

# “The Other Side of the Fence”: A Geriatric Surgical Case Study of Error Disclosure

By Robert Formanek, Jr, MD  
Doug Bonacum, MBA, CSA

## Introduction

Learning and continuous improvement are cornerstones of the profession of medicine. Learning methods available for physicians and other health care professionals include case study and peer review. Through their application in the examination of clinical care, insights are gained to improve the performance of individual clinicians and teams as well as the health care system at large.

This article includes panel discussion, commentary, and excerpts from a letter entitled *The Other Side of the Fence*,<sup>a</sup> which was written by a patient's daughter to a Kaiser Permanente (KP) facility Healthcare Ombudsman/Mediator (HCOM) following her mother's death. It represents an actual case—a true story—that offers a number of dimensions from which to learn, including the unique point of view presented by the patient's daughter about her mother's course of care. In the letter, the daughter reflects on her mother's care experience, which involved an unanticipated adverse event.

Her disappointment regarding her relationship with and confidence in the health care team implores us to look deeply into the meaning of high-quality, patient-centered care. As individuals and as a health care organization we must ask: What can we do better to give our patients and their families the comfort of

knowing that their health care team is “on their side” and not “on the other side of the fence”?

Brent James, MD, a nationally renowned physician leader in clinical quality improvement at Intermountain Health Care in Utah, emphasizes the critical importance of trust in one's physicians and other health care professionals. This trust forms the basis for the therapeutic relationship—the trusting relationship—that is foundational to the provision of safe, high-quality health care. He argues<sup>b</sup> that to achieve this trust and, thus, to be a complete physician, a complete nurse, a complete social worker, ie, a complete health care professional, one must effectively play the “caring role” in concert with the more familiar “curing role.” By skillfully manifesting both, patients will know their health care team is indeed on their side.

In this case study, the patient's daughter and attending surgeon share the story of the 90-year-old mother admitted to the hospital with a hip fracture. In addition to the “factual,” objective information related by the storytellers, there are critical subjective elements—particular beliefs, values, and emotions—that interplay with the clinical decision-making process. Following the story, three KP experts provide analytic commentary.

The article challenges us to:

1. distinguish between the “curing role” and the “caring role”
2. expand the “caring role” as professionals, as teams, and as a health care system
3. be mindful of and address conflict between our own values and those of our patients
4. affirm the importance of timely, honest, and empathetic communication as essential to the therapeutic relationship, and
5. identify local resources for advice and support, especially following an adverse event.

## The Story

**Daughter:** My 90-year-old mom was on the frail side, but she lived independently in her own apartment. She played cards a couple times a week with her friends. She read three or four books a week, did a crossword puzzle every day, and watched one, and only one, TV show—*Jeopardy*. In December 2005, my mother fell at home and fractured her hip. She was taken by ambulance to the emergency room and I was informed that she would need to go to surgery. Her surgery had to be delayed for a day however, because she was in atrial fibrillation, which required medication control.

My mother wanted me to let everyone know about her advance directive and that the most important thing to her was the quality of her life, not the quantity. She didn't fear

**Robert Formanek, Jr, MD**, (left) is the Medical Director for Medical Directors' Quality Review (MDQR) at The Permanente Federation in Oakland, CA. E-mail: robert.formanek@kp.org.  
**Doug Bonacum, MBA, CSA**, (right) is the Vice President, Safety Management, the Department of Care and Service Quality of Kaiser Foundation Health Plan and Hospitals in Oakland, CA. E-mail: doug.bonacum@kp.org.



death; she feared the process of getting there. So, I was very clear with everyone from day one that she had an advance directive, and I made sure that everyone had a copy.

On the following day we waited for her to go to surgery and nothing was happening. The nurses on the floor didn't seem to know what was going on. Finally, around 7:00 pm, they told me they couldn't fit her into the schedule and she would have to go the next day. On the following day she did eventually go to surgery. She did well during surgery and woke up normally.

On the day after surgery the physical therapist came in and we went to get her out of bed. When she stood up on that leg, she really screamed in pain. We were both surprised. Later, the therapist mentioned to me she may have been being a bit melodramatic, because it shouldn't have been that painful.

**Attending Surgeon:** The surgery went well except I had a little trouble inserting the implant after the fracture was in place, but I didn't question it because everything came together well. Afterwards I checked the x-ray and then moved her hip; the motion was fine, and it appeared stable. On the third day after surgery I came to see her—I had been off the weekend—and I noticed her increasing need for pain medicine. She was not very communicative herself, but her daughter was concerned and had good reason to be, because I too did not expect that much pain on the third day after I had fixed the fracture.

