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How to Critically Evaluate a Complication and Learn From It

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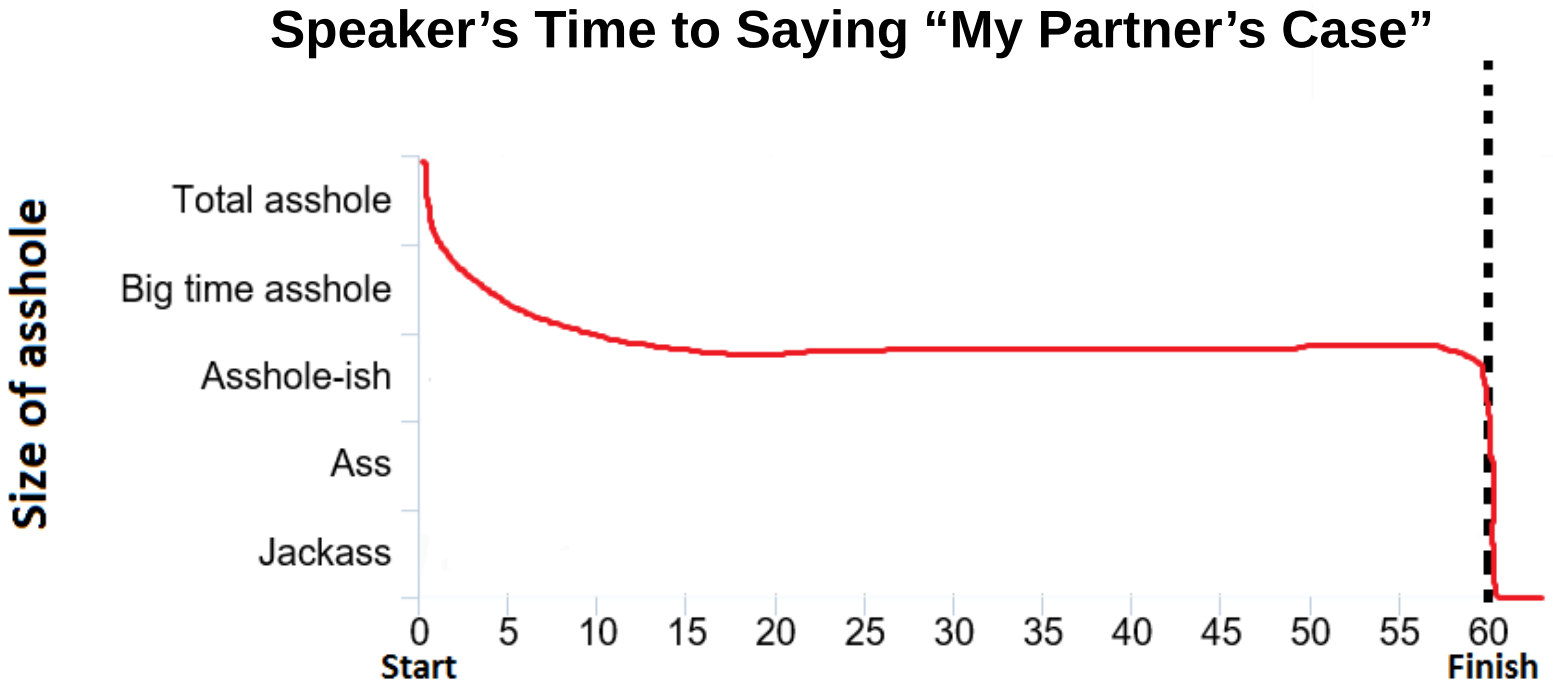
"The drastic consequences of our mistakes, the repeated opportunities to make them, the uncertainty about our own culpability when results are poor, and the medical and societal denial that mistakes must happen all result in an intolerable paradox for the physician."

Hilfiker D. Facing our mistakes. N Engl J Med 1984;310:118-22.

