

# Handling unexpected adverse incidents



Discussing an incident with a colleague may help you prepare for a meeting with the patient and/or relatives.

**It is part and parcel of clinical practice to encounter unintended or unexpected events. Here, we discuss how a doctor can best handle adverse incidents that result in harm to the patient.**

*'Experience is the name that everyone gives to their mistakes.'*

Oscar Wilde

Medical practice is all about challenges, and how a doctor deals with a situation is key to a doctor's wellbeing and that of the patient.

Patients don't just offer professional challenges in the diagnosis and treatment of their symptoms. There is a plethora of challenges that are important for a doctor to be prepared for, an example being the handling of unexpected adverse incidents. Being equipped to face these situations in the right way can influence outcomes in a positive way for both the doctor and the patient.

An adverse incident can be defined as an event or circumstance that could have or did lead to unintended or unexpected harm, loss or damage which might or might not be preventable. [Department of Health and NPSA, Doing Less Harm, August 2001. [www.npsa.org.uk](http://www.npsa.org.uk)] The commonest forms of adverse incidents faced by medical practitioners today are suspect drug reactions, equipment malfunction and breakdowns, erroneous test results, clinical errors like failure to diagnose and medication errors.

The Medical Defence Union reports that around 400 people a year die or are injured due to adverse incidents involving medical devices, while some 10,000 a year report a serious adverse drug reaction.

A study of general practice incident-monitoring in the *Medical Journal of Australia*, published in 1998, revealed that 4 percent of adverse incidents resulted in death, but 76 percent of events were considered preventable. [*Med J Aust* 1998;169:73-6] It is, therefore, evident that adverse incidents are a

growing problem that requires attention.

Once an adverse incident has occurred, handling the situation and imparting the information correctly and appropriately to the patient can be extremely stressful for the doctor. The evidence suggests that the bearer of the news experiences strong emotions such as anxiety, a burden of responsibility for the news and fear of repercussions. This stress can result in a reluctance to deliver the bad news. [Breaking bad news - Regional Guidelines. Department of Health, Social Services and Public Safety, Belfast. [www.dhsspsni.gov.uk/breaking\\_bad\\_news.pdf](http://www.dhsspsni.gov.uk/breaking_bad_news.pdf)] Clinicians are often uncomfortable breaking the news of an adverse incident to the patient due to a number of reasons, including:

- Fear of being blamed.
- Embarrassment of not having foreseen the possibility of such an incident occurring.
- Uncertainty of the patient's reaction.
- Fear of personal inadequacy to handle the patient's future needs.
- Not feeling prepared to manage the patient's anticipated emotional reactions.

However, doctors must bear in mind that patients and their relatives rely on them to impart any news to them as properly and as effectively as they can. It is not always possible to get this very complex emotional exchange of information right. But it must be realized that communicating an adverse incident to patients correctly is not an optional skill, but one that is essential to professional practice.

The most important first step in handling an unexpected adverse incident is to not ignore it. Key research findings indicate that

being open is the best approach ie, to tell the patient and/or his or her relative(s) of the adverse incident. [Being open: Communicating effectively following a patient-safety incident – Casebook volume 13 no.3 August 2005 issue, [www.medicalprotection.org](http://www.medicalprotection.org)] In the case of a team of medical practitioners being involved, a team meeting should be first held to examine the clinical issues and decide who is best equipped to talk to the patient. In respect of the discussion with the patient, the following contents are advised:

- The patient should be advised of the identity and role of all people attending the meeting.
- Acknowledge the stress that the adverse incident had caused.
- Offer a sincere and compassionate statement of regret for the distress that the patient or his/her relative is experiencing.
- Provide a factual explanation of what happened – use language that can be easily understood.
- Provide a clear statement of what is going to happen from then onwards.
- Offer a plan on what can be done medically to repair or redress the harm done.
- Offer support to the patient and carer.
- The concerns of the patient and carer must be noted, and it should be demonstrated to the patient and carer that their views and concerns are being heard and considered seriously.

Source: The Australian Council for Safety and Quality in Healthcare has drawn up standards for disclosing errors to patients. It is well worth a read in full, and can be found at [www.safetyandquality.org](http://www.safetyandquality.org)

#### DO NOT:

- Speculate, or
- Attribute blame.

Further, as a clinician, remember that the meeting with the patient and/or with his/her relatives will also be very stressful to yourself, so taking time to prepare for the meeting will help ensure that the process is more effective. Remember to prepare yourself and prepare your setting:

- Establish what went wrong.
- Identify the system failures, but don't use them to absolve yourself of responsibility.
- Do not, however, rush into a full confession in the immediate aftermath of an adverse incident. Take time to get a proper perspective.
- Recognize personal factors that may have contributed to the error – and decide what improvements you need to make in your practice as a consequence.
- Talk it over with a trusted colleague – don't just focus on the clinical aspects; share your feelings as well.
- Discuss how you are going to tell the patient – rehearse it if you need to.
- Be prepared for a patient to be angry – don't behave defensively.

Source: Forgiving fallibility – Casebook volume 13 no.3 August 2005, [www.medicalprotection.org](http://www.medicalprotection.org)

It is also important to bear in mind that accurate records are maintained of the conversation and the information and details exchanged. These will assist in the future care of the patient and enhance communication within the multidisciplinary team that may be needed for the patient's future care.

It would be helpful for clinicians to keep a detailed log of the adverse incidents that they have personally encountered. Each incident should be investigated and the root cause should be identified so as to eliminate the risk of recurrence. Discussions with fellow practitioners and clinical teams should be conducted so as to provide a learning experience.

It certainly takes moral courage to openly admit to having caused someone harm and be exposed to the brunt of their reaction or the reaction of their loved ones. Painful as the thought of this may be, the ethical obligation of being honest and forthcoming makes this course of action one that is unfortunately, unavoidable. **MI**

\* Article courtesy of Raja, Darryl and Loh.