Nurse's suicide highlights twin tragedies of medical errors

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Photo courtesy Lyn Hiatt

Kimberly Hiatt, a longtime critical care nurse at Seattle Children's Hospital, committed suicide in April, seven months after accidentally overdosing a fragile baby.

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For registered nurse Kimberly Hiatt, the horror began last Sept. 14, the moment she realized she'd overdosed a fragile baby with 10 times too much medication.

Stunned, she told nearby staff at the Cardiac Intensive Care Unit at Seattle Children's Hospital what had happened. "It was in the line of, 'Oh my God, I have given too much calcium,'" recalled a fellow nurse, Michelle Asplin, in a statement to state investigators.

In Hiatt's 24-year career, all of it at Seattle Children's, dispensing 1.4 grams of calcium chloride — instead of the correct dose of 140 milligrams — was the only serious medical mistake she'd ever made, public investigation records show.

"She was devastated, just devastated," said Lyn Hiatt, 49, of Seattle, Kim's partner and co-parent of their two children, Eli, 18, and Sydney, 16.

That mistake turned out to be the beginning of an unraveled life, contributing not only to the death of the child, 8-month-old Kaia Zautner, but also to Hiatt's firing, a state nursing commission investigation — and Hiatt's suicide on April 3 at age 50.

Hiatt's dismissal — and her death — raise larger questions about the impact of errors on providers, the so-called "second victims" of medical mistakes. That's a phrase coined a decade ago by Dr. Albert Wu, a professor of health policy and management at the Johns Hopkins Bloomberg School of Public Health.

It's meant to describe the twin casualties caused by a serious medical mistake: The first victim is the patient, the person hurt or killed by a preventable error — but the second victim is the person who has to live with the aftermath of making it.

No question, the patients are the top concern in a nation where 1 in 7 Medicare patients experiences serious harm because of medical errors and hospital infections each year, and 180,000 patients die, according to a November 2010 study by the Department of Health and Human Services' Office of Inspector General.

That's nearly double the 98,000 deaths attributed to preventable errors in the pivotal 2000 report "To Err is Human," by the Institute of Medicine, which galvanized the nation's patient safety movement.

In reality, though, the doctors, nurses and other medical workers who commit errors are often traumatized as well, with reactions that range from anxiety and sleeping problems to doubt about their professional abilities — and thoughts of suicide, according to two recent studies.

Surgeons who believed they made medical errors were more than three times as likely to have considered suicide as those who didn't, according to a January survey of more nearly 8,000 participants published in the Archives of Surgery.

Even when they don't think of killing themselves, medical workers who make errors are often shaken to their core, said Amy Waterman, an assistant professor of medicine at Washington University in St. Louis, who studied the issue in a 2007 survey of more than 3,100 practicing doctors in the U.S. and Canada. Ironically, the survey included doctors at Seattle Children's Hospital.

"It really affects their confidence as physicians and it affects their ability in the future," Waterman said.

Longtime caregiver

Records show that Hiatt had cared for Kaia Zautner many times since her birth, when the baby with severe heart problems was first brought to Seattle Children's. She was close to the child's family, who sought out her care, records show. She was Facebook friends with Alana Zautner, Kaia's mom, hospital officials said.

After the overdose, the child's parents asked that Hiatt not care directly for their baby, but they did not appear to seek retribution, according to an investigation report by Cathie Rea, the hospital's director of ICU.

"Very calm and reasonable people — understandably upset, but continued to say they 'didn't want us to cut off anyone's head over this,'" Rea wrote. Reached by msnbc.com, Alana Zautner declined to comment publicly.

It's not clear whether Hiatt's mistake actually caused the death of the child, who was critically ill. The mistake "exacerbated cardiac dysfunction" in the baby and led to her decline, according to a statement by cardiologist Dr. Harris P. Baden, who cared for Kaia. However, state lawyers said the child's fragile condition and poor prognosis would have made it difficult to prove legally that the overdose caused her death five days later, records show.

Still, Hiatt was escorted from the hospital after the mistake, immediately put on administrative leave and then fired within weeks.

After the incident, Hiatt "was a wreck," recalled Julie Stenger, 39, of Seattle, a critical care nurse who worked with Hiatt at the hospital. "No one needed to punish Kim. She was doing a good job of that herself."

Officials at Seattle Children's Hospital declined to discuss specifics about Hiatt's termination, although they said there is "more behind Kim's case than can be made public" because of personnel and privacy policies.

They said the hospital has since 2007 followed a so-called "Just Culture" model, which recognizes the need to use errors to identify and correct systemic problems, rather than focusing on penalizing individuals.

"The circumstances that led to Kim's departure from Children's were tragic on many levels and our heart goes out to the patient's family and to Kim's family," said hospital officials, who responded to msnbc.com only in written statements. "Within Just Culture, staff are not terminated for simple human error."

Experts in patient safety say terminating an individual worker is rarely the answer to even the worst mistakes, unless they're the result of repeated, willful flouting of established procedures or intentional harm.

It's far better to identify and address the problems in the system that contributed to the error, said Mary Z. Taylor, director of patient safety at the Washington University School of Medicine in St. Louis.

"To eliminate them is futile; you will make errors," said Taylor, who recently launched one of the nation's few peer coaching program aimed at helping providers cope with the aftermath of mistakes.

“You may think things are safer if you’ve gotten rid of that person, but that’s not necessarily so,” Taylor said.

The problem is not an isolated issue by any means. Waterman, the Washington University researcher, found that 92 percent of the doctors she surveyed said they’d experienced a near miss, a minor error or a serious error — and 57 percent confessed to a serious mistake.

Of those, two-thirds reported anxiety about future errors and half reported decreased job confidence and satisfaction, the study found. Although the survey focused on doctors, researchers said they believed the results could apply broadly to nurses and other health care workers as well.

