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CORE TRAINING FOR DOCTORS

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Dealing with a serious adverse event

You are human, therefore you are fallible. You will make not one but many mistakes in the course of your professional life. Fortunately, Mother Nature is kind to doctors. People who are otherwise reasonably healthy can be exposed to substantial physiological stress, for example, by prescribing the wrong intravenous fluids, and the body's homeostatic mechanisms will sort things out until you realize, and correct, your error. Occasionally the patient will be too sick or the insult too severe and the patient will suffer harm. Often, it is only a 'mistake' in retrospect – at the time, what you did may have been an entirely reasonable course of action, based on the information available to you at that time. However, even a blatant error does not mean you are a 'bad' doctor – it means you are a human one.

> **'The important question isn't how to keep bad physicians from harming patients; it's how to keep good physicians from harming patients (Gawande, 1999).'**

Atul Gawande is a surgeon at the Brigham Hospital in Boston and an Associate Professor in the Harvard School of Medicine and the Harvard School of Public Health. He writes essays on medical issues which are published in the *New Yorker* and have been collated in a number of books. He has a knack for encapsulating complex ideas in simple phrases. The above quote, for example, is echoed by the claims experience of The Medical Protection Society, and, I suspect, every other body that indemnifies doctors. The vast majority of the compensation payments we fund arise from the rare lapses in the performance of competent and usually high performing doctors. Yes, there are outliers whose multiple claims reflect marginal or sub-optimal performance, but they are rare.

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A truly tragic outcome from an adverse event is to fail to learn from it

Atul Gawande has also written that:

> **'It isn't reasonable to ask that we achieve perfection. What is reasonable is to ask that we never cease to aim for it (Gawande, 2003).'**

Sir Liam Donaldson put it more strongly, when speaking at the launch of the World Alliance for Patient Safety in Washington DC on 27 October 2004:

> **'To err is human, to cover up is unforgivable, and to fail to learn is inexcusable.'**

Professor Bruce Barraclough, Past-President of the Royal Australasian College of Surgeons and now Clinical Lead and Chair of the World Health Organization's Patient Safety Curriculum Guide, summarized a three-step process for managing adverse events when speaking as Chair of the Australian Council of Safety and Quality in Healthcare in 2002:

1. When unintended harm occurs, inform patients and carers about what has gone wrong in an empathic way that includes an expression of regret
2. Undertake an in-depth analysis of the problem, including root cause analysis for severe problems
3. There must be a commitment by individuals and organizations to fix the system problems identified.

That approach can be succinctly summarized as:

- Fix the patient
- Find the problem
- Fix the problem.

Saying 'sorry' is not enough

The focus over the last 10–15 years has tended to be on 'fixing the patient' by acknowledging the patient's distress, offering a heartfelt apology for what has happened and giving detailed information about what in fact did happen and its possible consequences. Dealing promptly, fairly, openly and compassionately with the patient is essential – but it is not the

end of the process. We have an ethical and clinical obligation to explore in detail what happened, and how it came to happen, so we can learn from the event and minimize the chance of recurrence. That means accepting an obligation to report the event, to enable detailed review. In the process called root cause analysis, three questions are asked:

1. What happened?
2. How did it come to happen?
3. What can we do to stop it happening again?

Even that is not enough. Two further steps are required:

Reporting back to the patient and relatives

Patients take very great comfort from knowing that something good has come out of the bad thing that happened to them; something has been learnt to reduce the chance of someone else having to go through what they went through.

Many press reports of the outcome of a court case quote the patient as saying: 'It was never about the money, I just wanted to make sure this never happens to anyone else.' In that context it sounds self-serving but it is the experience of the Medical Protection Society that in, for example, a mediation conference, if the doctor offers a frank apology and tells the patient what has been learned from what happened to him/her, settlement is more readily achieved and a trial avoided.

Implementing what has been learned from the root cause analysis

The root cause analysis is not an end in itself. It only has meaning if the hospital or clinic or doctor implements the lessons learned.

In 2000 the University of Michigan Health System adopted what was then a new and radical approach:

'[T]hree broad – and we believe, inarguable – principles were identified, around which the risk management/claims management response would take place:

1. Compensate quickly and fairly when unreasonable medical care causes injury.

2. Defend medically reasonable care vigorously.

3. Reduce patient injuries (and therefore claims) by learning from patients' experiences (Boothman et al, 2009).'

This approach substantially reduced the cost and number of claims for compensation. Critically, the decision was made at the start that any savings achieved would be used to implement the recommendations arising from step 3. They implemented what they learnt. Safety improved. The incidence and cost of error plummeted.

The 'second victim'

But that doesn't help you personally, if you are at the centre of a major adverse event. In 2000, Albert Wu wrote a powerful article in the *British Medical Journal* highlighting that there is a 'second victim' to every major medical adverse event – the doctor who caused it or thinks that he/she caused it.

Fear and guilt are two very powerful emotions. Beset by guilt over what has happened, it is a natural instinct to want to hide what has happened. If we do, however, we deny ourselves the opportunity to learn. Fear can have many facets, but principally it divides into fear of consequences – litigation, complaint, a disciplinary process, reputational loss, employment consequences – and fear of inability to face the patient and relatives and cope with their anger. Most of us have very little experience of major adverse events and little if any training or experience in managing conversations with the patient and relatives after them.

Many doctors become profoundly depressed in these circumstances. Some have committed suicide. If you find yourself in such a situation, do not bottle it up. Seek counselling. Talk to an important mentor about what happened. If a friend of yours is involved in a major event, keep an eye on him/her to ensure he/she is OK – and intervene if he/she is not.