I repeated an x-ray and noticed that the two bottom screws had pulled out and the implant had displaced so there was no longer fracture reduction. This was obviously very upsetting. I went and told the daughter that the fracture had displaced, the implant wasn't in the right place, and that we should revise the surgery—do

it over—to get the best possible chance for her mother to heal the fracture and to walk again.

**Daughter:** The next day came and we weren't given a time for the surgery. When it got to be late in the afternoon I made a few calls and was asked to go to the recovery area to speak to the surgeon. When I arrived, another orthopedic surgeon and an anesthesiologist were there with my mother's doctor. The other orthopedic surgeon seemed to take the lead in talking to me and he said they had shown my mother's x-rays to nearly all the orthopedists in the department and the consensus was that they didn't want to take her back to surgery. There was a chance it could heal if she didn't weight-bear for 30 days and that she would be able to get up after that. They were very concerned about the risk of taking a 90-year-old back to surgery. I was very clear with him that my mother was 90, she had led a good life, and these were her words more than mine: What was important to her was some kind of quality of life and being as independent as possible. It would be okay if she passed away in surgery. Her biggest worry was suffering in her last days and not being independent. He told me, "If it was my mother, I would not risk taking her back to surgery."

**Attending Surgeon:** I hadn't spoken yet and the daughter turned and asked me directly "What do you think?" And I didn't give her my opinion. I deferred to the other surgeon, saying he had a lot more experience than I did. And maybe they're right that she will heal in time, that there won't be any adverse effects, and her pain will decrease, and it would be too risky to have the surgery. So she accepted that and went along with it.

**Daughter:** So the plan was we

would wait three days, repeat the x-ray and if it looked like the bone was healing in place, we would wait three more days, repeat the x-ray, and if it looked okay, then my mom would go to the skilled nursing facility (SNF) and not weight bear for 30 days. Time went along and I was told the x-rays were either improved or looking the same. On day 13 of my mother's hospitalization, it was time for her to go to the SNF and she was scheduled for discharge. The medical, hospital-based physician who was managing her care told me he had concerns that if she didn't get up soon, she would never get out of bed. He asked if I would mind if he called the orthopedists and ask them to reconsider, and I didn't mind, and he called, and they declined.

**Attending Surgeon:** At that point, we admitted her to the SNF and ordered as much pain medicine as necessary. Over the course of the next month, we had x-ray follow-ups and conversations over the phone; however the mother's pain wasn't decreasing much. She still required heavy sedation and pain medicine.

**Daughter:** She was unable to eat much of anything. During her entire three-week stay she ate less than a cup of food. She told me, "I just really want to be comfortable and pass away." Nearly a month after she fell, the SNF doctor called me to say that she was still requiring a tremendous amount of pain medication, much of the time she was unarousable, and when she wasn't, she was crying. He was concerned that this just wasn't a normal course and decided to get another x-ray. He called me following the x-ray to say it was bad. All five screws were out of place. Even the plate itself was misplaced. He said we absolutely could not leave her in this condition and that she would have to be taken back for surgery.

**Attending Surgeon:** My patient's

... there are critical subjective elements—particular beliefs, values, and emotions—that interplay with the clinical decision-making process.

daughter and I discussed the fact that another surgery may be the best option for her mother, even now, a month later.

**Daughter:** My mother did return to the hospital. She was so fragile by that time from not eating. I just didn't know whether she could make it through surgery. I didn't want her to suffer any more. I did say to the doctors again; please don't worry if she doesn't make it through the surgery—at this point, if she doesn't, she would consider it a blessing. And again, it seemed that people were very uncomfortable with me saying that.

They did take her back to surgery, and on her second day post-op, she said, "My hip feels better, but I really don't want anything else done. I don't want to go through this anymore." At that point, I asked for the palliative care physician and nurse to come and see my mother.

I am not only a daughter of a KP patient; I'm a 25-year employee with KP. I'm the associate medical group administrator for a facility in the Northern California Region. And I thought to myself how helpless I felt in all of this, in dealing with physicians and their lack of putting a priority on the patient's wishes, especially a 90 year old with a very clear advance directive who comes in alert and awake and clearly stating her wishes. She didn't fear dying. She feared the process of getting there. I feel like we all let her down. She went to a nursing home under palliative care—she was there four days and passed away. That was February 2005.

