

Bridging Physician-Patient Perspectives Following an Adverse Medical Outcome

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“Human error and systems conditions periodically align and combine to contribute to unanticipated adverse outcomes for patients. What is most important is the manner in which we handle these adverse outcomes. Patient safety and clinician welfare will be best served if we are honest about unanticipated adverse outcomes with our patients, open with our colleagues and ourselves, and able to handle such occurrences with sympathy and empathy for our patients and our colleagues.”

—Kaiser Permanente’s Statement of Principle, from the Implementation Guidelines for Communicating Unanticipated Adverse Outcomes, October 2002¹

During the course of physician-patient interactions in today’s increasingly complex health care environment, conflict inevitably arises. Advances brought on by modern medical technology—effective drugs, accurate tests and diagnoses, physiological processes mapped and documented in electronic medical records—have raised the bar for consumer expectations of health care professionals. Physicians are held to very high standards, sometimes leaving them and their patients ill-equipped to cope with medical complications and unexpected outcomes. In the aftermath of an unanticipated adverse outcome, how health care professionals deal with errors has gained greater importance and attention, and has led to the creation of Kaiser Permanente’s (KP) HealthCare Ombudsman/Mediator (HCOM) program in 2003.^{2,3} (See sidebar: HealthCare Ombudsman/Mediator Program: Overview.)

The HCOM is involved in a variety of cases, ranging from unanticipated adverse outcomes and medical errors to physician-patient communication breakdown and patient dissatisfaction with treatment outcome or quality of care. Anyone who has an interest in the medical care of a patient may make a referral to the HCOM. To support better physician-patient communication, the HCOM actively listens to patient

concerns, makes informal inquiries within the health organization, seeks answers to those concerns, and facilitates frank and transparent discussions between patients and physicians. In preparation for these conversations, the HCOM will help physicians deal with their own reactions to these events and help frame thoughtful responses, particularly when an apology is warranted.

The following case is based upon a true story and presented to illustrate how divergent physician and patient perspectives can be bridged following an adverse outcome. The patient’s daughter provides insight into her mother’s experience and how it affected their family. The physician offers his point of view and thought process before initiating a disclosure conversation. The HCOM’s role is to understand the parties’ competing perspectives, find commonality in their objectives, unite them in overcoming earlier mistrusts and fears, and ensure that both parties emerge with a better understanding of the other’s intentions.

The Patient’s Story

Until my mother went through this experience, it never occurred to me how much medical professionals ask of us. Our family was asked to entrust the care of our loved one to strangers, her life and health to a system that sometimes creates barriers for the sake of efficiency. Then in the face of an error we are expected to stay quiet and accept this devastating impact on our loved one.

My 75-year old mother was plagued with multiple medical problems and consequently, I was very involved in her care. My mother was not a complainer and tolerated more pain than necessary. So, when she began complaining of pain in her left knee, we knew surgery might be imminent. However, as other medical problems needed resolution, she waited a long time for her total knee replacement.

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Finally, the surgery occurred, leaving us with the hope my mother's knee pain would resolve. Two weeks into her recuperation, however, her surgeon informed us that something had gone wrong. They inserted the wrong part in my mother's knee during surgery. I couldn't believe it. I was afraid once my mother was admitted for surgery she would become a number, no longer a person but a body part awaiting repair. My worst fears were realized. Worse yet, I was the one who talked my mother into getting this surgery. Although I appreciated his honesty, this was not the outcome my mother expected. And why did he wait two weeks to admit his error?

I felt somehow responsible. I had advocated for my mother to have this surgery. How could I have let this happen on my watch? Now she needed a second surgery and I worried that she may not be comforted by my advice. How was she ever going to trust her doctor again after all that had happened? This experience left us reeling and we didn't know who to turn to.

Working with the HCOM was initially not a consideration; however, the HCOM explained her role as a

neutral mediator who could facilitate our meeting with the doctor to address our many unanswered questions. Although I was still angry and frustrated and unsure the HCOM's involvement would lead to a productive conversation, it seemed the only way we were to get some answers and get mom the care she needed.

