CASE AND COMMENTARY
What Constitutes Effective Team Communication After an Error?

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Abstract

Many procedures performed today involve a team of specialists with their own training histories and backgrounds. Some errors are inevitable in the course of clinical careers. Because errors tend to lead to complications, they often also lead to assignations of blame. When this happens, too often clinicians are at odds with each other about how to respond to a patient or a patient's loved ones after that patient suffers harm. This commentary on a case of a surgical complication examines how transparency in communication, cooperative disclosure, and working collaboratively to restore an injured patient's health support clinicians' common purpose, long-standing work relationships, and collegiality.

Case

After taking over an all-day abdominal perineal resection in which a patient experienced "some blood loss," the patient's surgical team was informed about the anesthesiology team's plan to transfuse the patient with a third unit of packed red blood cells. The team members looked up in acknowledgement and continued surgery. A blood gas was drawn, revealing the patient's hemoglobin (Hgb) level as 6.6 g/dL, compared to 14.8 g/dL at the start of the surgery. When the surgeons were informed of the Hgb, they indicated that more bleeding should be expected but didn't say why. On 3 separate occasions, the attending anesthesiologist asked the surgeons for updates on the patient's current surgical situation because the anesthesiology team was not able to keep up with the patient's blood, fluid, and resuscitation demands. Specifically, the amount and source of blood loss (eg, arterial vs venous vs oozing) and the surgical team's plan to continue dissection despite continued bleeding was not clearly communicated to the anesthesia team. The patient's hemodynamics continued to worsen. A massive transfusion protocol, transesophageal electrocardiogram, and rapid infuser were initiated, and additional anesthesia personnel were called. The surgeons finally disclosed to the anesthesiology team that the patient's iliac vein was nicked earlier in the surgery. The extent of injury to the patient now became evident, as did one consequence of the absence of real-time communication from the surgeons: the anesthesia team had dramatically underestimated how much blood loss the patient would suffer during the earlier

intraoperative resuscitation. Fortunately, hemostasis was achieved, and the patient stabilized. The surgeons recommended additional blood resuscitation to the anesthesia team before completing the surgery and leaving the operating room. At the end of the surgery, the patient was not extubated as usual, and, based on the update provided by the surgeon, the patient's family members understood that the anesthesia team was responsible for the patient's unplanned postsurgical stay in the intensive care unit (ICU).

Commentary

Separated between the drape, 2 teams of physicians with different training backgrounds stand with the shared goal of patient safety. Their relationship with the patient is often quite different. The surgeon likely has a long-standing relationship with the patient, cultivated over the span of years, and has made a decision to bring the patient in for surgery. The anesthesiologist often meets the patient on the morning of surgery and must quickly establish trust in taking the patient's life into his or her hands. Physicians are human and errors or negative outcomes occur in these high-risk situations. When an error, harm, or unanticipated outcome occurs, one physician might blame the other. For example, in the above case, the surgeon could state that the patient hemorrhaged because the anesthesiologist did not resuscitate the patient appropriately. The anesthesiologist could argue that the surgeon ligated the vein, which caused the sudden and massive blood loss. In such cases, engaging both parties in speaking with the patient and family members after the surgery is better for patient care and improves health care systems.[1] This approach might seem logical, but only recently has it become standard to be transparent when communicating with patients and families, and, to this day, long-standing cultural norms in medical education and practice still need to be challenged to reach this goal.[2] Here, we examine how clinicians' disclosure of error, transparency, and accountability when communicating with patients and families and their collaborative efforts to restore injured patients' health can support their common purpose, long-standing work relationships, and collegiality.

Blame Gaming

Imagine taking a closer look at the previously mentioned scenario. During a complex case involving a tedious tumor removal, a vein is accidentally ligated that results in significant active bleeding. The surgical team takes appropriate measures to stem the bleeding while at the same time the anesthesiologist works to resuscitate the patient utilizing fluids and blood products as well as pressor agents. Unfortunately, even when a complication is addressed and the patient survives, it results in an unanticipated ICU stay and prolonged recovery.

The disclosure of the complication to the family could depend on who is doing the disclosing. The surgeon could focus on the possibly ineffective resuscitation by the anesthesiologist and how that led to worsening intraoperative conditions and affected the recovery. At the same time, the anesthesiologist could point

out that the main error was the ligation of the vein and that, if the surgeon had not made that mistake, the surgery and recovery would have progressed more smoothly. With these differing and confrontational explanations, the family could be caught in the middle, uncertain of whom to trust and believe. Additionally, the important working relationship between the surgeon and anesthesiologist would be harmed, potentially leading to problems with future cases.