Two days later, my mother's doctor came to my office in administration to tell me how sorry she was that my mom had passed away. She sat down and she told me a possible reason for things not going well: the wrong-angled plate had been put in my mother. She had ordered one

angle, but when it was handed to her in surgery, neither the tech, nor the nurse, nor she had checked to make sure it was the right angle. When they took her back to surgery, they realized this. She felt terrible about it.

**Attending Surgeon:** And then I drew a picture for her of the fracture and the implant, and how close the two angles were, and how easy it was to mistake them if you hadn't a suspicion. And that this may have been a cause for her mother's surgery failing, although I wasn't at all certain that it was. But even if it wasn't, I thought it was certainly something that she should know about ... And I was very surprised that she thanked me after I told her.

**Daughter:** I did appreciate her coming to apologize and telling me the truth of the events, and for the tears we shared together. It showed me that my mother wasn't just a number; that her doctor did care about her, and she felt very badly about what had happened. As a nurse, I know that medicine isn't always perfect and that mistakes happen, but I am hopeful that some lessons will be learned from my mom's case. I'm sorry that she had to suffer so much during the last weeks of her life, but I think she would be happy to know that some changes have been made so that this won't happen to someone else, and that her story will help physicians (and all health care professionals) think about the bigger picture of a patient's life, and their values and wishes.

### The Panel

Panel members are: Kate Scannell, MD, the Director of the Department of Medical Ethics for Kaiser Permanente Northern California; Sarah McCarthy, MD, the Assistant Physician-In-Chief (APIC) for Risk at a regional medical center; and Maureen Whitmore, the HCOM at

a regional medical center.

**Michael Ralston, MD (MR)** (retired Director of Quality Implementation from The Permanente Medical Group, the moderator): *What is KP's policy for communicating when an adverse event or outcome occurs?*

**Sarah McCarthy, MD:** When this happens, patients and their families want three things: first, they want an apology, if it's appropriate, or an expression of empathy for their experience; second, they want to know what occurred, how it occurred; and third, they want to know that we're doing something to prevent it from happening again to someone else.

We believe that it's our responsibility and our obligation to communicate with patients and their families, especially when an adverse event or outcome occurs. We also believe that it's the patient's right to have an explanation of what happened and to have that information in a timely, compassionate, and truthful manner. Using those three tenets, we train physicians and other practitioners to have these difficult conversations with patients. We also offer expertise through our HCOM, our Director of Risk Management, our APIC for Risk, and other physicians specially trained in communication techniques.

**MR:** *What is the role of the HCOM?*

**Maureen Whitmore:** The HCOM's role is to help resolve health care concerns and conflicts early, especially if an unanticipated adverse event occurs. An HCOM is an informal, impartial, neutral facilitator attempting to understand what happened—to understand the patients' and families' concerns—and to support physicians in communicating with patients and families when there's been an adverse outcome. In this case I coached the doctor, supporting her communication with the daughter. I offered to be present,

"... if she doesn't make it through the surgery ... she would consider it a blessing. ... people were very uncomfortable with me saying that."

if she wished. She felt comfortable making the communication without me, because of the strong relationship she had with the patient's daughter. After they met, she and I debriefed, and then I called the daughter to provide answers to any remaining questions and concerns. Our role is to support and advocate for the physicians, families, and patients, and for the organization; to understand and resolve the situation to the degree possible. Our role is also to highlight any system issues so these can be addressed in an effort to prevent something similar from happening to another patient in the future.

**MR:** *What is the role of the Ethics Committee or an ethics consultation?*

**Kate Scannell, MD:** When practitioners and patients feel they are on "opposite sides of a fence," that is a signal that the ethics committee or an ethics consultation could be helpful. I would like to think of that consultation as a search for a gate that opens opportunity for more effective communication, which reaches towards mutual and common understanding. The ethics committee would open the gate by opening a conversation in which different moral perspectives are aired and explored, and challenging ethical dilemmas are discussed in a

safe, reflective, nonjudgmental, and sensitive manner. This conversation often leads to decisions made with transparency, honesty, and inclusiveness, and it facilitates resolutions that people are committed to on a deep ethical and moral level.

