What to do in the event of an adverse anaesthetic event or medical error

Based on the principles of safe and patient-centred medical care, what would I want, if I, or a member of my family, was harmed during medical treatment? What is the right thing to do?

Definitions

An "adverse event" is harm, injury or a complication. It may or may not result from error.

A "medical error" can be serious (has the potential to cause permanent injury or is transient, but potentially constitutes life-threatening harm), minor (does not cause harm or have the potential to do so), a "near miss" (an error that could have caused harm, but did not because it was intercepted), one that does not cause harm nor result in an adverse event.

A "preventable adverse event" is an injury that results from an error or systems failure. There are three types. Type 1 is an error caused by the attending physician; type 2, an error caused by anyone else in the healthcare team; and type 3, a systems failure which cannot be attributed to an individual.

An "unpreventable adverse event" is an injury or complication which is not owing to an error or systems failure, and is not always preventable using currently available scientific knowledge. There are two types. Type 1 involves common well known risks associated with high-risk therapy. The patient understands and accepts the risks in order to receive the benefit of treatment. Type 2 involves rare, but known risks associated with ordinary treatment. The patient may not have been warned or informed about this in advance.

"Disclosure or communication" refers to providing information to a patient and/or his or her family about an incident which occurred.

Managing the patient and his or her family

When breaking bad news, it is important to communicate effectively, compassionately and thoughtfully with the patient and/or his or her family. It is not necessary to discuss minor (harmless) events with parents. It should be determined on an individual basis whether or not to discuss "near misses". Health practitioners and administrators need to decide on what should be discussed.

Four essential steps should be followed:

- Tell the family what happened.
- Take responsibility for the event. This does not mean assuming culpability.
- Apologise.
- Explain what will be carried out to prevent future events.

The aim during initial communication with the family should be to recognise their distress, respond to it and attempt to resolve the situation. Prompt, compassionate and honest communication is necessary as soon as possible, and certainly within 24 hours of the event being discovered. A quiet private area should be chosen in which to conduct the discussion with the family. The anaesthetist, surgeon and nurse need to talk to the parents together, having chosen a spokesperson. Only the facts of the incident, i.e. what happened, should be reported or explained. Do not discuss how or why you believe that the event occurred, or whether or not you were responsible. Do not speculate. It is preferable to leave the "how" and "why" until later. Consider how the event will affect the patient in terms of the immediate affect and prognosis. Take responsibility for the event, even if you did not actually make the mistake. This does not mean assuming sole culpability for the event. Apologise for the incident by saying: "We are so sorry that this has happened to you". Validate and acknowledge the family's anger and feelings of hurt, betrayal, humiliation or fear. Commit to finding out what happened. Communicate reliable information as it becomes available. Offer your recommendations for further diagnostics and therapeutics. Explain the implications of the prognosis. If the error is obvious, communicate this promptly, apologise, and commit to establishing the reasons behind it. Explain what will be carried out to prevent future events occurring. This may give more positive meaning to the patient's experience, knowing that his or her bad experience was not in vain.

Support of the patient and his or her family

There should be psychological, social and financial support of the patient. Ask about their feelings about the injury. Take their concerns seriously and address them completely. Answer questions as fully as possible. Maintain open-door communication if you are the treating doctor. Provide contact information for clinical and financial counselling support. Do not make personal promises to provide financial support. Place a hold on billing until full analysis of the event has been carried out. Contact hospital management in this regard. This is especially important in private practice.

Follow-up care of the patient and his or her family

Schedule times for clinical follow-up visits and follow-up communication. Provide continuing psychological and

social support. Communicate about the final results, investigations and the provision of long-term counselling.

Care of the health professional

The responsibility of the institution and department

Each department needs to establish a programme or protocol to support health professionals during such an event. A variety of support services is necessary to meet different needs, including short- or long-term private or group counselling options.

Suggested procedure to follow at the Red Cross War Memorial Children's Hospital

Debrief someone, i.e. the head of department, or a senior consultant or registrar. This is strongly encouraged because it is in your own interest to do so, and is compulsory in anaesthesia. A colleague within your discipline with experience of debriefing is the best person to consult in the first 24-48 hours after the event has occurred. A trained clinical psychologist may be needed. Adjust your responsibilities and/or take time off, as needed. This will depend on the circumstances of the event, the time of day and the policies of the specialty groups.

Structured debriefing and documentation of the event is crucial. Write a full description of the event. Do not try to make a diagnosis of what caused the event. Do not speculate. The caregiver should be coached to communicate effectively and correctly with the parents. Skills in peer review, quality control and root cause processes need to be taught. Independent Complaints Advocacy Services (ICAS) may be used immediately, or at a later stage, i.e. several days or weeks later.

The importance of education and training

Response to and management of an incident requires education, training and sufficient resources.

How this may affect you

What can you expect to feel after an anaesthetic catastrophe? How is this likely to affect you or a colleague?

This is the ultimate traumatic experience for a professional! You may experience one or all of these symptoms:

- *Re-living the event:* Flashbacks, nightmares and day dreams are common. This is alarming, but not uncommon.
- *Feeling shock:* You may not feel anything for a while, but you may then feel numb, tired, exhausted and cold. Completing even simple activities may require a huge effort.
- *Feeling restless and wound-up:* Difficulty with sleeping is common, accompanied by the inability to rest or concentrate, and a tendency to irritability and tearfulness.
- *Feeling doom and gloom:* You may feel vulnerable. "Everybody hates me and no-one loves me" feelings are common. It may seem as though your future is in jeopardy, and you may want to give up your profession and training. Wanting to leave your present employment is also common.
- *Feeling anger:* Anger and rage about where you find yourself may occur. You may think that nothing is fair, that it was not your fault, and may even try to find someone else who is guilty, i.e. to project the blame.
- *Feeling guilt and fear:* The most common feelings are probably guilt and fear.

