THE NEW ZEALAND MEDICAL JOURNAL
Vol 118 No 1219 ISSN 1175 8716

# ‘Doing the right thing’ after an adverse event

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**Abstract**

Each year, the New Zealand Health and Disability Commissioner receives over a thousand letters of complaint from patients and their families, many of whom have suffered an adverse event. Often, the focus of their hurt and anger is not the injury itself, but the failure of a health professional to ‘do the right thing’ in the aftermath of the event. And in most cases, ‘the right thing’ requires no more, and no less, than living up to the ethical standards that we practise in everyday life: honesty, compassion, saying sorry, and a willingness to learn. Acknowledging that an adverse event has occurred can be hard, and facing up to an injured patient or bereaved family can be even harder. But the alternative scenario of silence and abandonment is worse: for patients, their families, and their health professionals.

Each year, the New Zealand Health and Disability Commissioner receives over a thousand letters of complaint from aggrieved patients and their families.[1] Many complainants have suffered devastating losses—permanent disability or even the death of a spouse or a child—as a result of an adverse event, which may or may not have been preventable.

The spotlight of the Commissioner’s work is usually on the adverse events and the healthcare systems that may have contributed to their occurrence. Yet, in their letters of complaint, these patients also tell us a second story—the story of what happened after the event. For many of these people, the focus of their hurt and anger is not the injury itself, but the failure of their health professional to ‘do the right thing’ in the aftermath of the event.[2]

The following case studies, drawn from the Commissioner’s files, suggest that in responding to adverse events, we would do well to live by four simple sayings heard in homes around the world:

- Honesty is the best policy,
- Say sorry if you hurt someone,
- We can all learn from our mistakes, and
- Treat other people the way you would like to be treated.

## Honesty is the best policy

Following an adverse event, patients are entitled to an open, truthful, and timely discussion of what went wrong and why.[3,4] While many health professionals do offer their patients an honest explanation, some patients are still left with unanswered questions.

> Mrs A underwent a total abdominal hysterectomy for postmenopausal bleeding. Mrs A’s anatomy made the surgery unexpectedly difficult. She


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suffered significant blood loss during the surgery and required a blood transfusion. Postoperatively, Mrs A was admitted to an intensive care unit in a critically ill state, and remained there for 27 days. For most of the time she was ventilated and in a drug-induced coma.

After leaving the intensive care unit, Mrs A was noted to have weakness, numbness, and pain in her left leg, which had not been present prior to the admission. A magnetic resonance imaging (MRI) scan was performed, but the mechanism of injury remained unclear. Mrs A was in hospital for a total of 3 months. Her left-leg weakness remains a problem and she requires a walking frame.

Mrs A could not understand how an apparently straightforward operation could have gone so wrong, but her efforts to obtain an explanation were unsuccessful. She commented:

> My surgeon made a fleeting visit after I was discharged from the intensive care unit and that was the last I saw of him…What happened and who is responsible? I feel a mistake is being covered up.

It is not just patients who need an explanation; families crave information and understanding too, particularly after a sudden death.[5]

After 80-year-old Mr B died in hospital, his distraught widow wrote:

> I still do not know what happened to my husband. The hospital is not giving me detailed facts…nobody is letting me know what happened.

Due to the nature and complexity of healthcare, adverse events are sometimes unavoidable. However, in the absence of an explanation, patients and relatives may interpret silence and evasiveness as evidence of wrongdoing.

Following a motor accident, Mr C was left with brain damage and quadriplegia. His mother and sister devoted their lives to providing him with 24-hours-a-day care. During a brief stay in a respite facility, Mr C suffered a fracture of his left leg. His mother and sister could not understand how an immobile patient could break his leg, and the respite facility and hospital gave them 'no explanation'. They concluded that Mr C's caregivers must have mistreated him.

Mr C's family had never been told that his bed-bound condition put him at significant risk of a spontaneous fracture.

When things go wrong, patients and their families want to know what happened and why,[6,7] and we have a responsibility to tell them in an honest and compassionate way. In the immediate aftermath of an adverse event, healthcare professionals may be searching for answers too, and in these circumstances it is appropriate to acknowledge the limits of what is known, and to make a commitment to sharing further information as it becomes available.

When patients and their families are dealt with decently and with honesty and reason, they usually respond in kind.[8] Support for this notion of an 'honesty dividend' can be found in the experience of many United States healthcare providers who report a reduction in litigation following the implementation of open disclosure policies.[9–11]


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## The power of an apology

Following an adverse event, a heartfelt expression of regret or sincere apology (which need not involve any expression of fault) can bring comfort to the patient, forgiveness to the healthcare provider, and restore trust to their relationship. Apologies have a potential for healing that is matched only by the difficulty some people seem to have in offering them.[12]

> Mrs D, a frail 79-year-old, developed a urinary tract infection. Her general practitioner made a telephone order for antibiotics, which were delivered to the rest home by the local pharmacy. That evening, a rest home caregiver placed the antibiotics in the drug cupboard, and asked the night shift caregiver to notify the charge nurse in the morning. This was not done, and the charge nurse remained unaware that the antibiotics had been prescribed or delivered. Mrs D was not given the antibiotics and she deteriorated over the next 5 days before the error was picked up. She was admitted to hospital in septic shock and died 2 days later.
>
> Mrs D's daughter was upset and hurt by the rest home's response to her mother's death. She wrote to the Commissioner saying:
>
> The rest home played down the whole event and obviously haven't taken it up as their responsibility. I haven't even had an apology, phone call, or any contact since mum died.