The major reason an ethics consultation wasn't considered here was the lack of perception of moral conflict. The situation was viewed largely as a difference of opinion about the medical or surgical approach, rather than a difference in personal values. The mother professed certain deep and personal values about what mattered most in her life, and she made a concerted effort to express them. She also executed an advance directive in which she indicated her wishes and value priorities to inform medical decision making. The values of the practitioners differed from those of the patient. Her physicians may have prioritized a different value—quantity of life—over quality of life. An Ethics Committee consultation would have clarified these distinctions and framed the situation as an ethical conflict.

**MR:** *Since the initial focus was on the insertion of the wrong plate of a different angle than intended, was the issue of patient-centeredness overlooked?*

**Dr McCarthy:** As APIC for Risk and Patient Safety, my focus was to support the surgeon's communication with the daughter about the error that occurred. I was focused on how the error occurred, and what we could do to prevent this type of wrong device error in the future. At first, I didn't consider the more problematic issue, which was the patient's values and wishes not having been met and that this was an ethics issue. This makes it clear how readily available the Ethics Committee and consultants should be to practitioners.

**MR:** *What about the importance of understanding and respecting*

## Perspective from an Orthopedic Surgeon

By Thomas C Barber, MD

1. When to defer to a senior partner. The knowledge and understanding of older, more experienced partners should be valued. One of the great things about KP is the ready availability of more experienced physicians, to consult, either at our own facility or at another facility. However, care must be taken when advice is given from a physician who does not have an in-depth knowledge of the patient or case: even the most experienced physician may not be able to give the best advice for a specific situation. In this case a more experienced surgeon took responsibility for a patient he did not know well. In general we need to take advice from experienced physicians, filter it with the knowledge of the patient that we have, and come to our own conclusions. A physician who knew and was sensitive to the patient's advance directive wishes may have come to a different conclusion, as implied by the discomfort that the physician had with the senior physician's recommendation.

2. When to discuss adverse events. The fact that the wrong angle plate was used may have nothing to do with the outcome of this case. On the other hand, it might have been a contributing factor. When a physician feels that an adverse event might be related to outcome, it is important that it be discussed with the patient and family as mentioned in this case. Some reviewing orthopedic surgeons felt the error with the plate was not related to the outcome in this case, yet we still support discussing the issue with the patient and her family because the intent of the surgeon was to use a different angle plate.

3. Physicians may sometimes confuse a conservative approach to a problem with a nonoperative approach. It has been shown that the risk of mortality and morbidity is greater in letting an elderly hip-fracture patient lie in bed than it is to operate even in a patient who is at high risk for surgical morbidity.<sup>1</sup> The more conservative approach in this case would have been to reoperate as soon as the failure of fixation was noted. The mortality rate within one year of a hip fracture is about 20%,<sup>2</sup> and the patients who do better are those who are able to get up and walk quickly after injury. Given these statistics and the patient's desire for quality of life, a decision to reoperate as soon as the fixation failed might have been appropriate. ❖

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**Thomas C Barber, MD,** Associate Physician in Chief for IT and Surgical Services for the East Bay Service Area of Kaiser Permanente Northern California Region.

*patients' values during the medical decision-making process? How can we get better at doing this?*

**Dr Scannell:** Any time there is a conflict in thinking or approach, first make an intellectual shift from a medical conflict, a scientific conflict, to a conflict of values. Medicine is values-laden. The decision-making process should always incorporate a process of eliciting and sorting through values of the patients and physicians involved in the decision. Generally, once the conflict is understood as a values conflict, practitioners entrusted with the patient's care should honor the patient's wishes, promoting patient-centric care in which the values of the patient take priority in the decision. At times, that may not be feasible if practitioners hold contrary, deep-seated claims of conscience—another situation in which an ethics consultation could be helpful.

Throughout, it's important that practitioners remain conscious of their own values and not project them onto the patient; not use them to supplant the patient's values. Quality-of-life evaluations and decisions can only be made by the person living that life. Use the metaphor of "the fence." If you think you and a patient stand on opposite sides of a fence, look for a gate by looking for conversation about the moral dimensions characterizing the opposition.

**MR:** *The daughter and the surgeon did seem to have a close, trusting relationship. Is there a broader message about the physician-patient relationship?*

**Ms Whitmore:** What Dr Scannell has been saying underscores the importance of the caring role—listening for values and creating a trusting relationship early on with each patient, in this case starting in the Emergency Department, dur-

ing admission, while going to the operating room (OR), whether it be the physicians, nurses, respiratory therapists, other staff, and then continuing that relationship throughout the hospitalization, even, and especially, during and after an adverse event. Although such relationship building can be a great source of satisfaction, it requires skill, hard work, and the courage to have difficult conversations when necessary. We all need to support our practitioners in having these conversations.