That’s because medical workers invariably go into the profession to help people. When harm occurs, the providers are haunted by every detail of the mistakes, often for years, said Susan D. Scott, a registered nurse and patient safety director at the University of Missouri Health Care. That hospital is among a handful in the country to have established a formal support system to help providers cope with difficult patient outcomes or errors.

There are other options to punitive actions, including education, supervision, reparations to the patient or family — and allowing the person who made the mistake to help craft specific systems to make sure it can't happen again, Scott said.

In some ways, however, those who’ve made mistakes might be even safer than those who haven’t, she added.

“If my mom got an insulin overdose from a nurse in a hospital, I would want that nurse to give her that insulin tomorrow,” Scott said.

On the day of Hiatt’s error, she admitted the mistake in a report submitted on the hospital’s electronic feedback system — and vowed not to repeat it.

“I messed up,” she wrote. “I’ve been giving CaCl [calcium chloride] for years. I was talking to someone while drawing it up. Miscalculated in my head the correct mls according to the mg/ml. First med error in 25 yrs. of working here. I am simply sick about it. Will be more careful in the future.”

Other factors in the firing?

There’s some question about whether other factors contributed to Hiatt's firing. Hospital officials said that Hiatt should have recognized that the dose was far too large for such a small child, and that Hiatt violated other dosing protocols. Investigation records show that officials worried that Hiatt didn't fully recognize her role in the error.

"Kim has not shown an understanding of how her deviation from policy in medication administration was in any way responsible for this error," wrote ICU Director Cathie Rea. "Her attention to detail and her precision is not what I would expect it to be at this point in her career."

However, investigators also said they had concerns about “Patterns of behavior re: Boundaries, Authority, Relationships.”

A co-worker had filed a sexual harassment claim against Hiatt, who was a lesbian, in 2008, alleging Hiatt acted inappropriately by hugging her and kissing her on the cheek. In a letter, Hiatt denied there was anything sexual about the action, which she said was meant to comfort the co-worker during a tough time, and described the investigation as a “witch hunt.” She said the Human Resources department had a history of discriminating against her because of her sexual orientation with one document dating to 1994.

Seattle Children’s officials denied that Hiatt’s personal life had anything to do with her dismissal. “Our strong support for the diversity of our staff and the community we serve is well-established,” officials wrote. “Kim’s departure from Children’s was unrelated to her sexual orientation.”

Records show that Hiatt was stunned to be terminated for what she believed was a single medical error in nearly a quarter-century of service. Investigation records reveal multiple glowing reviews. Just two weeks before the overdose, an Aug. 30, 2010 evaluation identified her as a “leading performer,” earning a mark of 4 on a 5-point scale, records show.

"Kim's nursing practice was incredible," Lyn Hiatt said. "She was smart, she was quick."

A storm of media attention followed news of the error, spurring state nursing commission officials to open an investigation into whether Hiatt’s license should be revoked. Ultimately, the agency imposed sanctions instead, including a $3,000 fine, 80 hours of new coursework on medication administration and four years of probation in which any supervisor would be required to report on Hiatt's work every 90 days.

After fighting to keep her license, Hiatt didn’t think she’d find another position in Seattle, family members said.

“She said, ‘Who’s going to touch me? I’ve made a mistake,’” said Sharon Crum, 73, Hiatt’s mother and a retired nurse herself. “When she lost this job, it wasn’t just the job she lost, it was her future.”

‘She ran out of coping skills’

Faced with the prospect of not working again as a nurse, Hiatt was overcome with despair, family members said. On April 3, a Sunday, Kimberly Hiatt hanged herself in her family’s home, records show. Nearly 500 people, including many nurses, attended her memorial ceremony a week later.

“She was in such anguish,” Crum says. “She ran out of coping skills.”

Hiatt’s death has unleashed a storm of reaction from her family, her colleagues — and from fellow nurses. After Hiatt's firing, the Washington State Nurses Association, which represents nurses at Seattle Children's, grieved her dismissal and negotiated a confidential settlement

with the hospital on her behalf. Since then, WSNA officials have heard from many nurses worried about making mistakes themselves.

“It certainly has heightened that fear factor,” said Sally Watkins, assistant executive director of nursing practice, education and research for the WSNA.

A survey of WSNA nurses in the months after Hiatt’s case became public found that half of respondents believe their mistakes will be held against them personally. Even more worrisome, nearly a third say they would hesitate to report an error or patient safety concern because they’re afraid of retaliation or harsh discipline.

“Punitive actions are actually counterproductive. Everything in the literature points to that not being the right step to take,” Watkins said. “Nurses in that unit or hospital will not report things. There’s this heightened awareness: It could be me.”

Across the country, patient safety advocates — speaking both generally and about public reports of Hiatt's case — worry that firing providers after they make mistakes leaves patients at greater risk.

Hospital disputes safety experts

Officials at Seattle Children’s say armchair safety experts don’t know the details of Hiatt’s case. They indicated they changed the way calcium chloride is dispensed in response to Hiatt’s error to make it safer, even though a state investigation found that appropriate safeguards were already in place. They say critics haven't contacted them to ask about procedures for reporting and correcting errors, or for supporting staff when mistakes occur.

For Hiatt’s friends and family, all the debate in the world is useless unless it actually serves to change the circumstances that led to two tragedies: the loss of a fragile baby and the death of a nurse who loved her job.

“I promised Kim I’d do whatever I could to help,” said Stenger, Hiatt's colleague and friend, who said she left her job at Seattle Children’s in part because of how Hiatt was treated. “I thought it was sending the exact wrong message: If you make a mistake, you better keep your mouth shut about it.”