Talking About Complications…



Adapted from Billy Nichols' Slide (who probably took it from someone else)

Talking Honestly about Errors Improves Job Satisfaction

ELSEVIER

Patient Education and Counseling

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The role of talking (and keeping silent) in physician coping with medical error: A qualitative study

Natalie May, Margaret Plews-Ogan

"Don't tell your problems to people: eighty percent don't care; and the other twenty percent are glad you have them"

- Lou Holtz

Conversations on Complications

o Post-scripts to admissions of error:

Substrate is everything

It's a numbers' game

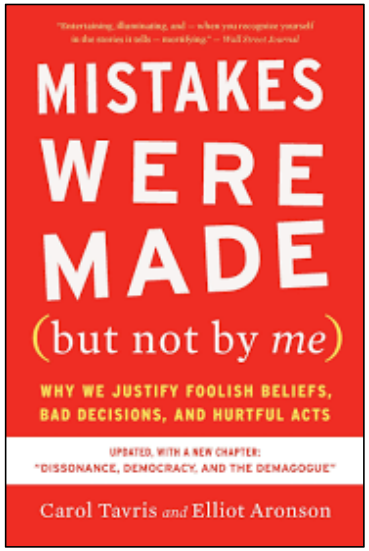
Act of God

No choice

Cognitive Dissonance

Unpleasant feeling when you hold two views that do not align

– e.g. ‘I am good at my job’ and ‘I made a bad mistake’



“The more costly a decision in terms of time, money, effort or inconvenience and the more irrevocable its consequences, the greater the dissonance and the greater the need to reduce it by overemphasizing the good things about the choice made.”

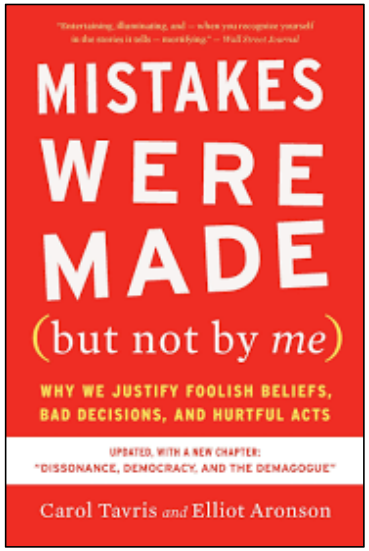
“Most people, when directly confronted by evidence that they are wrong, do not change their point of view or plan of action but justify it even more tenaciously”

Cognitive Dissonance

"The ability to reduce dissonance helps us in countless ways, preserving our beliefs, confidence, decisions, self-esteem & well-being."

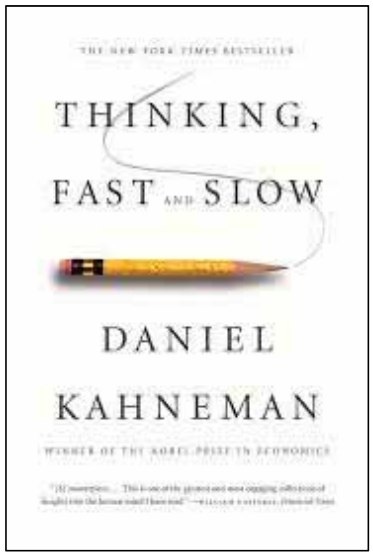
But

"…the pain that people feel when they cannot allow self-justification to erase the memory of the harms they caused, the mistakes they made, the decisions that backfired; that inability to let go can leave an indelible mark of regret and guilt, in extreme cases leading to despair, depression or alcoholism."



Engaging with your own systemic bias(es)

o Heuristics = enabling someone to discover for themselves (roughly translated to a rule of thumb based on our past experiences). Quick & often wrong



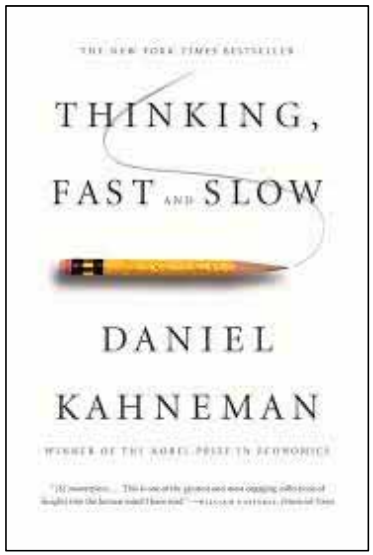
Example:

- Availability heuristic – the relative importance of an issue judged by how easy it is to recall

How We Think:

System 1:
Operates automatically & quickly with little effort and generally involuntarily. Originates impressions & feelings. Prolonged practice creates system 1 skills.

System 2:
Allocates attention to effortful mental activity when needed. Organizes ideas from system 1. Also, how we think of ourselves.