### Discussion

KP enjoys a rich array of committed, competent, and hard-working physicians, nurses, other health care professionals, and staff who are highly trained and adept in the "curing" role. In addition, these individuals bring a wide array of abilities that serve them well in the "caring" role. Indeed, many patients experience a trusting, therapeutic relationship with their physician, their health care team, and the health care system.

Trust is established one "touch point"<sup>c</sup> at a time. To the extent a trusting relationship exists, it is to the credit of each and every person who has effectively manifested the curing and the caring roles. Yet, there is a gap between the consistency with which trusting relationships are built with patients and what we would want. In the spirit of closing this gap, we turn to a patient's story for insights from which we can learn and change for the better.

The story reminds us that, given the demands, complexity, and invasive nature of health care today, even well-trained, highly competent and capable professionals, working with the best of intentions, are not immune to unintended dire consequences. While we constantly strive

to reduce or eliminate unwanted events and outcomes; failing this, especially if we have been mindful of the "caring" role, we can at least extend open communication and genuine empathy when an adverse event or outcome does occur.

After the occurrence of an adverse event, we are likely to ask—especially when closely involved in the care—"How could this have happened?" and "What does it say about me as a professional and as a person?" In the face of such questions, special courage is required to remain open to critical examination so that we and our colleagues can learn from what happened and make changes to prevent similar undesired results in the future.

When examining issues of clinical judgment and decision making related to the safety and quality of care, we cannot always reach definitive, straight-forward, or unequivocal answers, and that is in some ways the case here. On the other hand, unanswered or incompletely answered questions are more likely to remain vital for further consideration, which in the long run can be of greater value to self-discovery and beneficial change than arriving at an answer and thereby closing down further consideration.

### The Caring Role

The panel provides us with an insightful discussion of key issues related to patient-centered care, including open communication, respect for values, and shared clinical decision making. We see that it is through the "caring" role that we recognize and respond effectively to personal values, especially when conflict exists between our values and those of our patient. This is a central lesson of the story. With that in mind, we proceed to additional issues raised in the story.

**Open, timely, and empathetic communication is the foundation on which trusting, therapeutic relationships are based and on which the safety and quality of care depend.**

**The Long Delay**

Most striking is the long delay in returning the patient to surgery after the loss of reduction of her fracture repair. Was this, as alluded to, related to fears (conscious or subconscious) that she would die in the OR? If so, and especially if this concern conflicted with the patient's desires, should the patient have been afforded a second opinion? This aside, one physician reviewer's dictum was: "Especially in the geriatric patient you get one chance, maybe two, never three. With each passing day, the patient grows increasingly frail and less resilient. When there's a complication, when something goes wrong, respond aggressively—don't delay!"

Still, several reviewers found the initial decision to delay the patient's return to the OR acceptable as "a short-term strategy," during which to assess for signs of positive progress. However, even the "other surgeon," upon whose advice the initial delay

was based, stated that knowing the patient's condition continued to deteriorate (which he did not) he would have recommended return to the OR. Decision making can often be a dynamic process. In this instance the team's communication was not managed across time. As a result, a one-point-in-time recommendation carried unintended weight going forward.

**Ageism**

Another question raised is ageism. Did this, perhaps unwittingly, prejudice the decision-making process toward an overly conservative approach? Yet another avenue for reflection is whether there were issues related to "psychological power imbalance" among members of the health care team and how this may have influenced the decision-making process. Are there similar overlooked risks in our own settings? How can we recognize and ameliorate them?

**Pain Control**

Then there is the issue of pain control. Typically, in the immediate post-op period following an acute surgical intervention, we expect to see an increase in the need for pain medication. However, over time it should steadily decline. In this case, the patient's escalating analgesic requirements (Figure 1) were a "red flag" that seems to have been missed. Again we can ask, what are the potential "red flags" in our setting? How can we be sure to recognize and act on them when present?

**Wrong-Angle Plate**

Finally, the surgeon's discovery during re-operation that the "wrong angle" plate had been used in the initial surgery focused attention on the case as a sentinel event. A sentinel event is defined by The Joint Commission as an unexpected occurrence involving death or serious physical or psychologic injury, or the risk thereof.<sup>1</sup> Regarding the "wrong angle" error, the majority of expert reviewers believed it did not contribute to the failed fracture repair. But even if this were so, should the surgeon still have communicated it to the daughter? How soon? KP has a policy of transparency and full disclosure.<sup>2</sup> What would you have done?

