing circumstances" in a department or among care team members, revealing past grievances, anger, and frustration. Pre-event training, which includes simulation of adverse events and emotional reactions, and post-event support help resolve conflict and lead to better communication and performance.

Enhanced productivity of individuals and teams, and improved employee satisfaction and retention all help make the business case for this program.

Kaiser's program enjoys the support of executive and departmental leadership in addition to other powerful stakeholders such as labor. Labor unions are crucial supporters, as 75% of Kaiser Permanente employees are unionized, including all nurses. The

EAP works actively to sustain the support of these groups and individuals by continually reaching out with targeted information, training, and evaluation. Constant communication keeps the program relevant and top-of-mind. According to O'Keefe, "A constant finger on the pulse sustains culture change." The program also maintains its status by being written in to the policy and procedures for adverse event response.

O'Keefe describes the EAP's work in this area as managing and reconciling the "art and science" of critical event response. The science involves being clear with providers about discoverability and steering them to safe and appropriate outlets for discussion of the facts of an event: risk management, quality, medical/legal, ombudsmen, defense counsel, spouses, and domestic partners. The art lies in helping individuals evaluate and process their reactions as well as identifying individuals who may be in need but not seeking help. Anticipating problems and reaching out to individuals is different from the traditional role the EAP, but Kaiser has found

Kaiser's program enjoys the support of executive and departmental leadership in addition to other powerful stakeholders such as labor.

it to be important in adverse event response. O’Keefe says, “We don’t want to take the chance that we’ll miss something, that someone will be left alone.”

When an adverse event occurs, Kaiser’s Situation Management Team leads all aspects of the response and contacts the EAP. Before working directly with members of the care team, EAP staff members work behind the scene to learn as much about the event and individuals’ circumstances as possible to provide context. O’Keefe comments that some of the information gathering may seem excessive at the time, but allows the EAP to be most effective in its work. In collaboration with managers and the Situation Management Team, the EAP considers possible effects on all staff working on all shifts and provides appropriate interventions and follow-up. The EAP has a “best case” plan for providing support, but stays flexible about logistics, adapting to immediate circumstances and the needs of individuals.

Kaiser’s EAP also takes a flexible approach to the kinds of support it provides. The EAP has a targeted assistance program for physicians and also helps nurses with peer support by supplying guidance, consultation and direction, in addition to debriefing, one-on-one counseling, referral, and coordination with the institution’s chaplaincy and social services.

Kaiser’s approach to employee support includes honoring the individual’s perception of an event. What constitutes an adverse outcome or critical event is not

the same for everyone, and reactions will be highly individual. Caregivers and staff members who were not directly involved may still feel ripple effects from an adverse event. Similarly, different kinds of events—adverse clinical events, intense regulatory scrutiny, negative media exposure, and others—may cause anxiety and the need for support.

Kaiser’s EAP has learned valuable lessons during its five years of supporting clinicians and staff members after critical events. O’Keefe recommends careful planning in the early stages of program development, securing leadership support at all levels, and clarifying the roles of responders prior to rolling out the program. EAPs need to stay flexible and partner closely with the risk and quality departments. In addition to vigilance and outreach, it is important to follow up periodically with partners, providers, and staff members even after an event is considered closed.

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APPENDIX II

The Program for Clinician Support at Children's Hospital Boston

The Office of Clinician Support (OCS) at Children's Hospital Boston is a free, on-site service, available to anyone at Children's who does clinical work with patients, for help with any problem they may be having, whether it is work-related or personal. Dr. David DeMaso, psychiatrist-in-chief and chairman of psychiatry at Children's, has been head of the OCS since the program began in 2004. The OCS evolved from earlier programs as DeMaso, who started at Children's as consulting psychiatrist to the medical service, found himself called upon to provide broader services to groups of clinicians as well as individuals. That evolved into the Office of Physician Support and then the OCS, which was part of Children's response to a significant adverse event. The OCS has broad responsibility and works together with Children's employee assistance program (EAP), various sources of peer support, and other hospital departments, especially quality, patient safety, and legal services.

The premise of Children's OCS is that stress and burnout lead to suboptimal attitudes and practices, which compromise patient care and sometimes patient safety. The OCS offers proactive training and support to decrease stress and improve patient care. DeMaso believes that self-understanding promotes resiliency. He observes, "Too often in medical settings, people seek quick solutions before they really understand what is going on. The premise of a lot of what we do [at the OCS] is to help people understand what they're facing."

