When Things *go* Wrong

In the Ambulatory Setting

All health care professionals strive to provide high quality, compassionate, and error-free care. However, mistakes, sometimes serious mistakes, can and do occur. In such situations, we must strive to put ourselves in the patient's shoes, be honest, and work to preserve a healthy clinician-patient relationship. Sadly, fears of malpractice liability, guilt, insecurity, difficulty communicating bad news, lack of knowledge about how to effectively communicate following an error, and confusion about causation and responsibility too often complicate discussions of medical error. If physicians and practices have a strategy for dealing with these cases in an open and candid way, they begin a process that can create a healing and learning experience from even the worst situations.

In 2006, a historic consensus statement was produced and endorsed by all of the Harvard hospitals. The monograph, entitled ***When Things Go Wrong: Responding to Adverse Events***, broke new ground and set a new nationwide standard for hospitals to respond to inpatient adverse events and medical errors. However, nearly half of malpractice suits occur in the ambulatory setting. Though these errors are often not perceived to be as serious as those that occur in hospitals (i.e., catastrophic obstetrical or surgical errors), they can be just as serious. The greater patient volume in ambulatory clinics leads to a significant number of errors and malpractice claims, particularly related to delays or failures in diagnosis, and medication errors.

Many ambulatory practices struggle with time, staffing, and financial constraints, as well as a lack of risk managers, quality experts, and other support staff available in the hospital setting. To help primary care clinicians address these challenges, the AHRQ-funded Proactive Reduction in Outpatient Malpractice: Improving Safety, Efficiency, and Satisfaction (PROMISES) project brought together Massachusetts physicians, malpractice insurers, and policy experts to create this guide. It translates the techniques and recommendations of ***When Things Go Wrong*** for all staff working in the ambulatory setting.

Open communication with patients is especially important in the ambulatory setting, where adverse events can threaten long-term patient-clinician relationships. This guide offers the following aids for prioritizing safe and patient-focused care after an adverse event:

- **Guidelines for responding to an adverse event**
- **Tips and suggested language for communicating with patients after an adverse event**
- **Frequently asked questions about disclosure and handling of adverse events**

Guidelines for Responding to an Adverse Event

Disclose and Discuss All Significant Adverse Events

- Any injury to a patient caused by medical management is considered an ***adverse event***.
- All such events should be disclosed, regardless of whether they are due to clinician error.
- ***Acknowledge the event quickly.*** It is important to speak honestly with the patient as soon as possible when you learn something has gone wrong. Delays may allow the patient to assume you are hiding something, which can erode trust.
- ***Gather all information about the event*** as soon as possible to facilitate investigation of the causes of the event.
- ***Use the "golden rule" as a guide regarding harmless errors or "near-misses."*** Tell your patient anything that you would want to know about if you were in their position.
- ***Report only the facts of the incident.*** Initially tell the patient what occurred, not how or why. This second step should wait for a fuller investigation into the causes of the event.
- ***Minor errors generally do not need to be disclosed*** if not affecting patient well-being.
- Many times the patient (or family) will be the first to identify a problem or concern. ***Work collaboratively*** to listen to and investigate their concerns.

First Ensure Patient Safety by Providing Any Needed Further Care

- ***Address immediate patient safety concerns first*** to ensure the patient receives any urgently needed treatment, and is safe from continuing harm.
- ***Communicate with your malpractice insurer*** and take advantage of their resources. Most companies have both in-person and online risk management assistance available.

Express and Act with Empathy Throughout the Disclosure Process

- ***Acknowledge the event and express your natural feeling of empathy.*** Listen to the patient to show that you are genuinely sorry, and want to support them in any way you can.
- The physician responsible for the patient should ***meet with the patient and/or family*** in a quiet, unrushed setting. It is best if the PCP leads the discussion, even if the event involved other staff, doctors, or nurses.
- ***Follow up with the patient*** to offer further support and explain what you will do to prevent future similar events. Disclosure is a ongoing process and requires relationships built on trust over time.

Provide Feedback and Follow-Through

- ***Report the results of the investigation*** as soon as you have them. Patients have a right and a desire to know what happened.
- ***Apologize if there has been an error or systems failure.*** True apology requires that you ***take responsibility*** for what happened, ***show remorse***, and (to the extent possible) ***make amends***. If there was no mistake, then don't apologize, but explain how the event happened and reinforce your regret about what happened.
- ***Tell the patient what will be done to prevent a similar event from happening again.*** Knowing that others will not be hurt in the same way can ease the patient's pain and suffering.

Support Clinicians as Well as Patients

- ***Cultivate a blame-free atmosphere in the office.*** Recognize that most errors are due to system failures, not personal negligence. A blame-free structured debriefing of the event is the best way to understand its causes, and discover ways to prevent it from happening again.
- ***Doctors, nurses, and staff need support too.*** Clinicians are often emotionally and functionally affected by adverse events, and may benefit from counseling or other services, such as those offered by Medically Induced Trauma Support Services, an organization that provides assistance to all parties involved in medical errors (www.mitss.org).
- ***Provide coaching*** on communication with patients and families.