Don't just do something, stand there!

While time is of the essence, give yourself a brief window of time to think and take advice before you talk with the patient and relatives. 'Oh no! What have I done?' is a normal, visceral, immediate reaction. Stop, calm down, think it through. Perhaps make a phone call to a senior mentor to talk through the incident and seek advice. Think about what you are going to do and say – to the point of rehearsing the actual words and phrases you will use. As a junior, you will of course report to your registrar or consultant what has happened and look to them to tell you what they want you to do. You will need to check with them who is to meet and talk with the patient and relatives, where and when that should happen, whom else do they want you to inform.

Like any other 'procedure' in medicine, while as a junior you may only have a very small role in the meeting, it is important that you are there to see (and learn from) how the registrar or consultant manages the conversation. You will also need to check with the registrar or consultant about how many relatives or friends of the patient they are happy to have present. The patient will want support people present, but it can't be a football team. Ask about who will specifically have the task of taking notes and subsequently making a record of who said what – which, incidentally, should be shared with the patient.

Listen first

It has been written many times that we were made with two ears and one mouth because that is the ratio we are supposed to use them in. Or perhaps it is because listening is harder than talking.

Once the meeting with the patient is underway, there are some critical elements which should be discussed very early. The patient will want to hear the medical team acknowledge that an adverse event has occurred and also to acknowledge the distress that this has caused. Next, he/she will want to hear a genuine and heartfelt apology. The actual words and phrases used are critical. The word 'sorry', standing alone, is ambiguous. It can mean 'I'm sorry this has happened' or 'I'm sorry I/we did this to you'. Thus it is important to always finish the sentence – to make clear whether it is an apology of sympathy or an apology of responsibility.

The next step is to ask the patient what his/her understanding is, so far, as to what has happened. It is highly probable that someone else – another doctor, a nurse,

other ward staff – will already have said something to the patient. If you do not get the patient to tell you what he/she has already been told before you launch into your own explanation, it could be somewhat different to what the patient has already been told. Finding out first what the patient already 'knows' enables you either to confirm it or correct it.

The patient needs time and the opportunity to ask his/her own questions. It is essential, in answering them, not to speculate. If you do not know the answer, say so – but give an undertaking to find out the answer, and let the patient know.

Similarly, it is very respectful to ask the patient first what he/she would like to happen next, and from that open a discussion on the options, rather than rush in and tell the patient what you think needs to be done.

If you give commitments, meet them

The patient's trust in the health-care team is very fragile after an adverse event. Rebuilding trust means that if you say you will do something by a certain time, then do it – or come back at that time with a very good reason why you have not, yet.

These patients get an automatic 'upgrade' from economy to first class

Every 'i' needs to be dotted and 't' crossed in this patient's care. Do not rely on others to get that result or make that appointment, do it yourself. Make sure you visit the patient very frequently. No more mistakes can be allowed to happen. No delays. No miscommunications. Minor incidents that at other times would only be upsetting will now have the effect of rubbing salt in a very sensitive wound.

Keep close

There is a natural tendency to put distance between ourselves and an adverse event. It is a very human reaction to think that, provided the patient is recovering, we do not need to see them all that often – and be reminded of our fallibility. A very human reaction – but a very wrong one. You need to stay close to such patients and their relatives until they have fully recovered. The thought should never cross their mind that you have abandoned them.

Look after yourself

As time goes by, do not sweep the incident under an emotional carpet. Go back to the mentor you consulted when it happened, or seek counsel elsewhere, but make sure you appropriately debrief and come to terms with what has happened. Do not continue to beat yourself up when others are trying to tell you that it had nothing to do with you. Conversely, do not rationalize away any sense of responsibility when some is truly there. If it was your fault, accept that, learn from it – and move on.

People think that medical defence organizations still have a 'deny and defend' mentality. That's at least half a century out of date. The Medical Protection Society strongly supports a culture of openness in health care. A detailed explanation of what that means in practice is available in the Medical Protection Society (2011) booklet, *A Culture of Openness*, which can be downloaded from www.medicalprotection.org/uk/booklets/a-culture-of-openness. A workshop the Medical Protection Society provides to its members, 'Mastering Adverse Outcomes', details communication tools to assist when dealing with patients after adverse events.

Doctors tend to divide how they provide information to patients into two processes: 'informed consent' when it occurs pre-treatment and 'open disclosure' when it occurs after. It is more helpful to think of an information continuum which extends across the whole clinical journey of the patient, one based on empathic openness. The information continuum is one component of a relationship continuum. When something goes wrong, the patient's attitude to you after the event will be profoundly influenced by the relationship you created with them before the event occurred. Alice Burkin is a prominent claimant's lawyer in Boston. She can have the last word. In an interview in 2001 she said that in her experience: 'People just don't sue doctors they like (Rice, 2001).' **BJHM**

KEY POINTS

- It will happen to you.
- A truly tragic outcome of an adverse event is to fail to learn from it.
- Saying 'sorry' is not enough.
- Beware of becoming the 'second victim'.
- Don't just do something, stand there.
- Listen first.
- If you give commitments, meet them.
- Upgrade these patients from 'economy' to first class'.
- Keep close.
- 'People just don't sue doctors they like.'

Conflict of interest: Dr P Nisselle is an employee of the Medical Protection Society. One of his roles is to facilitate workshops for Medical Protection Society members, including the one mentioned in the text of this article. He also wrote sections of the Medical Protection Society booklet mentioned in the article 'A Culture of Openness – The MPS Perspective'.

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