You may be afraid to go out, return to work, or carry out the same activity that caused the event. You may be frightened to stay alone, try new things, leave home and/or your family, or face your colleagues again. Other distressing fears are breaking down and crying in public, losing control, or an intense fear that the event may occur again.

Fear may turn into paranoia if you think that everyone is talking about you and saying that you are hopeless. You might ask: "Could this have been prevented and could I have done more?"

It is common to be unable to cope with stresses that would have been manageable previously. There is a tendency to withdraw from loved ones or close colleagues, and this may lead to further problems of isolation, accompanied by the feeling that "no-one understands what I am going through".

Traumatic incidents consume considerable energy and this may continue for weeks to months. Prolonged hyper-arousal causes exhaustion and its consequences. Muscle tension may result in headaches, localised pain, dizziness, breathing and swallowing problems. Fluctuations between the sympathetic and parasympathetic systems may occur, involving nausea, palpitations, hand tremors and sweating. Experiencing any or all of these is an indication that you are coping with something which is very difficult.

Long-term reaction

Try not to become defensive. You may become emotionally detached, and become irritable and annoyed with the people with whom you are closest.

Seeking help from colleagues

Do not bottle up your feelings. Seek help from colleagues and/or professionals. Colleagues who have had a similar experience are a great source of support and advice. Be careful in your daily activities. Accidents are more common when under severe stress. Try not to isolate yourself. Don't drink or smoke too much, or self-medicate. Give yourself time to recover, and acknowledge that this may take time.

Seeking professional help

In some circumstances, your response to the event may not improve with time. It is then necessary to seek professional advice from a mentor, senior colleague or clinical psychologist. You may need to take medication too.

The following is a list of emotional responses which indicate that you need to seek professional help:

- Remaining exhausted, irritable and short-tempered.
- Realising that your work performance has been affected.
- Continuing to have nightmares, interrupted sleep patterns and somnolence during the day.
- Being unable to talk openly to anyone, or not having anyone with whom to share your inner thoughts and fears.
- Being increasingly accident prone or unable to concentrate.
- Noticing that people, especially those close to you, comment on the fact that you "have changed".
- Feeling isolated and lonely, and unable to communicate your misery.
- Starting to rely on alcohol or medication to help to induce sleep, or to make you feel better.

It is important for mentors and colleagues to recognise signs of stress in other health providers, and not to be reticent about offering help and support. Withdrawal and isolation are dangerous signs.

Medico-legal issues

Contact the consultants on call or the head of department within your specialty and ask for support. Clearly document the events as they occurred. Do not assume culpability as a "big picture" view of the event is necessary, in context with other things that occurred about which you may not be aware. If you made an error that is irrefutable, ensure that you ask a senior colleague to be present when you break the distressing news to the parents or family of the patient. Immediately contact the hospital manager who is on call. If there is an unexpected death of a patient in your care, each of these steps needs to be instituted within 12 hours of the event occurring. Personal medical defence is essential in the private sector in cases where the hospital indemnity does not cover individual doctors. State hospitals in South Africa provide some cover to doctors. Contact your medical defence as soon as you have been involved in a serious adverse event.

Here is a checklist of what to do after an adverse event or medical error has occurred:

- Contact your consultant and/or head of department.
- Communicate with or inform the parents of your patient.
- Plan for a further meeting the next day when there is greater clarity around the event. Senior staff must be present.
- After a death or event in theatre, the surgeon, anaesthetist and nurse should plan on how to discuss the event with the parents of the patient together.
- Phone the medical superintendent and matron on duty.
- Document the events as accurately as possible. Include a copy of the anaesthetic record. Photocopy this so that you can keep one yourself. A report of the event must be placed in the folder. Do not accept culpability for the event in this report until clarity around it has been fully established. Do not write anything that is speculative, or involves your private thoughts or opinion, as this may be held against you as evidence. You may want to write down your own version for yourself, but keep this for your personal reference in the future.
- Complete the legal forms (GW 7/24: this is the report on the person whose death is associated with the administration of an anaesthetic or diagnostic or therapeutic procedure). A copy is kept in a folder in the sister's office in theatre.
- Contact your medical insurer, e.g. Medical Protection Society (MPS).
- Complete a departmental adverse event form and place it, with a copy of the anaesthetic record, in the head of department's office.
- Arrange a debriefing time with your senior colleague as soon as possible. It must be within 24 hours of the event occurring. The head of department must be informed.
- If required, contact ICAS (Red Cross War Memorial Children's Hospital 6086).
- Reschedule, cancel or delay further surgeries. Contact the appropriate medical personnel.

Suggested procedure to follow in the private sector

Phone a colleague, e.g. the chief anaesthetist within your group, or the head of department of a teaching hospital. Contact the medical director of that hospital and your medical defence. Obtain technical back-up of the equipment that you were using. Download the monitor details, e.g. vital signs, to support your anaesthetic record. This is much more meaningful than your handwritten anaesthetic record. You are more isolated in the private sector when an adverse event or medical error occurs, and ultimately you have to rely on yourself. This is not always easy to do, but it is essential that the critical event is addressed with urgency and compassion. No-one intends to kill a patient, and the consequences of these events may be catastrophic for the individual anaesthetist.

The aforementioned advice applies in respect of the rest of the points raised.

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