# Managing Complications Part 2: The Patient and Family

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**Background:**

In Part 1, we discussed the importance of being honest with yourself when assessing a bad outcome. We discussed the goal, to remain emotionally healthy and to become a better surgeon. We mentioned that you will take this honesty to your hospital's Audit process, where it will be applied and used to make the hospital safer for future patients. (See "Quality Improvement.)

If you have not gone through this important process, your discussions with the family will be on a shaky foundation. It is likely that at least some of the family members will be able to tell that something is wrong.

Dealing with the family, it is also important to know the results of any hospital inquiry into the events, before you share your impression of what happened with them. You can be in a difficult situation here: they want (and deserve) answers right away, but likely the Audit is still ongoing. It is OK to tell them that the results are not fully available. But do commit to sharing the full results once they are available, and do not use this as an excuse to "bury" the ultimate findings of the investigation.

If you disagree with the results of the Audit, or if you are being told by your superiors to cover up the truth, you have a difficult problem. We discuss this special situation at the end of this Chapter.

**Basic Principles:**

Keep in mind some simple rules for navigating these difficult situations:

- Do not try to avoid the patient or the family, even though this will be your natural inclination. It is best to create open channels of communication so that you present yourself as easily approachable and transparent. This will create and encourage trust in your relationship with the patient and/or their family. Reestablishing this trust is paramount, given there is an assumed breakdown in trust due to the fact of the medical complication.
- Talking about difficult or emotional subjects takes time. Set aside enough time so that you never seem to be rushed, impatient, or annoyed that the process is taking so long.
- If you don't know what happened, do not speak too soon. Tell what you do know, but if it is not clear at the time, acknowledge this fact and promise full disclosure later on. It is OK not to know all of the pertinent details immediately, but it is essential to reassure that you will supply all the facts and details when they become available.
- Prepare by reviewing the events. Know the dates of every operation and of other important milestones. These include when the patient's condition worsened, when any imaging was done, and what other physicians did or said. If the course of events was complicated, take notes and use them when talking with the family. It rebuilds trust when you are well versed on the situation. Knowing the details reaffirms that you care about these details and therefore the care of the patient.
- Discuss in advance with the rest of the team especially if there was another provider involved. Make sure that everyone agrees on what happened. If there is disagreement, acknowledge it when you talk to the family. In such cases, you must wait until the Audit is concluded before giving them the "final word" on what happened.
- If the complication was caused by someone else's actions, it is especially important to talk with this person and find out what they believe happened. The patient or family will be confused if they are hearing two different stories. Again, hopefully any disagreement will be resolved by the Audit process. Especially avoid blaming, criticizing, or otherwise "talking down" other parties involved; this is unprofessional and makes everyone, including yourself, look bad.

**The Team**

Consider setting up a team meeting before engaging the patient and/or the family. Ideally, this should be led by the primary team caring for the patient e.g. the primary surgeon. Make sure that any residents or interns involved are present, as this event serves as a great opportunity for teaching and mentorship. It would also be ideal to have other teams involved well represented e.g. anesthesia, critical care team, nursing staff etc. In some faith – based settings, there may also be a chaplain or other religious leader available to assist in such situations.

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As mentioned above, discuss with the team in advance before meeting with the family.

The benefits of a team approach include, but are not limited to:

- Communicating to the family that the patient was cared for by a team (if indeed it was the case)
- Sharing the stress and challenge of such a meeting among all caregivers
- Safety in numbers, in the rare event that any verbal or physical altercation was to happen
- Teaching and mentoring for any trainees on the team, where applicable
- Setting the standard for clear and open communication in the future

**The Conversation with the Family**

Sitting with the family and explaining reasons for a poor outcome is an emotionally charged event. Expect people to be present whom you have never met before, especially if the patient has died. Sometimes these new people will be the angriest ones and those who ask the most questions. Words such as "negligence" or "malpractice" may be thrown around by people who have little understanding of their meaning.

You must absolutely keep calm and not become angry yourself. Remember that you are well trained, you did your best, and now it is your job to explain exactly what your reasoning was. Skeptical patients or family members may expect you to cover up or lie about the outcome. Disarm them by being completely honest and professional, while remaining even-tempered.

Start at the beginning- usually when you first met the patient. If another family member was present at that meeting, acknowledge that you met them as well, and recap the discussion. Briefly explain why you decided to operate, what concerns you had, and what you did to try to mitigate them. If you explained the risks of this specific complication, remind the patient and family of this fact, but do it in a gentle way, not an "I told you so" manner. In addition to setting the stage for all present, this approach establishes mutual trust and unites you and the family with shared memory and experience.

