Unexpected Intraoperative Patient Death

The Imperatives of Family- and Surgeon-Centered Care

Dan Taylor, PhD; Moustafa A. Hassan, MD; Arnold Luterman, MDCM, FRCS(C); Charles B. Rodning, MD, PhD

Conveying to family members that their loved one has unexpectedly died during an operation is perhaps the most stressful task a surgeon must perform. The loss of a patient’s life precipitates enormous personal and professional anxiety and stress on a surgeon: profound grief, damage to self-esteem, loss of self-confidence and reputation, and the specter of litigation. Most surgeons feel unskilled in such a setting, yet how they communicate—what they say and how they say it—is extremely important for everyone involved. Two distinct, but interactive, phases of response are relevant when communicating with a family before and after an unexpected death of their loved one: a proactive phase (“CARE”) intended to establish a positive therapeutic relationship, and a reactive phase (“SHARE”) intended to respond to the crisis in a compassionate and respectful manner and to ensure self-care for the physician.

Arch Surg. 2008;143(1):87-92

It is every surgeon’s nightmare. An otherwise healthy patient was scheduled for an outpatient operation under general anesthesia. The patient had no discernible underlying risk factors, and recovery was expected to be routine. Early postoperative discharge was anticipated after the patient’s condition stabilized. The preoperative interrogation, physical examination, and laboratory analyses were all unremarkable. Intraoperatively, however, something unexpectedly went dramatically and terribly wrong and the patient died.

We believe that the process of communicating with family members about an unexpected death of their loved one can be considered in 2 distinct phases: proactive and reactive. The arguments and perspectives herein are predicated on our individual and collaborative professional experiences and our review and critical analysis of the relevant published literature.

PROACTIVE PHASE

The intent of the proactive phase, which begins preoperatively, is to educate the patient and the family in the context of informed consent. It implies that the patient is mentally competent, able to comprehend his or her condition, and capable of making rational decisions regarding diagnostic and therapeutic recommendations vis-à-vis the natural course of the illness. Discussion of the indications, techniques, risks, benefits, and alternatives of various interventions is an ethical and moral mandate. Establishing an effective patient-surgeon relationship requires demonstration of the core competencies: medical knowledge, medical care, communication skills, interpersonal dynamics, practice-based learning, and systems-based practice. Application and mastery of the core competencies enables a surgeon to enact the first phase of communication, CARE (Figure 1):

- Create credibility and establish fiduciary responsibility
- Articulate the purpose and plan of an operation
- Relate to the whole person in body, mind, and spirit
- Empathize

CREATE CREDIBILITY AND ESTABLISH FIDUCIARY RESPONSIBILITY

Creating credibility and establishing fiduciary responsibility with a patient and his or her family begins by demonstrating a thorough knowledge of the patient’s medical condition and the therapy the sur-
In addition, the practice of “anticipatory guidance,” ie, explaining the most common complications associated with an operative procedure and what the surgeon plans to do if a complication occurs, has merit in that it balances an explanation of the serious complications with the hope for a normal recovery. The surgeon should make it easy for patients and family members to ask questions, encouraging them to write down their questions when they think of them so that they will remember what they want to ask when they are with the surgeon. It is important not to rush the process of communication with patients and to be an “active listener.” Listening to patients and family members is unspoken caring and substantially enhances the bonds of mutuality and compassion. The unhurried time the surgeon spends communicating with them will be very beneficial, particularly should an adverse event occur.

**RELATE TO THE WHOLE PERSON IN BODY, MIND, AND SPIRIT**

Taking the time to communicate with a patient and his or her family demonstrates that the surgeon really cares. Seeking to know the patient as more than just a “clinical case” humanizes and personalizes an encounter and helps to assure the anxiety and vulnerability the patient and family may be experiencing. Understanding and relating to their cultural, social, familial, and spiritual backgrounds nonjudgmentally is essential to this process. Rakel listed compassion (from the Latin *compati*, “to suffer with”), trust, and respect as the essential components necessary to effectively practice medicine in a primary care setting. Those perspectives are just as valid in a surgical arena. Platt et al reported that “growing evidence suggests that physicians who focus on the patient as well as the disease obtain more accurate and thorough historical data, increase patient adherence and satisfaction, and set the stage for more effective patient-physician relationships.” The renowned physician Sir William Osler encouraged physicians to “care more particularly for the individual patient than for the special features of the disease.”

