Patient Safety and Disclosure

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Attendees of our seventh annual JADPRO Live conference in Seattle are settling back into their routines after a fun-filled conference packed with practice-changing information. Over 1,500 advanced practitioners and other oncology-focused attendees enjoyed 4 days of networking and clinical updates with expert faculty. If you missed this year's conference, there's always next year, when we'll be meeting in Minneapolis. Be on the lookout for selected presentations from this year's meeting, both here in our journal and on our website.

PATIENT SAFETY

The opening panel discussion at JADPRO Live, *When Things Don't Go as Planned: The Role of Candor in Patient Safety Programs*, was especially relevant to me. Panel discussants included Katie Maletich, MBA, BSN, RN, Brandelyn Bergstedt, Dr. Thomas Gallagher, and Stephen Lovell. As we all know, medical errors and mistakes happen at every practice, but we try diligently not to make them.

Yet how we handle an error, as discussed by the panel, can lead to profoundly different patient and family outcomes. The discussants explained how a communication and resolution program (CRP) is different from our standard response to medical error, and how disclosure plays a key role in managing the fallout from an inadvertent medical error.

I listened intently because, as a nurse practitioner, I've been responsible for at least two medical errors in prescribing. The errors were made in my first years as a floor nurse, but when I mixed up Percodan and Percocet, it still counted as a dreaded medication error. As a provider, making errors in chemotherapy administration can have fatal consequences. We're all grateful for the checkpoints that usually prevent those types of medication errors. But as I listened to the panel discussion, I flashed back to a medical error that happened to me, as a patient. And I became frustrated all over again.

It may seem minor compared to mistakes in oncology care, but I had a cracked tooth diagnosed by my general dentist, who promptly referred me to a specialist in root canals. As a seasoned practitioner, I knew that I wanted to schedule my procedure for Monday at 8:00 am, the first patient of the day, when the endodontist would be rested and the equipment would be freshly sterilized. After arriving 10 minutes late, the endodontist identified tooth twenty-one. Before I could say much more, a dental dam was placed in my mouth. The procedure had begun.

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I am a person with severe dentophobia, and I was anxious when we started the root canal. But I became much more anxious as the staff continually interrupted the endodontist with questions during my procedure. The practice was expecting a dental representative to bring lunch for a planned in-service that day, so the endodontist was consulted on the number of attendees and what type of food he would prefer. Then he was interrupted for a discussion of a patient who needed to come in for an emergency procedure. I was getting rather upset, and when he finally concluded the procedure, I was shaking. The endodontist sent me home with instructions for postcare on tooth twenty-one, and told me he wouldn't call me but that I should call the office if any problems arose. As a good nurse practitioner, I drove home and promptly looked at my new root canal. I became slightly hysterical as I counted the teeth in my mouth and realized he'd done the wrong tooth. My husband thought I was crazy, but I downloaded a tooth chart off the internet (as a really good nurse practitioner!), and counted down the teeth. The endodontist had done the wrong tooth! And here's where I really got angry.

The endodontist called. His reason for calling ostensibly was to let me know he'd changed his mind during the procedure and that he thought tooth twenty was the likely source of the pain I'd been having. I stated that he'd made an error, as he'd clearly sent me home with discharge instructions for tooth twenty-one. And as a fellow healthcare provider and a savvy patient, I expected my money back, his payment for a root canal on the correct tooth, AND an apology.

I never got the apology, although he paid for the second root canal. I was furious and hurt. So, as a really, REALLY good nurse practitioner, I developed a quality assurance program outline for him and his practice, detailing where he'd gone wrong. A rushed entrance because he was late, and multiple interruptions during patient care led to his error. But his biggest mistake was not apologizing and admitting his error immediately.

The panel discussion emphasized disclosure. Patients need accurate information and emotional support, including an apology. Patients want empathy. A CRP should include communication planning skills, with full disclosure and answering of patient questions. Medical mistakes will continue to be made. And of course, we continue to do our best to limit those mistakes. But planning for and practicing the best way to handle a mistake is key to an optimal patient and family outcome.

IN THIS ISSUE

We've got a full issue for you, and I think you'll enjoy learning about the management of cytokine release syndrome, one of our Grand Rounds articles authored by Sherry Adkins. You can also earn credits after reading Ms. Adkins' article. Our Practice Matters author, Andrew Allred, discusses the utilization of advanced practitioners in radiation oncology, and we have two Prescriber's Corners selections for you, discussing axicabtagene ciloleucel and mogamulizumab-kpkc. We've also included the abstracts from our JADPRO Live meeting this year. And we especially want to thank the tireless efforts of our peer reviewers, who help to make this journal relevant and clinically focused.