Can do multiple at once: talk & drive on familiar roads

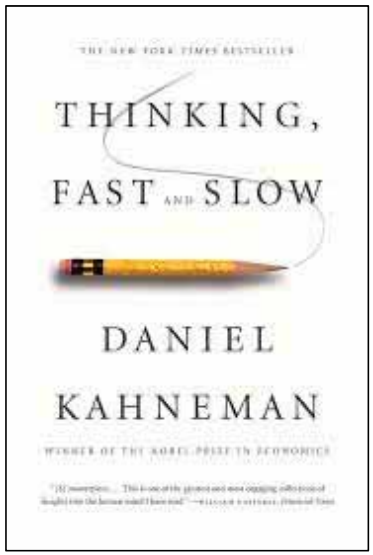
Can only perform one effortful activity at a time; hence, can be blinding.

How We Think:

System 1:

System 2:

Explains the value of purposeful practice and visualization exercises



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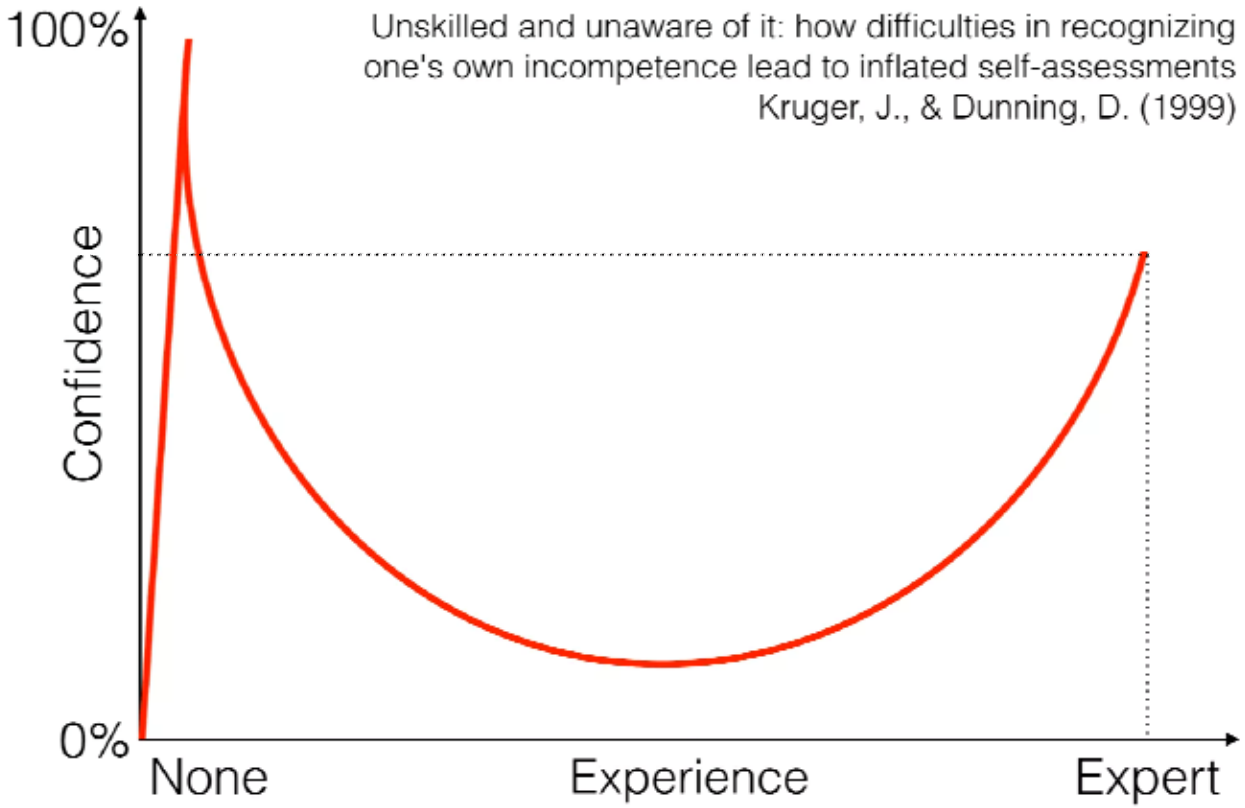
Dunning-Kruger Effect

