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FAST FACTS AND CONCEPTS #195

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Background When a physician makes an error that causes a patient harm, other physicians may be asked to explain the error or manage its consequences. Palliative care consultants may be involved to help provide terminal care and family support, or may be asked by families if a patient is dying as a result of error. We also have a professional duty to respond to a colleague's error if we are concerned about them personally or about patient safety. *Fast Fact* #194 addressed disclosing an error to a patient or family. This Fast Fact will discuss responding to a colleague's error.

Case: You are the accepting trauma surgeon at a major referral center. A community surgeon who is a friend from residency transfers to you a 45-year-old man involved in a motorcycle crash for further care of a closed head injury. The patient is found to have an unrecognized lower extremity fracture and an associated vascular injury that, in your opinion, should have been recognized and treated. The resultant compartment syndrome evolves into a severe soft tissue infection, and despite amputation and serial debridements, the patient remains in septic shock with a grave prognosis. The patient's family asks you if the outcome could have been avoided.

Responding to error as a consultant

- Reassure the family that they will have an honest and prompt explanation. Contact the referring doctor to learn all the details.
- If the referring physician agrees an error was made he or she should be encouraged to tell the patient/family directly. This may be impractical if the physician is from an outside institution.
- We have a duty to answer the patient's/family's questions honestly and to the best of our ability given the information at hand. Describe the facts as you know them, but without drawing conclusions or making value judgments about specific events in which you played no part. If asked, general statements about what constitutes usual standard of care are appropriate.
- Being purposefully vague or evasive during your explanation to the patient/family in order to spare the colleague is unethical. Affirm the patient's/family's right to open disclosure and refer them to the appropriate resources such as the hospital's patient advocate.

Responding to error as a colleague, mentor, and confidant

- Approach the colleague in a non-confrontational manner away from a public forum. *"I have concerns about Mr. X's care. Can you help me understand what happened?"*
- Offer emotional support. Your colleague may feel tremendous guilt and self-doubt, and the shame from harming a patient may prevent your colleague from seeking help. Reassure them that excellent physicians can make serious errors, can have psychiatric or family problems, and can need remediation in their professional skills from time to time.
- Was this event a sign of a colleague experiencing "burn-out" (see *Fast Facts* #167-170)? Help him or her identify and address professional or personal factors that are may be contributing (such as overwhelming practice load, relationship and family issues, depression, or substance abuse), as well as needed resources to address any problems.
- If appropriate, suggest the correct course of action in the future. This may be all the colleague needs to change practice. Offer to help with remediation: literature, courses, scrubbing together for the next few surgical cases.

- If there is any concern about the ongoing quality of medical care given by a colleague, most institutions have a peer review committee that can be contacted. In the case of substance abuse, most states and professional societies mandate the reporting of impaired physicians in a timely fashion in order to protect patients (see reference 5 below). Speaking with your institution's risk manager may give you a better sense of what are your specific options as well as your specific state regulations.

References

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