When my mother and I finally met with the physician, I sensed he was nervous and tentative, worried about how we were going to react to what he would share with us. He talked us through the surgery in detail, even showing us models of parts he used during surgery and explaining the function of each. He did so with patience and kindness, reminding me why we trusted him in the first place. He was a well-intended doctor having my mother's best interests at heart; a human being who simply had made a mistake. He thoughtfully offered to assist us in choosing another surgeon if we preferred not to have him perform my mother's repeat surgery. Although I anticipated my mother's anxiety, I knew there would be no other physician she would trust. It felt as though we had been on a long and difficult journey with him and it made sense for us to continue to travel this road together.

My mother and I really valued meeting with her physician who gave us a better understanding of the events surrounding her surgery. I recall how hesitant we were to bring forward our initial concerns, fearing we could compromise my mother's future care. I feel fortunate to have found a resource in the HCOM; she was honest, genuine and treated our entire family with respect and dignity, particularly during those times when we felt isolated and alone. Ultimately, it was the HCOM who reached out and supported us, helping to restore our faith in the physician's integrity and KP's efforts to prevent this error from happening to others. From the beginning we have said we believe things happen for a reason. My mom was chosen as she was strong enough to survive and because of what happened to her, care will be safer for other patients.

HealthCare Ombudsman/Mediator Program: Overview

The HealthCare Ombudsman/Mediator (HCOM) Program was established within Kaiser Permanente (KP) in 2003. There are 28 HCOMs serving KP in both Northern and Southern California. While the primary HCOM focus is to resolve patient disputes regarding the quality of care, for which there is over a 90% satisfaction rate among clinicians and staff, a significant time (hundreds of hours) is spent educating physicians and clinicians how to:

- communicate unanticipated adverse outcomes or medical error
- better listen and appreciate a patient's perspective of an adverse event
- facilitate a sincere apology when warranted
- re-establish clinician-patient trust through transparent communication regarding medical care.

The HCOM program is but one aspect of a fully integrated approach in handling unanticipated adverse outcomes. This approach also includes the Situation Management Team (SMT), Medical Legal and Early Resolution Payments (ERP), Communicating Unanticipated Adverse Outcomes (CUAO) training programs and formal processes contained within Quality, Risk Management and Member Services.

The Physician's Story

As a trained, experienced orthopedic surgeon having performed hundreds of knee arthroplasties in my career, I know surgical misadventures are an inherent risk of invasive surgery. But inserting a wrong femoral component into a patient is not something I'd ever done before. How could I have made such an obvious mistake? I recounted all the events of that day, retraced every step and wondered, and perhaps hoped it was someone else's misstep that caused the error. Even if that were true, I knew as primary surgeon I

bad to assume responsibility for what had happened and others would hold me accountable as well. Then I worried how this would affect my reputation, if I had put my medical license and livelihood at risk? How would I explain myself to a peer review? Then I had a rescuing thought; inserting the wrong prosthesis can be an incidental episode that happens during surgery without necessarily affecting the overall outcome. I decided to wait and see how the patient responded to the procedure. If she responded well, I saw no reason to worry her needlessly.

As days passed, then a week, I struggled with my decision to withhold this information from the patient and her family. I sought reassurance in medical literature and discussed the event with colleagues, still hoping the wrong prosthesis wouldn't cause a problem. Yet, the more information I discovered, the more I became aware that my patient may endure unexpected complications and require a second operation. One colleague suggested I speak confidentially with the HCOM. I was reticent to share my story with a nonphysician but did so anyway not knowing what to expect.

I approached the HCOM and asked if she thought I needed to disclose the error to the patient. She advised exactly that which I feared most—disclosure. Observing my hesitancy, she advised I consult with the Assistant Physician-in-Chief of Risk who also counseled disclosure. The decision was now clear; the way to go about it was not.

Fearing the disappointment and anger my patient and family would likely show me, the HCOM prepared me for this conversation, suggesting I use my anatomy model and sample surgical parts to help explain the wrong prosthesis inserted and its possible consequences. She also advised me to let the patient and family know this error is being taken very seriously and we are looking into how this happened so we can make sure it doesn't happen to someone else.