Tips for Communicating with Patients after an Adverse Event

Start Off on the Right Foot

- ***Be the initiator of the disclosure process.*** Don't wait for the patient to contact you.
- ***Choose a quiet, private area and time*** for communication with the patient. Invite family members whose presence is requested by the patient, and any involved clinical staff.
- ***Gather appropriate materials.*** Debrief the facts of the incident with all involved parties (respecting confidentiality concerns) before meeting with the patient. Continue gathering information as you investigate factors that led to the event.
- ***Pay attention to body language and tone.*** Make eye contact, speak calmly and slowly, and lower your voice; avoid crossing arms and legs, and lean forward to listen.
- ***Be prepared to handle your own emotions*** and reactions to those of the patient and/or family members present.

Address These Main Points at Your First Meeting

- ***Express empathy with the patient and family.*** Let them know you are sorry the incident occurred, and for the pain and suffering it caused. Show that you care and share their concerns.
- ***Describe what you know about the incident simply and concisely.*** Spend a few minutes outlining what happened. Stick to the known facts; don't speculate on causes or fault.
- ***Listen actively.*** Schedule as much time as needed for the family and patient to share their perspectives and tell you what can help them heal and move on. Do not interrupt or try to rush them.
- ***Explain your plan of action*** and what to expect. Explain that you will investigate what went wrong, and will let them know as soon as you have more information.
- ***Arrange for a follow-up meeting*** within a week or two. It is important that the patient feel your continuing concern. Make yourself available at any time they wish to contact you.
- ***Provide resources.*** You may want to offer a referral to community resources or another physician for care or a second opinion, as well as financial support where needed/appropriate.

Use Healing Words

- ***To express regret:*** "I am (we are) sorry this has happened to you."
- ***To apologize:*** "I (we) have made a mistake that has hurt you, and I am so deeply sorry."
- ***To tell your patient about what happened:*** "We failed to diagnose your prostate cancer as early as we could have," "You received a prescription for twice your normal dose of medication, leading you to bleed into your intestines."
- ***To show you are working to fix the problem:*** "We don't have all the information about what happened, but as soon as we learn more, we will let you know," "We are working to figure out what went wrong so that it doesn't happen to anyone else."
- ***To console the family:*** "I know it can be difficult for a family struggling with a medical injury. I am the responsible physician, and available for anything you need, as long as you need."

Follow Through with Your Patients and Your Promises

- ***Give the patient space to process.*** Some patients may be overwhelmed by too much physician contact. Just make sure they know that you are available and want to help.
- ***Follow up at regular intervals.*** Call after one week, one month, and three months. Arrange a meeting when you have learned more about the causes of the event, and are able to tell them what you are doing to avoid future incidents.
- ***Analyze the root causes of the injury.*** Think about what systems were involved, and at what point(s) they failed. Focus on small, practical process and system changes. (Resources on system thinking and quality improvement can be found at www.ihi.org).
- ***Implement changes to avoid a recurrence.*** Start with small changes: e.g., if a colorectal cancer diagnosis was missed due to poor communication with a specialist, reach out to their office to devise and test a better method of exchanging information.
- ***Take time to reflect*** on the event and your response to it. How did it affect the way you practice? How can you and your practice learn, grow, and change as a result of this experience?
- ***Get feedback on your disclosure and follow-up process.*** Ask the patient what was constructive in your process, and what you could have done better.

Frequently Asked Questions

Why is it important to communicate immediately with patients?

Early acknowledgement is essential to maintaining trust. It's not difficult to preserve trust when there have been no problems; the real test is when something has happened that may strain it.

In situations where the physician had nothing to do with an adverse event, why should he or she take personal responsibility for it?

Patients look to their physician for care and comfort. Although a host of factors likely contributed to the adverse event, patients look to their physician as the person responsible for their care.

Why should a physician personally apologize for an error, even if several systems failures are responsible rather than one person?

Apology is taking responsibility for the system of care that harmed the patient. Explaining the event, taking responsibility, communicating remorse, and making a gesture of reconciliation are essential to defuse the hurt and anger that follows an injury.

Won't apologizing for an error put me at greater risk for a malpractice suit?

Published literature and experience in malpractice cases indicate that contrary to belief, there is no evidence that disclosure or apology increases the risk of a malpractice suit. In fact, experience indicates just the opposite: failure to communicate openly, take responsibility, and apologize contributes to patients' anger and desire to sue.

Why is it important to work with families as well as patients after an error?

Family members are an integral part of the patient's medical care experience and the core of their support structure. Following an injury, patients and families need more support, not less, even though both patients and clinicians may feel a wish to distance themselves from one another.

Why is it important to support clinicians after an adverse event?

Doctors, nurses, and staff are likely to be deeply affected by an adverse event, especially if they made a serious error. Frequently they are unrecognized "second victims," blaming themselves. Providing a structured support system can help them heal and reduce the emotional impact of the event.

Why should clinicians tell patients what changes will be put into place to prevent future similar events?

Injured patients have a strong interest in seeing that what happened to them does not happen to someone else. Knowing that changes were made, and that some good came of their experience, can help patients and families cope with their pain or loss.

Won't my patient lose confidence in me or be upset if I describe what went wrong?

Patients expect honesty, not infallibility. They don't sue doctors for failing to be God; they sue for failure to be human. Acknowledging mistakes shows patients that you put their welfare above your pride. Even after reaching out honestly, you must recognize that patients/families may still be angry. While we may not always have a happy ending, we can rest assured when we've done the right thing.

If you are interested in learning more, the original ***When Things Go Wrong*** article is available for free at http://www.macoalition.org/documents/respondingToAdverseEvents.pdf.

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