When Things go Wrong in Regional Anesthesia: Strategies for Disclosure of Bad News

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Disclaimer

• Within the past 12 months, I have had NO financial relationships with proprietary entities that produce health care goods and services.
Objectives

• Understand the types of adverse events that need to be disclosed
• Differentiate between statements of empathy and statements of apology
• Develop a strategy for structuring a disclosure conversation
• Learn the main reasons that patients sue anesthesia providers

Case Study

• Your patient is a 32 yo woman who will undergo left rotator cuff repair under general anesthesia.

• At the end of the case, the patient is spontaneously breathing but still anesthetized. You perform a single shot interscalene nerve block for postoperative pain control

• 30 cc of 0.5% bupivacaine is injected incrementally with frequent aspiration after finding appropriate twitches.
• After the block, blood pressure falls, the patient becomes apneic and standard resuscitation is started. The patient awakens and is eventually extubated.

• The patient has no motor or sensory function in the LUE and weakness on the right. She has burning in her lower extremities. MRI of the cervical spine shows syrinx in the central portion of the left half of the C4-7 spinal cord.

• She is permanently disabled.

Adapted from Benumof JL; Permanent Loss of Cervical Spinal Cord Function Associated with Interscalene Block Performed under General Anesthesia, Anesthesiology 2000; 93:1541-4

Adverse Event

• Defined as an unfavorable and unintended sign, symptom or outcome

• Result from things you “do” and things you “don’t do”

• Can be major (death) or minor (delay)

• When analyzed, often lead to change at the level of the provider, the team, or the system
Regional Anesthesia Adverse Events

- Drugs
  - Local Anesthetic Toxicity
  - Anaphylaxis or severe allergic reaction
  - Over sedation, loss of airway, hypoxia
  - Hypotension, bradycardia

- Procedural Problems
  - Infection
  - Bleeding
  - Broken needles, lost wires
  - Nerve injury

- Systems Mistakes
  - Blocking the wrong side or site
  - Not having monitors on the patient
  - Inadequate resuscitation/emergency equipment

The Culture of Disclosure

- Anesthesia related adverse events are rare
- As such, the practice of disclosure is also rare and many practitioners have never been taught to disclose bad news
- The culture of medicine is changing
  - “Cover and hide” and “point and blame” are not acceptable

Why Should You Disclose?

- It is the right thing to do, ethically and morally
  
  Dudzinski, DM et al: The Disclosure Dilemma — Large-Scale Adverse Events. NEJM 2010; 363:978-986

- Reduces liability exposure, and costs associated with litigation
  
  Schvve, P et al: Full Disclosure of Medical Errors Reduces Malpractice Claims and Claim Costs for Health System. The Joint Commission, AHRQ
  

- It is good for YOU, abrogates the second victim effect and associated negative psychological outcomes
  

- It is good for your staff, who want to be involved and understand what happened. They can be helpful with service recovery.

What Should You Disclose?

1. Complications—are known risks to procedures or surgery. Requires a statement of empathy.

2. Mistakes or medical errors-imply fault in thinking, judgment or action. Requires a statement of apology, AFTER a discussion with risk management.

3. System or service issues—equipment malfunction, patients are forgotten, professional codes of conduct are not followed. Requires a statement of empathy and sometimes a statement of apology.
Apologies May Be Part of Disclosure

- An apology is an acceptance of responsibility of error
- Due diligence must precede an apology
- Apologies should include risk management
- Therefore, an apology is never appropriate immediately following an event
- Disclosure conversations should occur before an investigation; don’t wait until you have all the facts to speak with the family

Development of a Framework for Disclosure

- SPIKES
  - The SPIKES model was developed by oncologists at MD Anderson to help deliver unfavorable news
  - The acronym stands for:
    - Setting
    - Perception
    - Information
    - Knowledge
    - Empathy
    - Summary

Before You Go to the Patient

• Talk with the surgeon to discuss the disclosure plan
  – Agree on the facts together
  – Agree on who will take the lead
  – Find a way to achieve mutual support before entering the patient’s room
  – Practice the disclosure

• The addition of one more trained person in disclosure is helpful
  – This can be a nurse in the room, an anesthesia trainee, or even another colleague not part of the case

