Mastering Difficult Family Conversations in Surgical Care

Error Prevention

Explaining the Error

Welcome to the second of several short instructional modules on medical error disclosure. In this module you will consider several strategies for explaining an error.

Imagine yourself on night call. It is 8:20 in the morning, and you’ve just come from the OR. This was supposed to be a routine procedure for a middle-aged adult. But it turned into a nightmare after you accidentally injured a major blood vessel. You eventually controlled the bleeding, but not before the patient went into shock. She is now in the ICU. It is uncertain whether she will fully recover. You know this is a potentially preventable adverse event – a harmful error.

So what are your next steps? Following the guidelines from Module 1, you’ve

- organized all the facts
- notified your senior colleagues
- quickly debriefed with staff
- reviewed the patient’s chart showing next of kin
- found a place to hold the conference, and
- tried to calm your nerves and collect your thoughts.

Now it’s time to face the family. But what, exactly, are you going to tell them?

Following our model for error disclosure, you will need to tell them that something unexpected happened. You need to describe what went wrong in the operation, why it went wrong, how that affected the patient, and what you are doing to do about it. You need to be clear that this was an error. You need to be honest about what you know, and what you don’t know about the patient’s prognosis. While there are various strategies for delivering this information, no part of this explanation should be left out.

Given this stressful situation, what things are actually working in your favor? If you already know the family and have a relationship with them -- that is a huge plus. You can also draw on your experience in explaining things to patients in a logical sequence using lay language.

Surgeons are generally good at explaining things. In a study of error disclosure using standardized patients, surgeons were rated highest on their ability to explain the medical facts about the error. Other studies that have examined communication skills have found that surgeons generally excel in discussing procedures and risks during informed consent.
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The literature is clear about the factual content of disclosure. There is also agreement that for most cases, the information should be delivered soon (within 48 hours of the event). If patients and families are left in the dark for too long, or only find out days or weeks later that the cause of the complication was due to physician error, their trust in the system evaporates. They fear that even more information is being withheld from them. They become angrier, and more likely to pursue legal options in order to discover “the truth.”

Some of the guidelines for starting an End of Life Family Conference are similar for error disclosure. You might begin with what family knows about the purpose of the operation, or their relative’s current status. Be sure you are asking this, however, not in order to decide how much of the error to disclose, but rather, to learn what gaps in their knowledge you need to fill. You’ll want to give them a warning shot. Expect to spend a significant amount of time explaining what happened; they may not be able to absorb it all at once. It is critical that you answer all of their questions, and verify their understanding by asking them to tell you what they have heard you say.

Unlike an End of Life conference, in Error Disclosure we have two kinds of bad news to convey: first, that the family’s loved one has suffered a poor outcome; and second, that this outcome was at least partly preventable. This leaves providers with the challenge of deciding just how to sequence these two kinds of bad news. Which should you explain first: the poor outcome or the error?

Should you start with the patient’s current status and lead backwards into the problem and error?

Or should you start with the error, which led to the problem and the patient’s current status?
Or should you tell the story chronologically, beginning with the patient’s initial history and an error? The literature provides no guidance on the best way to order the information.

So let’s look’s look at some examples. How did this provider sequence the information? What might you do differently?

It appears that this provider, in an effort to be as direct and honest as possible, focused too early and too abruptly on the error. The family had no context for what he was talking about. They didn’t know that a chest x-ray had been taken. They had come to the meeting expecting to hear a simple update about their patient.
The encounter would probably have gone better had the provider taken a step back and thought a little more about how to organize the conversation. His tone might also strike some people as too casual, and he seemed caught off-guard by the family’s questions.

Let’s look at another example. How does this provider sequence the information? What might you do differently?

In this example, the provider began by reassuring the family that the patient was okay. That likely communicated to the family that the patient’s well-being was her first concern, as well as theirs. She then gave the family a warning shot – “I came to talk with you about a complication.” She then said an error had occurred – a delayed reading of the EKG. It wasn’t entirely clear that the family understood why she was talking about an “un-read EKG,” since they didn’t know there was a problem. The provider then revealed that the patient had suffered a heart attack.

She had a warm but serious tone of voice that seemed effective. When the family pressed her for information, she readily reiterated that the “heart attack happened here at the hospital,” and two days had passed before they caught it. While this news was obviously distressing, her ready answers may have reassured the family that she wasn’t holding anything back.

In our final example, we see a somewhat different sequencing of information. What is it, and what might you do differently?

In this excerpt, we see the provider begins the conversation with what the family knows. She then reviewed the history of colon cancer and what the medical team was doing to treat it. She then described the team’s concern for potential sepsis, and their decision to replace the central line due to a suspicion that it was causing some infection.

She then explained the error (the pneumothorax). She elaborated how it happened by pantomiming different points of entry. Overall, she presented the information in a very logical sequence and with a respectful, serious tone. Although she used some technical words, she appeared not to confuse the family.

The bottom line is you need to cover all 5 components of disclosure. The order in which you cover them will likely depend on your prior relationship with the family and their needs. It may also depend on the severity of harm. The greater the harm, the greater the need to work up to (a) the problem, and (b) the fact that it was caused by an error.
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With a harmful or horrific error, you may want to start with the patient history and your best intentions with treatment, followed by the unexpected problem. It may take a while for that to sink in. Once that information is absorbed, you would then explain that, unfortunately, this outcome was due to an error. With a less harmful error, you might start off by saying the patient is doing well; however there were some problems, caused by error. You would then explain what happened; and end with what’s being done about it.

In closing, you might experiment on your own with different ways to sequence the five components of the error message. In the next module, we will discuss the emotional impact of disclosure on families, and how the manner in which you address their feelings probably trumps even the facts surrounding the event.