Explaining the timeline of what happened will allow the family to integrate your explanation with their experience as they saw their loved one's condition worsen. Even though you will be telling some of the family members things that they already knew, it is important to make sure everyone understands every step of the patient's progress. Remember, the point of this summary is to remind everyone that the process started out of sound medical diagnosis and with the intent to help. Reminding the family that you started with common goals will again help reestablish trust and disarm the emotionally charged situation.

To further help explain the situation, It is often good to use drawings or other illustrations, even for simple anatomy. A line drawing of the biliary system, for example, makes it much easier for the layman to understand where you think the bile is currently leaking from. If you are not gifted artistically, download and print an illustration from the internet to use as a teaching aid.

If you use medical terms, be sure to use these along with an explanation in layman's terms. . To continue the previous example, before you start talking about injury to the common bile duct, draw or show an illustration of the liver and duodenum and explain that there is a system of tubes that carry bile from one to the other. If there is one crucial concept that includes medical jargon, stop and write down those words along with their definition ("Obstructive Jaundice- yellowing eyes and itchy skin caused by blockage of the bile ducts.")

Allow the family to keep the drawings and definitions- sign and date them and take a photo for your own records, especially if you are concerned about litigation.

Stop frequently and take questions. Do not be impatient with questions. It is also important to make sure your body language also shows patience and compassion (do not roll your eyes or sigh at questions.) This is your chance to make sure everyone is on the same page.

When possible, it is important to explain what you propose to do next, including referral to a specialist if appropriate. If another operation is needed because of the complication, be clear on whether you are going to do it yourself, whether you'll be asking another colleague to assist you, or whether you'll be referring to a specialist. Making a

plan of action will again affirm that you have the patient's best interest and outcome at heart.

Regardless of whether another physician takes over, you must continue to follow the patient, be aware of their progress, and explain it to the family. Do not "disappear" if another physician takes over. Talk regularly to this physician and keep the family updated.

You may think you're giving a malpractice attorney some "fuel" by giving an in-depth explanation of the mistakes you made, supplemented with drawings of those complications, signed and dated by you. Actually, the opposite is true. We know from several studies that this kind of in-depth explanation is what patients want. Conversely, lack of a believable and honest explanation of the events that led to a bad outcome is what makes people sue.

To conclude this section: Physicians are sued because of poor communication skills. This is an unavoidable fact: 2-8% of physicians by discipline have a higher rate of litigation, even though they are not less competent, nor do they care for sicker patients. **The physicians who are sued more often are those who have a difficult time creating and maintaining rapport with their patients and families.** If you find this skill difficult, seek a coach to help you with people skills. Open and honest communication is more than just the best way to avoid a lawsuit: it is what's best for your patient.

## Other Considerations

Hospitalization Expenses:

A patient or family who is paying out of pocket will face increased expenses due to a complication. After a thorough explanation of oversights or adverse events, the family may ask for a reduction in the hospital's bill. In our opinion this is a reasonable request, though not automatically one that should be granted. Some complications are unavoidable. The process of informed consent includes an explanation that surgery is an unpredictable process, prone to unexpected outcomes.

Nevertheless, if the outcome is a result of an oversight, a preventable error, or outright negligence, it is reasonable for the hospital to lower the patient's bill. Discuss this matter with the Director of the Finance Department and explain to them, as well, exactly what happened. Let the family members know that you have done this and then leave the matter to be settled by them.

Team Disagreement

Not every member of the team will agree with the findings of the Audit. Some members may even try to manipulate the outcome for their own gain. Leadership may expect, openly or tacitly, an approach that covers up or confuses the picture. This can put you in a very difficult situation. This is especially true if you are a junior member of the staff. Consider whether your interpretation of the events is actually the correct one, especially if you find yourself in the minority opinion.

The Audit process depends entirely on the integrity and honesty of those involved. A surgeon shows great integrity and honesty when they say those most difficult words, "I made a mistake." Over the course of your career, you will encounter people who are incapable of making such admissions. You would be wise to avoid working with them as much as possible.

If your "fate" in a poor outcome is linked with such a person, or such a group of people, do your best to maintain your own integrity. Take the opportunity to lead by example, by telling the truth and expecting others to do the same. If you have trainees, this is an excellent chance to impress on them the importance of doing right even when it is not easy to do so.

Do you have a chance to change the culture? If dishonesty and blame-shifting is being modeled from the top down in your organization, you need to consider whether it is worth the battle, or whether you would be better off working in a different place. But do not underestimate your ability, as one person, to change the culture by acting in a professional and virtuous manner. Though it may not seem so, chances are good that most people are disgusted with a negative culture and would love to see it change. Try to find allies and encourage each other to respect patient rights, healthy team dynamics, and accountability. See "Culture Change" for a more in-depth discussion of this matter.

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