In some situations, the issue of an apology may be critical in the decision whether to lay a formal complaint. We are aware of matters that were resolved by expressions of regret and contrition, as well as matters that were not resolved owing to someone's stubborn refusal to apologise when they should have.[13]

One mother of a baby who required surgery after delayed diagnosis of an imperforate anus wrote to the Commissioner: 'Had the doctor apologised as soon as he found out about the problem, or had he enquired after baby's health, I would not be making this complaint now.' Anecdotal observations in this area[14] are increasingly supported by a growing body of research literature on the power of apology.[15]

## We can all learn from mistakes

Around a third of adverse events are likely to be preventable,[16] and patients have a legitimate expectation that the healthcare system will learn from such events, using them as portals for discovery. This focus on improving systems of care to 'make sure it doesn't happen to someone else' is particularly apparent in cases where a young person has died.

> A young mother, Mrs F, developed puerperal sepsis after childbirth. Her condition was not recognised for some hours and she died in hospital, leaving her husband to care for their young children. Her parents wrote: 'We believed our daughter would be well cared for by the hospital and doctors. We were wrong. In all of our dealings over her death, our main concern is to ensure that the lessons that could be learnt from our tragic loss were learnt.'

Many patients tell us that if their experience leads to some change for the better, then they will feel that their loss or suffering has not been in vain.

> Mrs E underwent breast reconstruction surgery after a mastectomy for breast cancer. Three days after the surgery, Mrs E became concerned about swelling

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in her wound. An on-call surgeon examined her, but did not speak to her surgeon or read the operation note. Mistaking the breast prosthesis for a fluid collection, he tried to aspirate it. The prosthesis punctured, and Mrs E had to undergo further reconstructive surgery.

Mrs E wrote:

I was very pleased with the care of the nursing staff and would not wish any adverse effects towards the surgeon involved, but am writing to you in the hope that systems could be put in place so a similar situation does not occur again…I think the surgeons are overworked to the point of making mistakes [and] I also see the need for all staff to read patient notes before treatment. I do hope those involved have been able to learn from this small mistake and thus prevent a mistake which could result in loss of life.

The true mistakes are the ones from which we learn nothing, and injured patients can be powerful allies in health professionals' efforts to create a safer system.

## Do unto others as you would have them do unto you

And finally, we would do well to remember the golden rule we all learnt as children: treat other people the way you would like them to treat you. When we are injured, we hope to be treated with kindness and compassion, not abandoned or ignored. In many cases, the difference between forgiveness and anger may be as simple as a phone call.

Mrs G was admitted to hospital following a fall in her rest home and died the same day. Her daughter commented:

It is perhaps a commentary on the situation that the only correspondence we have received from the rest home is the ambulance account.

An insensitive response to an adverse event can add insult to injury. Patients are left feeling hurt and confused when a health professional with whom they have had a longstanding relationship cuts them off cold after an adverse event.

Mrs H saw her general practitioner several times over a 7-month period complaining of breast discomfort. She was eventually diagnosed with metastatic breast cancer. Her daughter expressed her concern about the way Mrs H's doctor responded to the diagnosis:

Living in a small community, the doctor is well aware of what has happened to my mother yet not once has he so much as telephoned to see how things are with her. She has heard not a word from the doctor, not even a nod on the street.

As Don Berwick writes: 'Those of us who work in health care need to get much better at seeing images of ourselves in the people we help.'[17]

## Conclusions

Growing up, we all learn to 'do the right thing' when things go wrong, and wise health professionals and managers appreciate that understanding, healing, and forgiveness are possible following even the most tragic of events.[18] A quality of compassion should be found in every health professional and, if it is, it will be healing for the carer and the patient.

Acknowledging that an adverse event has occurred can be hard, and facing up to an injured patient or bereaved family can be even harder. But the alternative scenario of silence and abandonment is worse, for patients, their families, and their healthcare providers.[19]

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**Note:** The views presented here are those of the authors.

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**Acknowledgements:** Funding for Marie Bismark's Harkness Fellowship was provided by the Commonwealth Fund, an independent New York-based non-profit foundation. The authors also thank David Studdert, Robin Youngson, Tom McLean, Wayne Cunningham, and an anonymous reviewer for their thoughtful comments.

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