The OCS is a safe place where clinicians can voice concerns, organize and evaluate their thoughts, assess their feelings, and reach decisions. This work is done in the context of self-awareness, transparency, and problem-solving. As they listen to individuals who come for help, DeMaso and his colleague, Linda Coyne, RN, MSW, listen also for trends indicating larger problems that may have impact on patient care and the culture within the hospital.

Clinicians who come to the OCS for help relative to adverse events come with different mind sets, from certainty that they have committed an error that caused harm, to ambiguity about what role they played in an event, to doubts about what may or may not have been a preventable outcome. DeMaso

emphasizes the importance of understanding the context for all of these circumstances. The work environment at Children's is high volume, high tech, and high demand. Recent budget reductions have increased pressure on clinicians to do more with less. Their patients tend to be extremely sick, and parents are often highly stressed and frightened. The environment has lots of safety and quality requirements. Clinicians working in this environment tend to be altruistic high-achievers who have high expectations for their own performance and a deep sense of responsibility for the well being of patients and families. An adverse event will often cause these clinicians to doubt their practice, fear losing their job or license, fear facing legal actions, and dread losing the respect of their peers.

When dealing with the aftermath of an actual adverse event, DeMaso and Coyne watch for symptoms in individuals who were in close proximity to the event as well as those involved indirectly. DeMaso describes what he often sees in these circumstances as traumatic stress

The Office of Clinician Support is a safe place where clinicians can voice concerns, organize and evaluate their thoughts, assess their feelings, and reach decisions. This work is done in the context of self-awareness, transparency, and problem-solving.

symptoms: numbness, intrusiveness, and hyper-arousal.

DeMaso and Coyne are also alert to the “re-traumatizing” effect of debriefing and investigation. Regardless of how supportive and nice the investigators may be, the process of reliving the effect, sometimes repeatedly, may contribute to a post-traumatic stress response.

DeMaso reports that the beneficial effects of peer support can’t be over-estimated. He describes the power of what he calls the “modeling surprise,” when a colleague, especially in a position of power, shares his or her own story of error or adverse outcome with a clinician dealing with a recent event. For each clinician involved, telling his or her own story and examining all contributing factors can help develop understanding and, in time, resiliency. In addition to simply listening, counselors can help by correcting cognitive distortions, either in individual sessions or during group interventions.

Peer support can take many forms. At Children’s, Collaborative Office Rounds offer peer support in the course of discussing cases on a regular basis with a pediatrician and child psychiatrist as facilitators. Two of these groups at Children’s have been meeting for 20 years, which seems to require consistent leadership within the group. DeMaso points out that other triggers for meetings, such as the Joint Commission requirement for team meetings, offer opportunities for collaboration and support. Even if the meeting is only 10 minutes long, it’s an opportunity for peer engagement.

The OCS has worked with others at Children’s to help clinicians develop knowledge and resilience proactively, without reference to a specific event. Simulation training programs prepare clinicians to act as coaches for their peers when bad things happen. For this program, Children’s Institute for Professionalism and Ethical

For each clinician involved, telling his or her own story and examining all contributing factors can help develop understanding and, in time, resiliency.

Practice has developed specific scenarios and hires professional actors to play the roles of patients and families, improvising as clinicians react spontaneously to events in the scenarios. The OCS facilitates numerous support groups and educational programs for specific needs and to enhance collaboration and communication while reducing stress in the work environment. On a number of occasions, the OCS has provided consultation and coaching regarding difficult personnel and systems issues that impact adversely on program management, staff morale, and patient care.

The OCS at Children’s has surveyed its clients about satisfaction with their office visits in 2005, 2006, and 2008. With an overall 36% response rate, the OCS has seen improvement since 2005 and mean scores in 2008 of 95 to 100 on a 100-point scale. The single question that received a lesser score—of 84.80—asked if clients experienced reduced stress after consultation. DeMaso comments that many problems can’t be fixed quickly or completely. He points out, “You can’t get rid of all your stress, but even a few minutes of support can help reduce it. That kind of outreach can begin to change the culture. It can help people be more alert and work together. It can help banish the ‘cone of silence’ that’s been true for a long time. This is just one example of one program that can be helpful. OCS can be a first step.”

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Medically Induced Trauma Support Services, Inc.

830 Boylston Street, Suite 206, Chestnut Hill MA 02467

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