Transparency Is Collective Accountability
The need for better patient-physician communication has long been recognized. Beginning in the 1990s, studies were conducted on the relation between effective patient-physician communication and patient outcomes.[3] Moreover, the paternalistic and authoritative approach to decision making is slowly being replaced with a team-based approach wherein every stakeholder—including the patient, the patient's family, and the clinician—has a voice in the treatment plan. Indeed, patients are being appropriately cast as equal stakeholders and decision makers in their health. Accordingly, in communicating with patients and families, physicians place emphasis on laying out various treatment options, when applicable, as well as providing thorough and easy-to-understand summaries of outcomes and prognoses. With a view to promoting shared decision making, multiple organizations, including the Agency for Healthcare Research and Quality,[4] the American Medical Association,[5] and specialty specific organizations such as the American Society of Anesthesiologists[6] and the American College of Surgeons,[7] have developed guidelines outlining how to communicate with families. Additionally, institutions have created internal policies that provide guidance on the aims and methods of communicating with patients about errors, adverse events, and unanticipated complications.[8]

One element common to all these programs is acknowledgement that it is acceptable to apologize for errors or negative outcomes.[1,2,9,10] Disclosure is no longer viewed as an admission of guilt but instead as helping to build empathy among all parties and as reinforcing a commitment to patient safety and well-being. Along with their acceptance of apologizing to patients, health care organizations have emphasized full and complete error disclosure to patients.[1,2] Guidelines and policies concerning patient communication and error disclosure can be used to help guide conversations with patients and their families about medical errors.

As discussed in more detail below, in cases of surgical error, both the surgeon and the anesthesiologist could come together to meet with the family. Together, they could explain the course of events, what measures they each took to help fix the problem, and how they are going to avoid future mistakes. Jointly, they could apologize for the outcome but emphasize that together they are going to work to improve the situation. In this way, trust between the medical teams and family could potentially be restored and an ongoing open line of communication maintained.

Owning an Error Together

After a medical error has occurred and the decision has been made to discuss the situation with the patient and family, preparation and adherence to certain key steps can help make the process more effective. The key medical clinicians involved in the complication should come together and review the case and reach an agreement on the specifics of what happened.[9] At this meeting, it should be determined who is going to take the lead in the discussion with the patient and family. Typically, it would be advisable for the team responsible for the error to guide the discussion, but it can be helpful to have all teams represented: surgical team, anesthesia team, and nursing staff. If it is unclear who is responsible, then jointly leading the discussion would be appropriate. This team approach helps to demonstrate that all parties are concerned about what happened and similarly focused on finding a solution. However, having a point person lead the conversation can help make it seem less intimidating for the patient and family, as this approach will make the conversation seem one-on-one. Equally important is ensuring that the key members of the family are all present. The setting of the conversation is also a notable factor. Ideally, it should be quiet and free of distractions, with an emphasis on privacy and comfort. With the right setting, the discussion can focus on what is truly important about the situation: the patient.

After the setup for the meeting is complete, the most important step is the disclosure. Keeping a few principles in mind and adhering to a general plan can help make the conversation more constructive and less confrontational not only for the clinicians and family but also for the clinicians themselves. When communicating medical errors, it is important to use language that is easily understandable to all parties involved to avoid confusion and misinterpretation. Additionally, it can be helpful to take the cultural background of the patient and family into consideration. What is perfectly acceptable discussion material in one culture might be taboo in another. For example, in some Asian or Pacific Islander cultures, asking about the health of family members can be considered rude or only appropriate when discussed as a group but can be pivotal to discussion of a patient's family medical history.[11] Throughout the discussion, it is important to demonstrate empathy and concern while at the same time clearly stating the facts as they are currently understood. Instead of focusing on who is to blame and pointing fingers, delineate what happened but, just as importantly, what is going to be done. Explaining the steps being taken to currently care for the patient is also essential to demonstrating that the team truly cares for the patient and family and is concerned about their well-being. Also, it is helpful to reassure the patient and family that the source of the error is being investigated and to clarify that changes will be made to prevent future recurrences.[1,2,4,5,6,7,9,10] Throughout the conversation, it is important to be responsive to family members as opposed to merely lecturing to them. It is helpful to them to answer questions, provide comfort, and say "I'm sorry."

Admittedly, there is no one correct way to disclose errors. There is no well-studied and validated algorithm to help smooth over the problem and satisfy all involved parties in every situation. The immediate aftermath of a serious complication can be emotionally charged, and the tendency is protect oneself and blame others. Too often, colleagues with great working relationships built on trust can resort to an adversarial confrontation. Unfortunately, this not only can negatively affect workplaces and careers, but also—and more importantly—can prohibit effective communication with the patient and family and harm the patient's ongoing health care.

In the case described at the beginning of his article, it is obvious that there is a lack of communication between the 2 teams. And, unfortunately, this led to inadequate patient care in the setting of an unforeseen but honest error. After the case, if the 2 teams came together and debriefed each other about the sequence of events and how they could have more effectively handled the situation, possibly their working relationship could be restored and similar situations in the future could be avoided.

Keep Caring
The goal when discussing negative outcomes or errors should be full disclosure with an emphasis on a constructive conversation.[1] Without laying blame or finger-pointing, the conversation should include a full disclosure of the error in simple-to-understand terminology and an explanation as to why the error occurred, how the error's side effects will be minimized, and steps the team will take to prevent recurrences. The side of the drape that is responsible for the error can lead the discussion, but members of the other team can be present to offer support, their perspective, and their standpoint on how the error will be redressed. The aim should be to facilitate not service recovery (ie, risk management optimization) but an extension of the patient care process. Accidents and errors are going to occur because no one is infallible. The natural tendency when they occur is for medical practitioners to go on the defensive and start assigning blame to others. However, doing so only serves to hurt working relationships and patient-physician relationships. The common goal for all clinicians is to focus on taking care of the patient; but by also caring for each other, clinicians can reach that common goal more effectively. Through coming together and addressing the problem as a team, clinicians can maintain the integrity of the medical system.

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