**Summary**

This is an unfortunate story of care that went wrong for an elderly patient, her daughter, and her surgeon. The daughter, in spite of a close relationship with the attending surgeon, was left questioning whether the health care team had been on "the other side of the fence." As the story unfolded, all experienced great pain in one way or another. In the aftermath, the daughter resolved to share her mother's story as a learning device with the aim of preventing

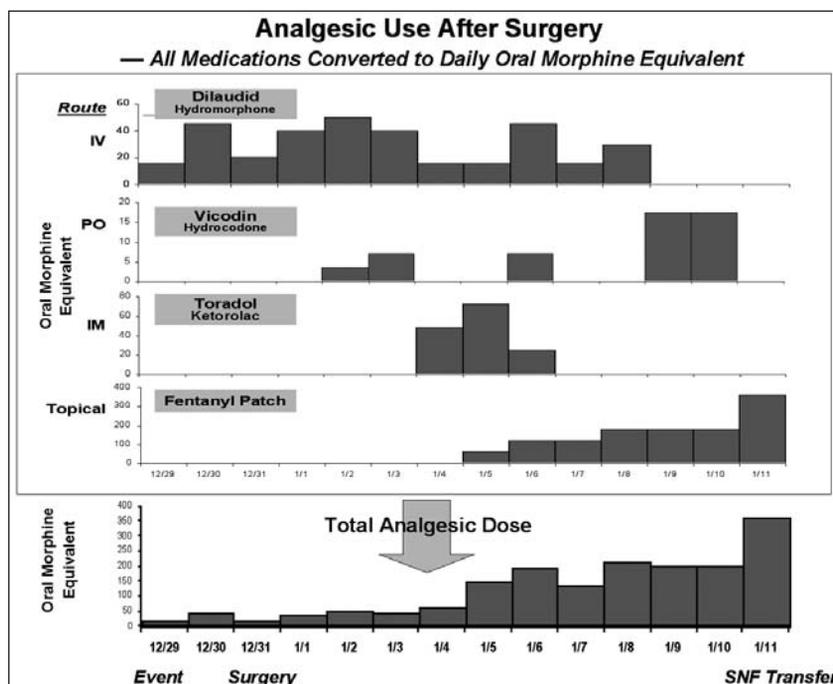


Figure 1. Chart of patient's analgesic use after surgery.

similar future occurrences.

The story is not unique because of its rarity, as most health care professionals can attest. In all likelihood it is not the "worst case we've ever encountered." Neither does it stand apart because it so perfectly illustrates a single point. It is special simply because it is available for our examination, not having been lost to the vagaries of the legal system or conveniently concealed as an embarrassment or threat.

In telling the story, the daughter and attending surgeon display great personal and professional courage, openness, and humanity as models for all of us to emulate when things go wrong. For this we are indebted to them. The issues involved were multiple and complex. We are invited to take the lessons, directly or by analogy, to our own clinical settings and apply them through the prism of the "curing" and "caring"

roles that we all strive to fulfill in our quest to be complete professionals in a complete and caring health care delivery system.

Open, timely, and empathetic communication is the foundation on which trusting, therapeutic relationships are based and on which the safety and quality of care depend. Our opportunity is to continuously improve the safety and quality of care for our patients by respecting their values and beliefs, and in this way to provide them, to the best of our ability, with the knowledge and confidence that their health care team is on their side. ❖

<sup>a</sup> *The Other Side of the Fence* is based on transcripts from an educational session that includes videos. To inquire about using the session materials for training and education within KP, you may contact Robert Formanek, Jr, MD, by e-mail or at 510-271-5853.

- <sup>b</sup> Brent James, MD. Meet in the middle: Key infrastructure to drive organizational change. Presentation at the Institute for Healthcare Improvement (IHI) Quality Form 2005 Dec.
- <sup>c</sup> A "touch point" is created every time a member/patient experiences any involvement with the organization. When these experiences degrade confidence, rather than building it, the results can be devastating.

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## Illusion

The greatest problem with communication is the illusion that it has been accomplished.

— George Bernard Shaw, 1856–1950, Irish poet and playwright, 1925 Nobel Laureate in Literature