Two weeks had passed since the surgery and I anxiously waited to meet with the patient and family to discuss my surgical mishap. As I did so, I awkwardly felt a sense of relief in telling the truth and apologizing for any harm I may have caused, even as I feared the backlash of anger that was sure to follow. However, the patient became only tearful and disheartened as I explained the need for a revision surgery. The family consoled her and appreciated my honesty, although clearly disappointed with the news. I offered, for the patient's consideration, the option of choosing another surgeon for her second operation.

Days later, the family informed me of their wish that

I perform the corrective surgery. My patient expressed her trust in me, noting the importance of our long-standing relationship to her successful knee repair and recovery. I had graciously been given a second chance and looked forward to performing her surgical repair. As the surgery day arrived, the patient's daughter told me how difficult it was to persuade her mother to undergo a second surgery; I again experienced a pang of conscience simultaneously with a resolve to set things right. The surgery, in fact, did go well. I remained vigilant if not anxious to see if my patient would recover without complication, which she did. Thereafter, I followed-up with my patient and her family, explaining the systemic changes made to prevent a wrong part from ever being introduced during a surgical procedure.

This process of explaining myself, opening me up to colleague scrutiny and patient disappointment, was by no means easy. Nevertheless, I know the price paid was infinitely less than living with the thought I had caused harm to a patient and did nothing to remedy it with a truthful disclosure and a heartfelt apology.

The orthopedic surgeon in our story, not unlike the patient's daughter, experiences mental anguish and soul-searching. As commonly occurs, this physician questions his competence, relentlessly revisiting details of his patient's surgery in his awakened mind and sleepless nights. Nothing prepares physicians for how to appropriately respond to errors, as an atmosphere of mastery, precision, and competency pervades their rigorous medical education and training. The competitive nature underlying one's medical training does not encourage physicians to easily share guilt, fear, and uncertainty with colleagues.⁴ Moreover, a medical error of this import may thrust the physician into the unfamiliar and intimidating medical legal world, further isolating him and threatening his medical reputation.

Physicians are healers who have taken a sacred oath to "do no harm." To the physician, it can be demoralizing when years of rigorous education and training, all designed to help the patient, result in harm. The initial impulse may be to turn away from the patient who was harmed, even though this is the time they need their physician the most.⁴ Obviously, a medical error is devastating, but in its aftermath, miscalculating what is important to the patient and the family can make things worse. Going back and picking up communication that has been dropped can bring healing to a difficult situation. Stepping closer to the flame

is counterintuitive, but it is exactly what is needed. This physician and patient were courageous enough to take that step.

It is an HCOM's responsibility to connect these two very different stories in a way that creates a new story of collaboration and relatedness. Stories such as these take on a life of their own and become the road map for everything that befalls the patient and the physician. The more the stories are retold, the more divergent the different perspectives become. Yet, the common theme between these two stories is humanness. The physician and the family both feel guilt for their role in what occurred, each feeling accountable and invested in the patient's well-being. An HCOM's intervention is instrumental in assisting physicians and patients to restore a trusting relationship. Re-established communication following an unanticipated adverse outcome often yields a deeper, more meaningful relationship than existed before: a relationship built on collaboration, understanding, and respect.⁵ Highly skilled and expertly trained HCOMs draw upon their diverse backgrounds and disciplines to identify participants' differing perspectives, share individual feelings and draw parallels between their common experiences and intentions. Participants are moved beyond their respective roles as physician and family to embrace their shared humanity and concern for a better outcome, not just for this patient but for others who follow.

Ultimately, the HCOM's goal is to help the patient, family, and care team inhabit their best version of themselves by being honest and transparent in their communications. Donald Berwick, MD, Administrator for the Centers for Medicare and Medicaid Services and former President and CEO of the Institute for Healthcare Improvement writes, "... extend transparency to all aspects of care, including science, costs, outcomes, processes, and errors. Apologize when things go wrong."⁶ Through skillful shuttle diplomacy and face-to-face mediation, the HCOM process allows both physicians and patients to gain insight into the other's inner narrative, moving ever closer to resolution. ❖

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