Supporting the Physician/Patient Relationship During an Adverse Outcome

CAPCARES

The Cooperative of American Physicians' Early Intervention Program

800-252-0555

Table of Contents

Page 3 About CAP Cares

What is CAP Cares?

Page 4 Contacting CAP Cares

An Adverse Event Just Occurred – Now What?

Preparing for the Call

Page 6 Effectively Communicating with the Patient and Family

The Initial Discussion

Best Practices Immediately After an Adverse Event is Recognized

Be Aware of the Patient's Emotions and Expectations

The Power of Empathy

Disclosure is a Continuum

Documentation – Write it Right

A Good Informed Consent Before the Event Helps

Set Proper Expectations

"Thank you. You have a gift for putting my mind at ease."

About CAP Cares

What is CAP Cares?

CAP Cares is an early intervention program that provides support to members in the immediate aftermath of an adverse outcome. CAP defines "adverse outcome" as an outcome that was a known risk of medical care (a complication) or a medical error.

Unfortunately, adverse or "sentinel" events occur every day in health care. It may happen to the physician's own patient or to one for whom he is the consultant. Either situation exposes a CAP physician member to a potential medical professional liability lawsuit.

By calling the 24-hour, seven-day-a-week CAP Cares Hotline immediately following the occurrence of an adverse outcome, a specially trained CAP Cares team member will help you navigate through the complex issues inherent in the situation.

The information contained in this brochure is designed to prepare the affected physician for the initial discussion with a CAP Cares team member and to provide valuable support throughout the process. Even if you have not encountered an adverse outcome, we strongly recommend that you read this brochure in its entirety and keep it in a convenient location, in the event of a future occurrence.

Contacting CAP Cares

An Adverse Event Has Just Occurred … Now What?

CAP encourages its members to **contact the CAP Cares Hotline at 800-252-0555 the moment the adverse outcome is recognized** – 24 hours a day, seven days a week.

When you call, you will promptly speak with a CAP Cares team member, experienced in providing assistance. He or she will guide you through the process to help garner the best outcome possible for all involved parties.

"The fact that this (program) was able to help me maintain a good physician-patient relationship is extremely important to me, particularly in the relatively small community in which I practice."

During the first call, the CAP Cares team member will help you:

- Conduct the initial fact gathering
- Thoughtfully analyze the occurrence
- Anticipate discussions with the patient and family
- Prepare for questions likely to be raised
- Determine appropriate patient disclosure – both initial and ongoing
- Coordinate discussions among hospital personnel and other involved providers

Further discussions with a member of the CAP Cares team is determined on a case-by-case basis.

Preparing for the Call

When calling the CAP Cares Hotline, be prepared to provide the following information, when possible:

- Patient information, such as name, date of birth, insurance, Medicare status, and Social Security number, if available
- Date and approximate time of the adverse outcome
- Location where the treatment was delivered
- Names of other physicians involved
- Clinically detailed description of the adverse outcome

Effectively Communicating with the Patient and Family Members

Following an adverse outcome, an investigation may take place, spanning days, weeks, or even months. Effective communication with the affected patient and family members throughout the process may reduce the likelihood of a lawsuit and improve the chances of preserving the physician-patient relationship.

Once the initial call to CAP Cares is made, the following are recommendations on how to communicate with the patient and his or her family members throughout the investigation.

The Initial Discussion

Once the patient is stabilized, the patient or family member needs to be told of the adverse outcome as soon as possible. The physician often becomes aware of the unexpected outcome before the patient does. Thus, it may be the physician who controls the timing of the initial acknowledgment of the adverse outcome. The discussion will be different with each situation. For example, a physician may need to:

- Call a patient into the office to reveal a missed abnormal CT finding
- Explain to a parent that the wrong vaccine was given to her child
- Go to the patient's bedside to explain a nerve block was given to the wrong leg
- Explain that an intraoperative complication occurred

Universally, patients need the same basic questions addressed after the unexpected occurs:

- What happened?
- How did it happen?
- What will be done to prevent this from happening again?

To address these questions, the response should reflect the information presently known. If the immediate cause is not known, the best information to provide is exactly that.

> *"While we do not know at this time, we are working to understand what happened and will keep you informed as information is learned."*