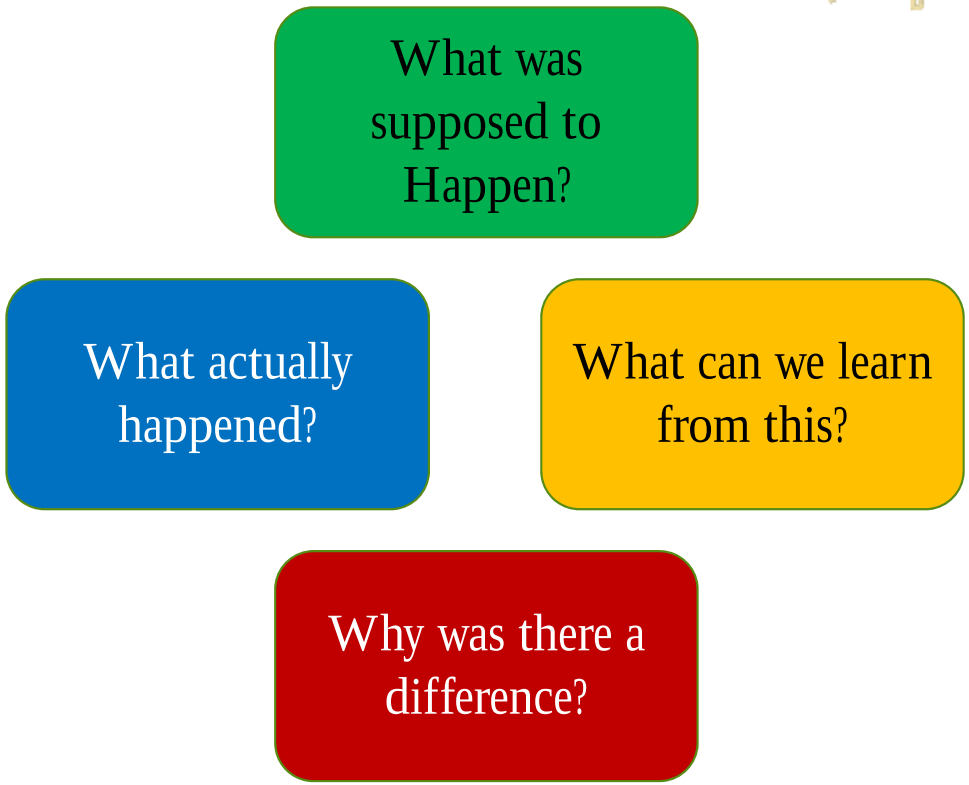


Moving Forward:

“An error does not become a mistake until you refuse to correct it…”

John F. Kennedy

What is After Action Review?



Participate in Building a Culture You Want

o Admit failures / mistakes / errors / complications. Particularly to patients and family

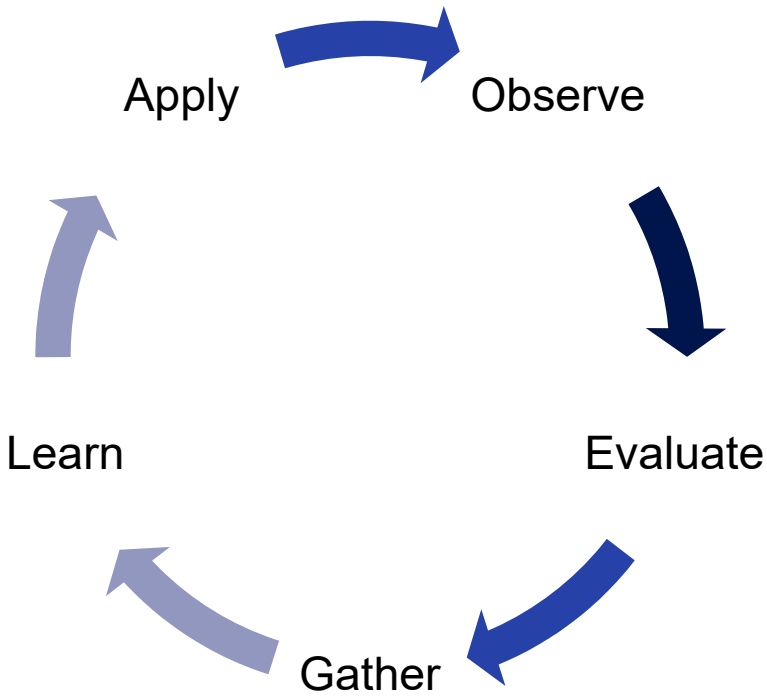
o Trust colleagues to listen & help and do the same in return.

o Acknowledge dissonance to move past it

"When a friend makes a mistake, the friend remains a friend and the mistake remains a mistake."

