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Extended Abstract

Branding mistakes and how to cure them"- Laura Beauparlant - Lab Creative Inc, Canada

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Abstract

You're really good at what you do. But it takes so much more than just an idea or your incredible skills to start and run a business. Laura shares her experience working with successful small businesses over the last fifteen years to help entrepreneur's fast-track their own success. You will learn what branding is and why it matters to your small business, as well as 5 of the most common branding mistakes that are costing you money, and how to avoid them to build a strong, memorable business that attracts the right clients. While ascribing medical errors primarily to systems factors can free clinicians from individual blame, there are elements of medical errors that can and should be attributed to individual factors. These factors are related less commonly to lack of knowledge and skill than to the inability to apply the clinician's abilities to situations under certain circumstances. In concert with efforts to improve health care systems, refining physicians' emotional and cognitive capacities might also prevent many errors. In general, physicians have the sensation of making a mistake because of the interference of emotional elements. We propose a so-called rational-emotive model that emphasizes 2 factors in error causation difficulty in reframing the first hypothesis that goes to the physician's mind in an automatic way, and premature closure of the clinical act to avoid confronting inconsistencies, low-level decision rules, and emotions. We propose a teaching strategy based on developing the physician's insight and self-awareness to detect the inappropriate use of low-level decision rules, as well as detecting the factors that limit a physician's capacity to tolerate the tension of uncertainty and ambiguity. Emotional self-awareness and self-regulation of attention can be consciously cultivated as habits to help physicians function better in clinical situations. The discussion of clinical errors has shifted from being an almost taboo matter to being a major focus of decision theory epidemiology, health services research, and quality assurance policy. A systemic perspective on clinical errors proposes that behind each error there is often a chain of circumstances involving multiple actors within the organization as a whole The current tendency is to displace individual guilt to a more institutional perspective. The positive consequence is that physicians can examine their own errors without activating feelings of blame, which usually paralyze the individual's and the team's capacity to correct the error and prevent future ones. This systemic perspective, however, should not reduce the degree to which physicians should be held accountable to be vigilant and engage in self-monitoring. Some evidence indicates that errors often result not from a lack of knowledge but from the mindless application of unexamined habits and the interference of unexamined emotions.

A 47-year-old man with abdominal pain and decreased urination was seen in the emergency department of a well-respected hospital. The board-certified and experienced physician taking a cursory history assumed that the decreased urinary flow was due to dehydration, even though he was aware that the patient had recently had bladder surgery for localized carcinoma and just had a Foley catheter removed. The patient was signed out to another physician at the end of the shift. When intravenous hydration did not result in improvement, the new physician increased the rate of the intravenous infusion. Only the next day, when seen by another resident, did the situation seem obvious: a new catheter was inserted with relief of the pain and a yield of 1.5 L of urine. By then, the patient had developed a fever, and the urine appeared to be infected.

Whereas it is clear that some errors may have been made in the hand-offs of care, lack of individual vigilance and inability to think about the concrete situation in a new way contributed to poor care. To a certain degree, each physician's competence in this situation depended on the ability to avoid routine and to tune clinical abilities to deal with the situation. We use the terms tune or calibrate in the same way one might use them when referring to tuning a musical instrument or calibrating a glucometer. Self-awareness is the process whereby the physician self-calibrates to produce the desired effect: an effective communication process, or an accurate physical examination. The cognitive and emotional processes that physicians use to increase self-awareness in the moment during every day medical practice, however, have not been described in depth until recently.

We present this article as a preliminary step to answer the question of whether training in self-awareness can prevent clinical errors. To that end, we explore a rational-emotive model of clinical error prevention, building on our own clinical, teaching, and research experience, and develop some educational strategies that can help to prevent clinical errors by increasing access to the thoughts and feelings that guide clinical actions.

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