Setting

• Turn off pagers and cell phones
• Ask the patient “Is this a good time to talk?”
  – Starting a conversation on the patient’s terms is better than assuming the patient will listen because you are ready to talk
• Gather other members of the family that the patient would like present
  – This saves you from repeating information when the loved one arrives. “Are there other people you would like present while we discuss what has happened?” is one way of doing this.
• Things that are helpful (but may be difficult for anesthesia providers)
  – tissues, enough chairs, comfortable temperature, something to drink, private room
**Perception**

- Discover what perceptions exist about the event
  - Has the surgical team already disclosed the event?
  - Did the PACU nurse already smooth things out for you...or perhaps make things worse?

- Understanding what the patient has been told is helpful for tailoring your approach
  - One way of doing this is to ask the patient, “Has anyone had a chance to talk to you yet about what happened today in the operating room?”

**Information**

- Determine how much detail the patient wants
- Reassure that you will provide as much information as you know
- Some patients don’t want details, especially if details are gory; others want minutiae relayed
- Asking up front tailors the conversation to the needs of the patient
  - One way of doing this is: “I want to assure you that I will tell you everything I know about what happened today. Can you let me know how much detail you want? I don’t want to overwhelm you with details, nor do I want to give you too little.”
Knowledge

• Share the knowledge about what has happened
  – Speak plainly, slowly, and in a normal tone
  – Silence is helpful
  – Ask the patient/family to repeat back what you have said
  – Avoid assigning blame and remain neutral

• If confronted with a question you don’t know, do not guess. Assure them you will continue to look for answers to ambiguous situations
  – One approach is, “That is a good question. At this time, I don’t have enough information to answer that. My team will be looking into this, and when I have more information, I will share it with you. I ask for your patience while we sort out some of these issues.”

Empathy

• A genuine feeling of empathy needs to be conveyed
  – The words “I’m sorry” can convey empathy, but can also convey responsibility. Context is key.

• Examples where Sorry is empathetic:
  – “I am sorry for this complication. Let’s talk about what we think happened.”
  – “I am sorry for your loss. I was saddened to hear about it and I offer my deepest condolence.”
  – “I am sorry your family has had to wait for your surgery today. We are looking into the cause of the delay.”
Empathy

• Personalize the response-this is only possible with a good informed consent and pre-procedure discussion
  – “I know your mom was looking forward to her upcoming anniversary party next week and this complication will make it impossible for her to attend. I’m sorry this incident is causing your family to rearrange plans.”

• Healthcare providers can be afraid to say ‘sorry’
  – Data support the benefit to the patient, care provider and family when this word is spoken


Summary

• As the conversation moves to a close, answer questions the family has

• Provide them with the next steps in their care

• Give them a way to contact you, using a business card, a direct line to your assistant, or, if you feel comfortable, your email or cell phone number
  – Patients become angry when they feel abandoned and having a written way of contacting you provides immense comfort

• If you say you will do something - DO IT! You will cause further damage if you don’t follow through
Documentation

• The medical record should contain a summary of the meeting: who was present, the date, time, location of the meeting
• The record can contain medical information and advice given to patients
• More significant documentation should be done after consultation with risk management or counsel
  — A detailed letter to the hospital attorney with your recollection of facts is not discoverable

Risk Factors for Getting Sued

• Failure to disclose a medical error
• Failure to accept responsibility
• Failure to communicate simply
• Failure to follow up
• Failure to be truthful
• Failure to show empathy
• Failure to make attempts to prevent the same mistake from happening to someone else
Avoid Phrases with Blame

• “These things happen all the time. It’s a good thing I was there, I was able to prevent the local anesthetic toxicity from killing him.”

• “You are overreacting. It is common for patients to have seizures after a block. He will be fine.”

• “You should have told the nurse you were taking that medication.”

• “The radiologist should have caught that. No one with a tumor in the axilla should have this block.”

A Better Way

• “Your husband is okay and awake. During your husband’s block a complication occurred. We are sorry this happened. We are going to do a complete evaluation to find out exactly what happened. We want to share with you and answer any questions you have....”
Conclusions

Adverse event has occurred

Initiate investigation if unclear

Communicate with provider teams +/- risk management to develop your disclosure plan

Speak with the patient and family

Follow up

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