-Shimon Peres of Israel speaking about a decision by Ronald Reagan

Plan ahead, run drills, debrief, repeat



Build Kits in Portable Containers to Centralize

Slow is smooth & smooth is fast. Be Prepared

Coronary Disaster Kit	MCS Kit	Access Disaster Kit
1. Pericardiocentesis tray, coils, 2. mircocatheters, 3. plugs, 4. covered stents, 5. snares, 6. 3.0 & 4.0 compliant balloons, 7. perfusion balloons (when available), 8. +/- thrombin 9. +/- Adsons (for fat extraction)	1. Stiff wire(s), 2. dilator kits, 3. pigtail catheter, 4. 0.018” spring coiled ≥ 260 cm wire, 5. 16/18 Fem flex, 6. braided 6 & 8 Fr Sheath, 7. 12” tubing, 8. male to male connector, 9. ‘turkey baster’, 10. basic instruments (heavy needle driver, 4 clamps, pickups), 11. ‘up & over’ catheter,	1. 'Up & Over” Catheter 2. 7Fr glideslender sheath, 3. Glide wire/GlideAdvantage wire, 4. Stiff wire, 5. 0.018” spring coiled wire, 6. 6-8Fr Ansel or similar, 7. Coda balloon, 8. 6/8/10 mm Peripheral balloons 9. 6-9 x 25 mm Viabhan (0.018” platform) 10. +/- 8-12 mm VBX

Summary - CASTLE

- **C**are for the patient first
- **A**dmit to the error
- **S**earch for ways to improve
- **T**alk with trusted colleagues
- **L**earn to live with it (‘Let it go’, if you prefer)
- **E**ducate others

- Fully admitted mistake at the time and provided a complete report on her mistake.
- Her report was quoted by the prosecution in closing arguments
- Found guilty of criminally negligent homicide & gross neglect.
- Sentenced to 3 years probation.

