Why Patient Advocacy is Hurting Patients

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Thinking Exercise #1:

“The Nurse as the Patient’s Advocate”

1. Take 1 minute.
2. On a blank piece of paper, write about a time from your own practice when you felt you exemplified being the patient’s advocate.
   • What was the situation?
   • Were other clinicians involved?
   • In what ways?
   • What was the outcome?

NY Times 2013

March 16, 2013
Theresa Brown, RN

“This particular doctor was known for his explosive impatience. On a good day his temper simmered just below the surface. On a bad day, he openly seethed.”

408 comments

Nursing Ethics: A Short History

- Nurse as the Virtuous Person (ie, Woman)
- Nurse as the Loyal Soldier
  (with the Physician as Captain of the Ship)
- Nurse as the Patient Advocate
- Nurse as ... ?????

Acknowledgements

Rheba deTornyay
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Anna M. Shannon
Al Jonsen
The Nurse as Patient Advocate


Deluge!


IOM Report 1999: To Err is Human

- 45,000 chart reviews done in 1997 – extrapolated to US
- 44,000–98,000 annual deaths as a result of medication errors - 8th leading cause of death
- Medical errors are the leading cause, followed by surgical mistakes and complications
- More Americans die from medical errors than from breast cancer, AIDS, or car accidents
- 7% of hospital patients experience a serious medication error

Cost associated with medical errors is $8–29 billion annually

1999 Institute of Medicine Report

November, 1999

"approximately 100,000 patients die in the hospital each year from medical errors and 72% resulted from communication errors"

Report lays out a comprehensive strategy by which government, health care providers, industry, and consumers can reduce preventable medical errors. Concludes that the know-how already exists to prevent many of the mistakes, the report sets a minimum goal of 50% reduction in errors over next five years.

JCAHO Sentinel Events

HealthGrades Quality Study 2004

- Applied AHRQ (Agency for Healthcare Research & Quality) Patient Safety Indicator software to Medicare data
- 37 million Medicare discharges in 2000-2002
- Extrapolated to all discharges from every hospital in U.S. (excluding OB):
  - $6.3 billion annually in excess costs
  - 191,000 preventable deaths each year from patient safety incidents
ED Teamwork Failures

- Retrospective analysis of 54 large closed-claims cases from emergency depts within 8 hospitals
- Communication / teamwork failures were major cause of adverse events in 80%


Communication Failures

- Confidential interviews with 38 randomly selected surgeons in 3 teaching hospitals to elicit detailed reports on surgical adverse events resulting from errors in management
- Communication breakdowns among personnel were a major contributing factor in 43% of adverse surgical events


Errors by Type of Adverse Drug Event (ADE) and Stage of Drug Ordering and Delivery

<table>
<thead>
<tr>
<th></th>
<th>MD Ordering</th>
<th>Transcription &amp; Verification</th>
<th>Pharmacy Dispensing</th>
<th>RN Administration</th>
<th>ALL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventable ADEs</td>
<td>41 (32%)</td>
<td>2 (5%)</td>
<td>4 (11%)</td>
<td>40 (32%)</td>
<td>87  (26%)</td>
</tr>
<tr>
<td>Potential ADEs, nonintercepted</td>
<td>26 (20%)</td>
<td>25 (63%)</td>
<td>21 (55%)</td>
<td>84 (67%)</td>
<td>156 (47%)</td>
</tr>
<tr>
<td>Potential ADEs, intercepted</td>
<td>63 (48%)</td>
<td>13 (33%)</td>
<td>12 (34%)</td>
<td>2 (2%)</td>
<td>91  (27%)</td>
</tr>
<tr>
<td>Totals</td>
<td>130 (100%)</td>
<td>40 (100%)</td>
<td>38 (100%)</td>
<td>126 (100%)</td>
<td>334 (100%)</td>
</tr>
<tr>
<td>% by stage</td>
<td>39%</td>
<td>12%</td>
<td>11%</td>
<td>38%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Perceptions of Inappropriate ICU Care

- Cross-sectional design
- 82 adult ICUs in 9 European countries and Israel
- 1,953 ICU nurses and MDs
- Examined perceived inappropriateness of care = specific pt care situation in which clinician acts in a manner contrary to his or her personal or professional beliefs
- 27% reported perceived inappropriate care (usually “too much care”)  
- Perceptions of inappropriate ICU care were inversely associated with factors indicating good teamwork