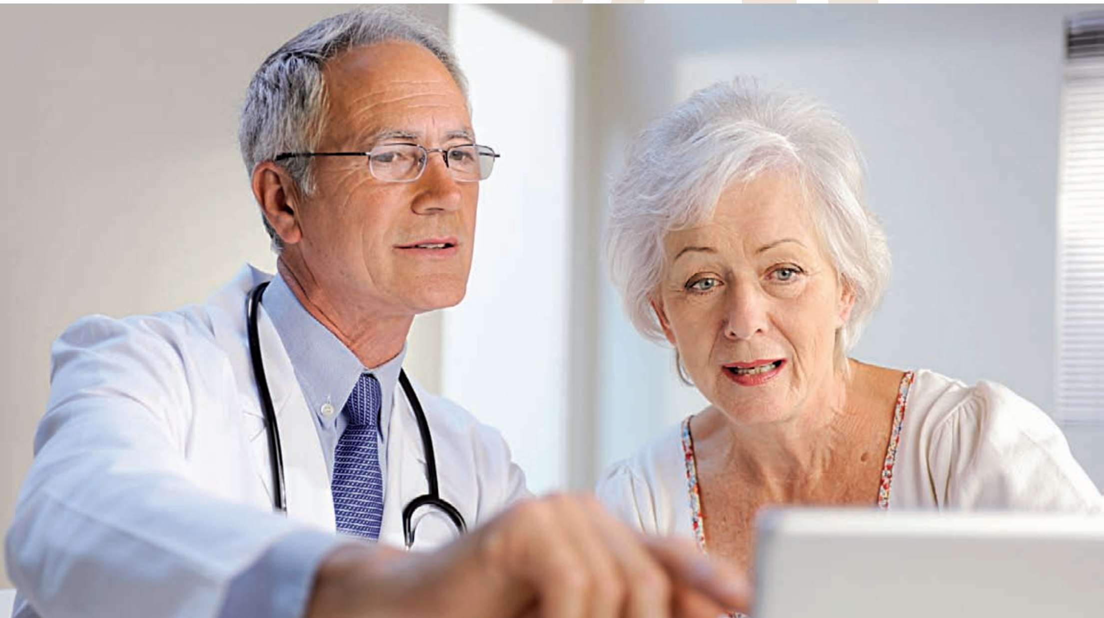
Speculation is never helpful. Do not guess. That maxim applies to every physician, nurse, medical assistant, and provider who interacts with the patient. Incorrect information is indeed worse than incomplete information. With shifting explanations, one will lose credibility. One cannot "un-ring the bell."

Simultaneously, the physician should be aware of his or her own state of mind. Members in these situations later relate that they experienced complex emotions ranging from anxiety to self-doubt. If the adverse outcome involves a treatment risk, the patient may have poor recall of the informed consent discussion including the risks involved. While the informed consent discussion may have been supplemented with a comprehensive informed consent form, patients never expect they will experience one or more of the injuries disclosed. *Regardless of the detail in the consent conversation and form, patients never expect to be injured by their physician - and then billed for it!*

Best Practices Immediately After an Adverse Event is Recognized

The recommendations below are appropriate after any adverse outcome.

- Give the patient or family your contact information. Be available to answer questions by returning their phone calls in a timely manner. This defuses the perception of avoidance or aloofness. With a complex injury, a series of follow-up encounters will occur and should be expected.
- Share what information is factually known at the time. The absence of information allows the patent's mind to speculate – usually in the negative. Perceptions drive human behavior, and misunderstandings are more difficult to correct later.
- Timely interaction with the patient after an unexpected outcome prevents the assertion that *"No one told me what happened; no one talked to me about this."*
- Be patient and tolerant. The patient may have an emotional need for communication at this time and wish to talk more frequently to the physician than the physician feels necessary.
- Follow up and stay in touch with the patient and family during this time. Review the treatment plan, update it as needed, and discuss changes with the patient and family.



Be Aware of the Patient's Emotions and Expectations

A patient who has experienced a complication or medical error has been impacted physically, emotionally and likely, financially. The patient will have a markedly different perspective from that of the health care provider. Be prepared for a range of complex emotions and reactions including fear, anxiety, depression, anger, frustration, and loss of trust.

Awareness and recognition of the patient's sensitive emotional state at this time is one of the first steps in mitigating an adverse outcome.

Endeavor to understand the situation from the patient's vantage point. Defensiveness and/or avoidance will be perceived as insensitive, incompetent, or worse – a cover up. The patient needs a compassionate and confident leader at this time. This is an opportunity to reinforce the relationship and rebuild the patient's trust.

If the patient responds with anger, do not respond in kind and do not be defensive. Acknowledge his or her feeling with responses such as:

> *"It is perfectly normal to be upset about this."*

> *"I'm so sorry that you had this complication. As we discussed, we knew this was a risk and this is what we're doing about it…."*

A heartfelt *"I'm sorry you are going through this"* goes a long way towards preserving the physician-patient relationship.

The Power of Empathy

In the initial conversation after the outcome, **what is said** and **how it is said** sets the stage for the quality of all discussions that follow. Empathetic communication, which reflects the physician's core humanity, is always appropriate after an adverse outcome. Empathic communication shows recognition and understanding of the psychological impact this outcome has on the patient's physical and mental well being.

Expressions of empathy and acknowledgement of bad or unfortunate occurrences reflect the human value of compassion and are globally recognized. Health care is no exception. Acknowledging the patient's emotions is encouraged. It also lets the patient see the physician's compassionate side.

It is important to understand the difference between **empathy and apology.**

Under California law, benevolent gestures of **empathy and compassion** cannot be used against a physician in a professional liability lawsuit. However, statements that **reflect fault** are admissible.

