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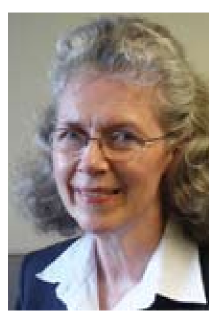

*Ophthalmologist Kathleen Stoessel specializes in retinopathy of prematurity, a disorder of developing retinal vessels in premature infants.*

## Physician at Work

# Preserving eyesight in the most vulnerable patients

Ophthalmologist **Kathleen M. Stoessel**, MD, is often pitted in a race against the clock when treating her youngest patients. Stoessel heads the Retinopathy of Prematurity (ROP) program, monitoring and treating premature infants who risk impaired vision or even blindness if she doesn't act quickly.

Retinal vessels normally develop between the 16th and 38th weeks of gestation, but that growth can be disrupted in babies born prematurely. As a result, these infants are prone to ROP—abnormal cellular proliferation where the vessels have stopped growing. ROP will often resolve on its own, but if it progresses, the resulting neovascularization and scar tissue can lead to a detached retina. "If that happens, there's a limited chance for any really good vision in these premature babies, even after retinal detachment surgery," said Stoessel.

Stoessel checks premature infants for the earliest signs of ROP and monitors their progress. "ROP is never static," she said. "It's always changing until they get to the point where it resolves one way or another, either by laser treatment or by nature." An ongoing clinical trial sponsored by the National Eye Institute has determined specific "threshold" criteria at which the risk of retinal detachment is greater than 50 percent and laser treatment is recommended. For best results laser treatment must be done within 48 hours of the infant developing those threshold criteria, which relate to the degree of abnormal cell growth and how far from the retina it occurs. Treatment involves a laser that makes a 360-degree circuit, focusing on an area adjacent to the abnormal vessel junction. Each year Stoessel and her colleagues perform the treatment on about 48 babies at Yale.

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# When it helps to say "I'm sorry."

*The Yale Medical Group is taking steps to ensure that patients and families receive full disclosure about unintended outcomes.*

Harmful outcomes, including those caused by medical errors or device failures, hurt patients and may erode trust in caregivers. But many clinicians feel they must avoid discussing adverse events with patients; legal experts have traditionally advised them to "deny and defend" in such cases. Recently, though, as research has shown that communication can improve outcomes and reduce lawsuits, medical centers and physician groups around the country, including Yale Medical Group (YMG), have adopted a more open approach. Disclosures of bad outcomes—clear, factual explanations, often coupled with an apology, an analysis of what happened, and sometimes financial compensation—have become a priority for American hospitals in recent years. The American Medical Association has called for disclosure since 1981, and the Joint Commission on the Accreditation of Healthcare Organizations has required it of hospitals since 2001.

Some hospitals, such as the University of Michigan Health System, notify patients and families of errors and invite them to meet for discussion and mediation. Despite naysayers' warnings, this approach has led to a decrease in lawsuits. Why? "People who decide to sue are often looking for answers," says **Stuart G. Warner**, JD, assistant general counsel in the Legal and Risk Services Department of the medical center. "Nobody goes to work wanting to hurt somebody."

Disclosures not only help patients understand what went wrong, but also reassure them that doctors and nurses will learn from the event and try to make sure that it doesn't happen again. Responsible disclosures, along with apologies and compensation when appropriate, are so effective that lawsuits at the University of Michigan have become a last resort, according to a recent *New York Times* article.

Old habits die hard, though, and a culture of openness takes time to instill. Last month YMG took

*"Nobody goes to work wanting to hurt somebody," says Stuart Warner, assistant general counsel at the medical center. Warner has been spearheading an effort to encourage open discussion of unintended medical outcomes.*

an important step toward culture change. A two-day training session spearheaded by the medical center's Legal and Risk Services Department and YMG leadership, and led by Daniel O'Connell, PhD, a consultant to the Institute for Healthcare Communication, taught disclosure techniques to 30 Yale and Yale-New Haven Hospital health care providers, including physicians, nurses and risk management and quality improvement staff. While the session was designed as a "train the trainers" program, YMG also sponsored an evening session that drew more than 75 faculty.