Perceptions of Inappropriate ICU Care

<table>
<thead>
<tr>
<th>Factors</th>
<th>OR (95% CI)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptom control decisions (MD only vs MD-RN together)</td>
<td>1.73 (1.17-2.56)</td>
<td>.006</td>
</tr>
<tr>
<td>Involvement of RN in EOL decisions (agree vs not agree)</td>
<td>0.76 (0.60-0.96)</td>
<td>.02</td>
</tr>
<tr>
<td>RN-MD collaboration (good vs poor)</td>
<td>0.72 (0.56-0.92)</td>
<td>.009</td>
</tr>
<tr>
<td>Freedom to decide how to facilitate own work (agree vs not agree)</td>
<td>0.72 (0.59-0.89)</td>
<td>.002</td>
</tr>
<tr>
<td>RN workload (high vs not)</td>
<td>1.49 (1.07-2.06)</td>
<td>.02</td>
</tr>
<tr>
<td>MD workload (high vs not)</td>
<td>0.81 (0.56-1.19)</td>
<td>.29</td>
</tr>
</tbody>
</table>

Regression path analysis showing open communication to mediate the relationship between unit leadership and understanding patient care goals, with unit leadership being a predictor of open communication in the ICU, and open communication in the ICU being a predictor of understanding patient care goals. The Sobel test statistic shows open communication to be a significant partial mediator of the relationship between unit leadership and understanding patient care goals (P < 0.001), with it accounting for approximately 52% of the variance between the two variables.

Yaguchi, Arch Intern Med, 2005; 165:1970

Cross-sectional survey prevalence, characteristics, and risk factors for conflicts in 323 ICUs/24 countries (7,498 ICU staff members)

Intra-team disputes = majority of conflicts (half EOL care)

Poor communication within the ICU team (in general or during EOL care) perceived as common.

Conflicts were less likely to occur in ICUs that held regular interprofessional staff meetings

Respondents were asked to report conflicts that occurred within the last week.

- fewer than half reported the conflict was resolved at time of study
- 80% believed the same type of conflict was likely to recur
- 20% indicated reported conflict was related to a previous conflict

Azoulay, et al. AJRCCM 2009;180(9):853-60.
Conflictus Study: Sources of behavior related conflicts

TAXONOMY OF CONFLICT

<table>
<thead>
<tr>
<th>Task-Based Conflict</th>
<th>Relationship-based Conflict</th>
<th>Disruptive Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness of differences in viewpoints and opinions pertaining to a group task.</td>
<td>Awareness of interpersonal incompatibilities, includes affective components such as feeling tension and friction.</td>
<td>Intimidating and disruptive behaviors.</td>
</tr>
<tr>
<td>Tends to not involve intense interpersonal negative emotions although may be animated.</td>
<td>Involves personal issues such as dislike, annoyance, frustration, irritation.</td>
<td>Verbal outbursts and physical threats</td>
</tr>
<tr>
<td>• Awareness of differences in viewpoints and opinions pertaining to a group task.</td>
<td>• Intimidating and disruptive behaviors.</td>
<td>• Refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes.</td>
</tr>
</tbody>
</table>

Conflict in Health Care

Task-Based

- Honest and inevitable
- Slips and Errors

FACTORS

- Poor hand-writing, confusing labels
- Competing tasks, language barriers, distractions (workload)

SOLUTIONS

- Hand-off protocols, checklists, CPOE, automated medication dispensing systems, alerts
- Team communication training (ie, TeamSTEPPS)
- Conflict skills: CUS, Two challenge rule, DESC

Conflict in Health Care

Relationship-Based

- People know of risks and do not speak up
- Wait for the train wreck vs stopping train
- Often presents as entrenched conflicts

FACTORS

- Calculated decisions to avoid or back down from conversations
- Harsh language interpreted as disrespect
- Top three problems: dangerous shortcuts, incompetence, disrespect

SOLUTIONS

- Understanding the fundamental attribution error: motivation for behavior attributed to context versus personality (also called misattribution)
- Conflict management training

Conflict in Health Care

Disruptive Behavior

FACTORS

- Culture of tolerance
- Power differential and high stakes, high tension environment
- Fear of retaliation
- Revenue-generating versus paid-employee differences in status

SOLUTIONS

- Zero tolerance policies
- Codes of conduct
- Disciplinary actions

Fundamental Attribution Error

I’m stressed – you’re rude.
I’m overworked – you’re lazy.
I’m worried – you’re hypervigilant.

- My behavior is best explained by situational factors and context.
- Your behavior is best explained by a personality flaw or stable trait deficit.
Evidence

Strong Communication

Summary

Behaviors that undermine a culture of safety

Root causes and contributing factors

disruptive behaviors among physicians and nurses, there is evidence that these behaviors occur among other health care

By the Institute for Safe Medication Practices found that 40 percent of clinicians have kept quiet or remained passive during

Intimidating and disruptive behaviors in health care organizations are not rare. A survey on intimidation conducted

impatience with questions. Overt and passive behaviors undermine team effectiveness and can compromise the safety of

include reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and

Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive

activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities.

Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable

Adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek

New positions in more professional environments. Safety and quality of patient care is dependent on teamwork,

and a collaborative work environment. To assure quality and to promote a culture of safety, health care

organizations must address the problem of behaviors that threaten the performance of the health care team.

There is a history of tolerance and indifference to intimidating and disruptive behaviors in health care. Organizations that

situations can contribute to occasional intimidating or disruptive behavior, particularly in the presence of factors such as fatigue.

behavior stems from both individual and systemic factors. The inherent stresses of dealing with high stakes, high emotion

In the majority of episodes of intimidating or disruptive behaviors, it is important that organizations recognize

behaviors confined to the small number of individuals who habitually exhibit them. It is likely that these individuals are not

involved in the large majority of episodes of intimidating or disruptive behavior. It is important that organizations recognize

that it is the behaviors that threaten patient safety, irrespective of who engages in them.

The majority of health care professionals enter their chosen discipline for altruistic reasons and have a strong interest in caring

for patients. Yet, many find that the realities of health care can undermine these ideals and responsibilities. It is not uncommon

for health care professionals to experience burnout. The frustration of dealing with patients and their families who seem reluctant

to cooperate in treatment or are poorly informed or even uncommunicative; the emotional and physical stress of trying to

protect patients who cannot protect themselves; and the overwhelming pressures of continuity of care, quality of care, and

safety of care can make the job of health care professionals challenging. In addition, the policies and procedures that govern

health care environments can be rigid and inflexible, creating barriers to the development of a culture of safety.

Increased

Improved Patient Outcomes

Increased Patient Satisfaction

Increased Staff Satisfaction

Decreased Morality Distress

Evidence of Impact from Team Training Programs

In healthcare (as in other industries such as aviation)

Three years for maximum effect

Thinking Exercise #2:

Recall an example a professor used to help you understand your future role as a patient advocate?

[Or an example you commonly use in your teaching.]
<table>
<thead>
<tr>
<th>The Nurse as Patient Advocate</th>
<th>The Physician as Patient Advocate</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ What did you notice about these messages?</td>
<td>➢ What did you notice about these messages?</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>The Social Worker as Patient Advocate</th>
<th>Advocate: Noun or Verb?</th>
</tr>
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<tbody>
<tr>
<td>➢ What did you notice about these messages?</td>
<td>Noun: The Patient’s Advocate</td>
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<tr>
<td></td>
<td>Focus?</td>
</tr>
<tr>
<td></td>
<td>Benefits to patient</td>
</tr>
<tr>
<td></td>
<td>Benefits to professional</td>
</tr>
<tr>
<td></td>
<td>Verb: To advocate</td>
</tr>
<tr>
<td></td>
<td>Focus?</td>
</tr>
<tr>
<td></td>
<td>Benefits to patient</td>
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<td></td>
<td>Benefits to professional</td>
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<table>
<thead>
<tr>
<th>Interprofessional Advocacy</th>
<th>Thinking Exercise #3</th>
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</table>

I am the patient’s advocate.

What are the advocacy needs of this patient and who can best meet them?

Formation of professional identity and agency:
1. Think of a recent “win” that:
2. Demonstrated interprofessionalism
3. Where the team was the hero
4. Illustrated a communication skill
Patient Advocacy and Ethics in Nursing

- Focus on principle of respect for autonomy
- Perpetuated a straw man argument with beneficence (i.e., paternalism)?
- Limited adding our voices to the calls for justice in health care?

Nursing Ethics: A Short History

- Nurse as the Virtuous Person (i.e., Woman)
- Nurse as the Loyal Soldier (with the Physician as Captain of the Ship)
- Nurse as the Patient Advocate
- Nurse as . . . 

NURSE

Key Issues in Health Care Ethics Today

- Futility: how do we negotiate the rising requests by non-random groups for “more” health care than “we” believe is beneficial?
- Shared decision-making: how do we navigate away from a strict legal model of pure autonomy to one that acknowledges professional recommendations?
- Just Culture: how do we remove the barriers to honesty within our professional societies to justly treat the 1st, 2nd and 3rd victims of errors?

Is Advocacy Hurting Our Patients?

- Conflict / lack of teamwork is killing them
- “Nurses are the patient’s advocate” is the language of conflict
- Need language of collaboration
- Address conflict in nuanced manner
  - CUS – conflict skills – limit setting
- Think of advocacy as verb
- Lend our voices and intellects to the pressing ethics and health issues of today!

Key Issues in Health Care Ethics Today

- Justice: how do we help to create a culture of solidarity in the U.S. where minimum health care is viewed as a right?
- Costs and Financing: how do we reduce incentives for increased costs and use while increasing incentives for increased access and health outcomes?
- Fidelity: how do we address disparities in patient experiences in health care where some groups are treated badly and poorly?