The following statements reflect an **empathetic** interaction with the patient:

- *"I'm sorry you are experiencing this…."*
- *"I'm sorry this happened; I feel bad for you"*
- *"I'm sorry you are going through this…."*
- *"I'm sorry this complication occurred…."*

"I appreciate your guidance; it gave me peace of mind."

In contrast, the following statements reflect **admittance of fault**:

- *"I'm sorry; **this was my fault**"*
- *"This was **my mistake**"*
- *"I'm sorry I injured the artery; this was **my error**"*

If a thorough investigation suggests a true medical error occurred, there are multiple paths the CAP Cares team may recommend. However, in the immediate aftermath of recognition of an adverse outcome, empathy is the best communication tool. The physician should use it wisely to reflect understanding of the patient's feelings at the time.

Thus, an **apology** is only offered *after* an investigation proves a true medical mistake has occurred. The disclosure to the patient and the apology is done in a coordinated manner, and as the conditions dictate.

Remember, patients expect the situation to be taken seriously. Although physicians have seen this outcome before, this is a novel and serious experience for the patient. Perception management is vital at this time and it is important the patient does not perceive his or her physician as insensitive to his or her situation. This includes the use of comedy to "lighten the mood" in an attempt to diffuse tension. The patient may not remember the discussion but will certainly remember a flip or disrespectful comment that may obstruct further open communication.

Disclosure is a Continuum

Disclosure is a conversation continuum with the patient that evolves over the clinical course of the case.

Hospital-based events will involve risk managers or other specialists. If involved in an adverse outcome at a hospital, the physician needs to know what has been disclosed by the hospital. The patient should receive consistent information. Equipment may need to be sequestered to preserve evidence. As the hospital conducts its analysis, the physician is often asked to participate in a Root Cause Analysis process.

Some adverse outcome events may require the hospital report to the California Department of Public Health (DPH). DPH may perform an independent investigation and physician interview. Physicians should notify CAP Cares before participating in such an investigation.

At the end of the investigation, a meeting may be scheduled with the patient and all involved persons to review the care and disclose findings of the investigation. Member physicians should notify CAP Cares *prior* to such a meeting.

Documentation - Write it Right

It is hard to argue that good medical care was provided when the medical record is poorly documented. It calls into question both the care and the physician's credibility. In addition, the use of certain terms in the record may be taken out of context by attorneys when, in truth, what occurred was a known risk of the treatment. For example, words like *injury, iatrogenic, mistake, error,* and *accident,* to mention a few, should be carefully considered before using them to describe the adverse outcome in the medical record.

On the other hand, the value of capturing a patient's spontaneous comments that support the consent, care, or treatment is golden. Hence, the best practice in this situation is to document (in quotes) a patient's comments supportive of the care, e.g., *"I remember you telling me this could happen."*

Good medical record documentation preserves the facts. The following are some guidelines for documentation of an adverse outcome. Members are also invited to call the CAP Cares team when necessary to document an adverse outcome:

- Document only *objective* observations or known facts
- Complications that were manifested during care should be reflected
- Document specifically what the patient/family was told
- Do not blame other professionals or facilities in the medical record
- Do not *change anything* previously written. An addendum may be added as facts become available by dating an addendum on the day it is actually written
- Do not document the call to CAP Cares or the CAP Hotline

A Good Informed Consent, Before the Event, Helps Set Proper Expectations

Informed consent is a process by which a fully informed patient can participate in choices about their health care. It originates from the legal and ethical right of a patient to direct what happens to their body and the physician's ethical legal duty to involve the patient in the health care decisions. A physician should not delegate the informed consent discussion except as allowed by law to a Nurse Practitioner or Physician Assistant pursuant to the physician's written instructions.

The objective of the consent process is to align the patient's expectations with medical reality. Failure to provide a good informed consent may allow unrealistic expectations to develop. In the presence of an adverse outcome, the patient may perceive that the physician's failure to meet his or her expectations suggests substandard care. When a complication occurs, the physician wants the patient to remember and acknowledge that he or she was informed about it.

Comprehension on the part of the patient is equally as important as the information provided. Consequently, carry on the discussion in a layperson's terms. Assess the patient's understanding along the way and document it well in the medical record. Include the following elements in any discussion about a procedure or treatment:

- Nature of treatment
- Expected benefits or effects
- Specific risks of the treatment
- Possible complications
- Alternative treatments
- Specific risks and benefits of alternative treatments
- Alternatives - including doing nothing!

"I am grateful for your efforts. I feel I am in truly caring and capable hands with you . . . and the CAP Cares team"

COOPERATIVE OF AMERICAN PHYSICIANS

333 S. Hope St, 8th Floor
Los Angeles, CA 90071
CAP Cares Hotline: 800-252-0555
www.CAPphysicians.com

A publication of the Cooperative of American Physicians, Inc.
© Copyright 2011