In September 2010, Kimberly Hiatt made a medical error. The critical care nurse at Seattle Children’s Hospital miscalculated and gave a fragile 8-month-old baby 1.4 grams of calcium chloride, 10 times the correct dose of 140 milligrams. The mistake contributed to the death of the child and led to Hiatt's firing and an investigation by the state’s nursing commission. In April 2011, devastated by the loss of her job and an infant patient, Hiatt committed suicide.

Hiatt, who had worked as a nurse for more than two decades, was another in a long line of “second victims” of medical error, the term used in medical literature to describe physicians and other health professionals who often feel guilty and depressed after adverse events. Many physicians and other health professionals hold themselves to a standard of perfection, and when things go wrong, they feel alone.

Physician health experts estimate that 250 doctors commit suicide annually — a rate about double that of the general population. When doctors believe they have made a major medical error, they are three times likelier than other physicians to contemplate suicide, said a January Archives of Surgery study.

If the first instinct after an adverse event is to retreat from scrutiny into a spiral of shame and fear, sharing the ordeal publicly is probably the last thing to cross a physician’s mind. But a small group of doctors has done just that. Here are three physicians who shared their stories with the world in an effort to tell their colleagues and their patients that to err is human.

Why three doctors went public

To err is human. To tell the world about the cases when things went wrong requires courage.

STORY BY KEVIN B. O’REILLY
PHOTO BY CJ GUNther

“BIGGEST MISTAKE”

It was not until he was dictating a report on the last of his six operations that hectic day that orthopedic surgeon David C. Ring, MD, PhD, realized his mistake. He had performed the wrong surgery on a patient.

A 65-year-old Spanish-speaking woman was scheduled for a trigger-finger release procedure, but Dr. Ring mistakenly performed a carpal-tunnel release. A change in the operating room’s location meant a nurse who sat in on a preoperative assessment was not present to catch Dr. Ring's error. Another nurse mistook Dr. Ring’s conversation in Spanish with the patient for a preoperative timeout. The marking on the site for the correct procedure — the trigger-finger release — vanished once the skin was cleaned in preparation for surgery.

Dr. Ring was distracted. Earlier in the day, he performed a carpal-tunnel release for another patient, who was upset about the injection of anesthetic for the procedure because it caused her a great deal of pain. Shortly before the wrong surgery, he visited this other, highly agitated patient in the recovery area and struggled to calm her down.

“I felt bad for her,” says Dr. Ring, associate professor of orthopedic surgery at Massachusetts General Hospital in Boston. “She was really stressed out from that painful shot. I was resolved in my mind that my next surgery would be my best carpal-tunnel release ever. And it probably was — it was just on someone who was supposed to have a trigger release.”

Dr. Ring alerted the patient to the error and offered to immediately perform the correct procedure, which he did. The unnecessary wound from the wrong procedure would take about a month to heal and be sensitive to the touch for several months, Dr. Ring says.

“It could have been a lot, lot, lot worse,” he says. The patient got follow-up care from another physician, and the family received a prompt,

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Supporting physicians when things go wrong

Few physicians talk publicly about their medical errors, but a growing number are benefitting from programs dedicated to helping doctors deal with the emotional turmoil that often comes in the wake of adverse events. Jo Shapiro, MD, helped start the Center for Professionalism & Peer Support at Boston’s Brigham and Women’s Hospital in October 2008. There are 55 physicians and other health professionals at the hospital trained to offer emotional support to peers involved in cases of patient harm.

“Then the kind of adverse event that we hear about, one of us will make an outreach call to the physician involved,” Dr. Shapiro says. “We ask them simple questions like, ‘How are you doing? How are you feeling?’”

A call from another doctor means a lot, she says. “They say, ‘That’s the last time I have felt so comfortable saying how I’m feeling.’” Dr. Shapiro says. The encounter gives doctors a chance to talk in confidence with a peer about the guilt, fear and shame that often accompany adverse events.

“We point out how unrealistic it is that we’re trained to think that we should never make a mistake,” she says. “We also validate what they are feeling. We tell them that the suffering they’re feeling means they care. We wouldn’t want people not to care. It is very hard when someone comes to harm.”

Two other health care organizations such as Children’s Hospital Boston, Johns Hopkins Hospital in Baltimore, the University of Illinois Medical Center in Chicago and the University of Missouri Health System have peer support programs, says Linda K. Kenney, president and executive director of Medically Induced Trauma Support Services in Chelmsford, Mass.

Kenney, who was nearly killed by a medical error in November 1999, now advises hospitals on how to disclose adverse events and support the patients, families, physicians and other health professionals involved.

“Nearly 400 people have requested her organization’s tool kit on setting up peer support systems.”

“I feel like we’ve reached the tipping point,” Kenney says. “Several years ago, people in health care were putting me on the head saying, ‘You’re doing a good thing, but we’re really OK. Now, they’re saying, ‘We really need to do something. We’re now acknowledging that things go wrong in health care.’”

Dr. Shapiro also sees momentum. She has spoken to 10 groups about peer support programs. “The interest level is off the charts. This resonates so well with the idea that we’ve got to do something to help each other”.

Kevin B. O’Reilly