Thanks

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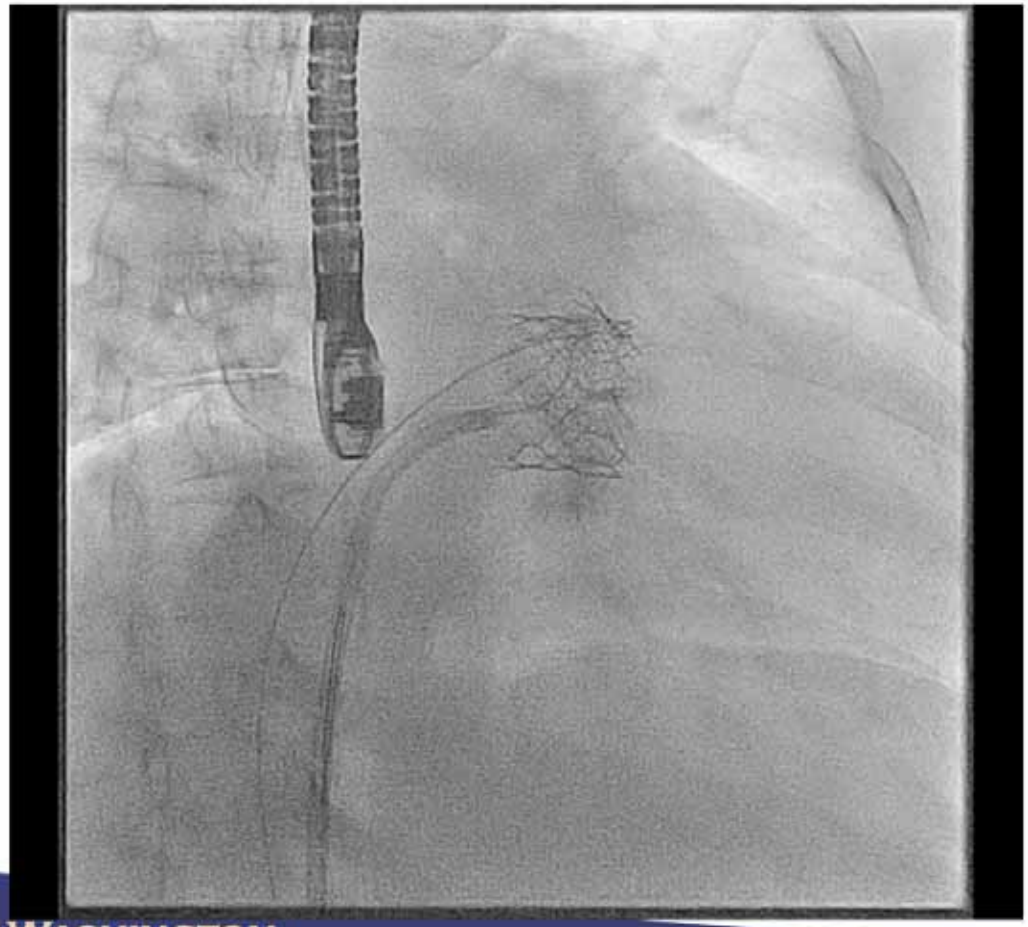
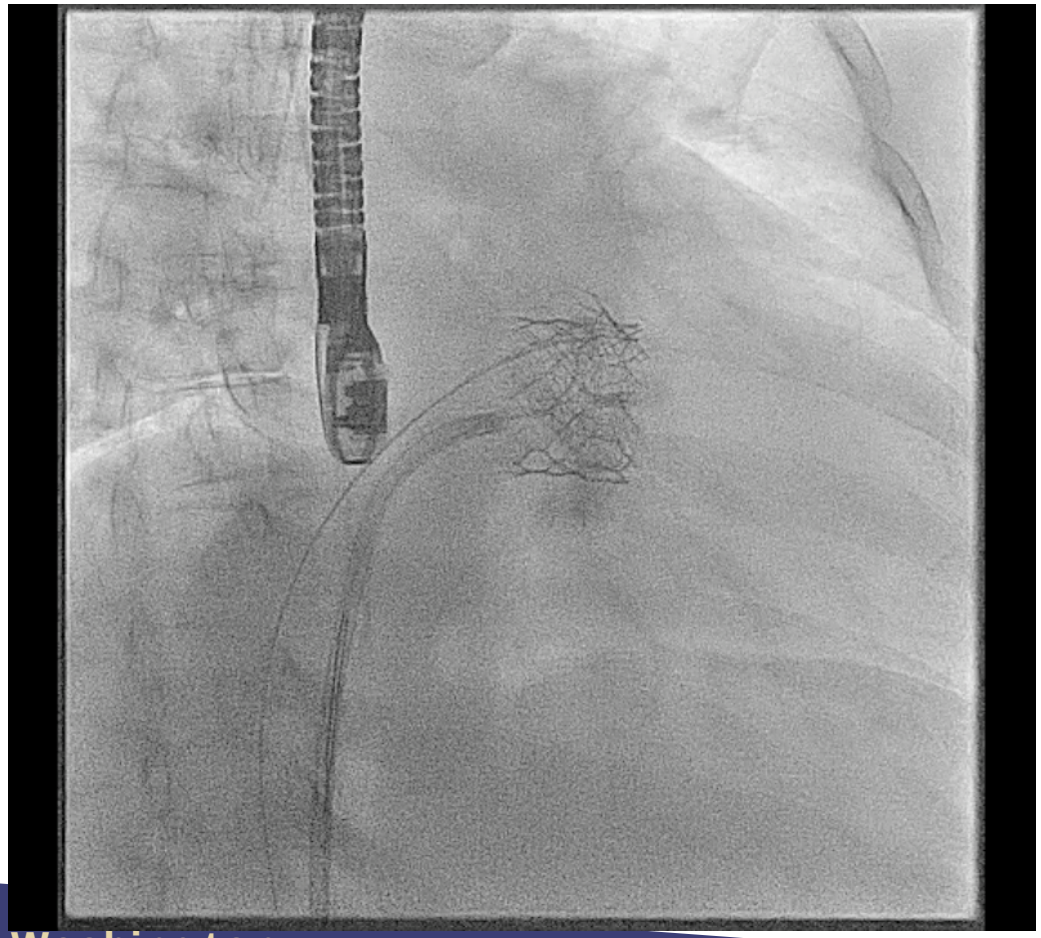
Obligatory Disaster Porn: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