According to **David J. Leffell**, MD, CEO of YMG and deputy dean for clinical affairs at the medical school, "Fundamental to any doctor-patient relationship is a foundation of trust. Disclosure training can provide additional skills for our faculty to build on that foundation."

Following an unanticipated outcome, Warner said, staff must first mitigate the harm to the patient. Once the immediate medical aspects have been dealt with, clinicians can tell the patient and

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## Physician at Work *continued*

Stoessel also evaluates children under two years of age for retinal hemorrhages in cases where there might be a history of abuse. "Certain clinical appearances of retinal hemorrhages are consistent with shaking, even though there may be no other external injuries to the baby," she said. While many of her patients are children, she also treats adults for conditions such as diabetic retinopathy and macular degeneration.

Although she originally planned to pursue internal medicine, Stoessel realized during her internship the importance of visual function. "My patients taught me that they can deal with other problems if they have visual function," she said, "but if that goes too, they can't do something as simple as read a book or look out a window."

**Name:** Kathleen M. Stoessel, MD

**Title:** associate professor of ophthalmology

**Area of expertise:** Vitreoretinal diseases, especially retinopathy of prematurity, diabetic retinopathy, sickle cell retinopathy, macular degeneration and evaluation of children with head trauma.

**Place of birth:** New York, NY

**College:** College of New Rochelle, New Rochelle, NY

**Med School:** State University of New York, Downstate, NY

**Training:** Internship in internal medicine, Montefiore Medical Center, Bronx, NY; ophthalmology residency and vitreoretinal fellowship, Yale University.

**Family:** Son: Sean, 18

**What is most challenging to you in academic medicine?** Balancing the time for patient care, clinical research, teaching, lectures and family.

**What is most rewarding?** Having the privilege of examining the eyes and retinas of patients and sometimes being able to stabilize or improve vision. It's especially gratifying when former premature infants who needed laser treatment to try to prevent retinal detachments come back as older children with good or usable vision.

**What do you like most about your practice?** 1) My patients—I always learn from them. 2) My colleagues—they are a great group of dedicated, accomplished professionals who willingly share their expertise.

**Personal interests or pastimes?** Music, reading (nonfiction), walking, watching lacrosse games, spending time with my family.

**What would you do to improve our clinical environment if you had a magic wand?** Have more interaction between the research scientists and the clinicians, so we might better understand each other's expertise and maybe direct research to specific clinical problems to show researchers how their work may help patients.

## When it helps to say "I'm sorry." *continued*

families what occurred. Listening to the patient's questions and concerns allows clinicians to empathize and offer further clarification. Although not all unexpected outcomes are preventable—and many are not due to caregivers' errors—empathy is always appropriate and preventable harm requires a sincere apology. The patient should be assured that he or she will be kept abreast of the results of any investigation. Giving the patient or family member contact information will keep lines of communication open and may help to restore trust.

> Clinicians who believe a serious event has occurred should speak with the Legal and Risk Services Department before starting a discussion with patients and family, so they can be advised on the most sensitive and effective approach. The office can be reached at 688-2291, or for urgent matters after hours, via the page operator.

More plans are afoot to help Yale clinicians make disclosure a habit. O'Connell's 2008 seminar lecture is available to the Yale community online at www.cme.yale.edu. A rapid response team is being assembled to help clinicians handle situations in which patients have been harmed. The 30 original trainees are guiding their colleagues and, in some cases, heading disclosure meetings. Risk management grand rounds have begun to feature disclosure discussions. A training seminar is planned for the nursing staff and leadership. Finally, a support network is being contemplated for clinicians whose actions have led to patient harm. "Blaming is never good; we have to see ourselves as a team," says Warner. Removing some of the fear of blame helps clinicians and their colleagues learn from mistakes.

"Disclosure is not just about avoiding lawsuits," says **Ronald J. Vender**, MD, chief medical officer of YMG. "It is a way to enhance communication and trust in the doctor-patient relationship. It is the correct thing to do."

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