Physicians and surgeons pro forma acknowledge and address the physical, psychological, and social aspects of patient care. However, the gap between the spiritual beliefs of patients and the practices of clinicians is very wide. In a CBS News poll conducted April 20 to 22, 1998, 59% of respondents stated that religion was very important in their daily lives, 60% reported praying at least once a day, 64% prayed for their own health, 68% prayed for the health of others, and 80% believed that personal prayer or other spiritual practices could speed or help the medical treatment of people who were ill. In addition, 63% believed that physicians, if requested, should join their patients in prayer to ask for help in curing an illness and 34% believed prayer should be a standard part of the practice of medicine. A USA Weekend poll conducted April 5 to 7, 1996, reported that 79% of respondents believed that spiritual faith could help patients recover from an illness and that 63% believed it was good for physicians to talk to patients about spiritual beliefs but that, in their experience, only 10% of physicians actually did so. In an
AP/Ipsos poll conducted May 13 to 26, 2005, 70% of respondents agreed with the statement, “I know God exists and I have no doubt about it,” while another 10% stated that “while I do have doubts, I feel that I do believe in God.” When asked “How important is religion in your life?” 84% of those respondents stated that it was important.

It is paradoxical that only 10% of physicians actually discussed spiritual beliefs with their patients, although most patients expressed strong spiritual beliefs and would welcome such discussions. A survey of family physicians in Missouri discovered that most family physicians believed spiritual well-being was an important factor in health. Despite that belief, however, most reported infrequent discussions of spiritual issues with patients and infrequent referrals of hospitalized patients to chaplains.

To identify the spiritual inclinations and needs of a patient, Puchalski and Romer developed a method for assessing a patient’s spirituality. The key elements included the following, under the acronym FICA:

- Faith: Do you consider yourself religious and/or spiritual? Do you have a faith tradition? What gives meaning to your life?
- Importance: Is religion and/or spirituality important in your life?
- Community: Are you part of a religious and/or spiritual community?
- Address: How can we as health care providers address and respect your religion and/or spirituality in your care?

Implicit in assessing a patient’s spirituality is endorsing the importance of and granting permission to discuss those issues. When addressing the spiritual needs and concerns of a patient, previous authors have suggested that there are several important principles to affirm.

Spirituality is an important, if not essential, component of each patient’s overall well-being. Spirituality is an ongoing issue, to be addressed over time. Caregivers should not impose their beliefs on others. There should be consistent respect for a patient’s values, autonomy, and vulnerability. Referrals to chaplains or spiritual directors are appropriate with the consent and desire of the patient. Perhaps the most important principle for the caregiver is to know oneself: “You can’t address a patient’s spirituality until you address your own.”

EMPATHIZE

Expressing and demonstrating concern, compassion, and respect are important building blocks to developing trust in a patient-surgeon relationship. Thom and Campbell concluded that 7 categories of physician behavior increased patients’ trust:

- Thoroughly evaluating problems
- Conveying an understanding of a patient’s personal experience
- Expressing concern for a patient
- Providing appropriate and effective treatment(s)
- Communicating clearly and completely
- Building partnerships
- Demonstrating honesty and respect

Thom expanded on that study and concluded that care and comfort, technical competence, and communication were the 3 behaviors most strongly correlated with patient trust.

Sympathy (from the Greek sympatheia, “affected by like feelings”) and the more introspective empathy (from the Greek empatheia, “passion within”) have been suggested as effective methods for expressing concern, compassion, and respect. Coulehan et al defined empathy as an “ability to understand the patient’s situation, perspective, and feelings and to communicate that understanding to the patient.” In that regard, Platt et al suggested 5 perspectives a physician needs to know about the personhood of a patient:

- Who is this patient?
- What does this patient want from the physician?
- How does this patient experience this illness?
- What are this patient’s ideas about this illness?
- What are this patient’s feelings about this illness?

Platt et al advised physicians to give special heed to common responses of patients and their families to those questions: apprehension, fear, alienation, loneliness, distrust, anger, sadness, ambivalence, depression, and vulnerability. Surgeons would do well to be attentive to all of the aforementioned perspectives.

REACTIVE PHASE

The proactive phase segues to the reactive phase. The intent of the reactive response (SHARE; Figure 2) is to carry out the following:

- Scrutinize the care provided perioperatively
- Honestly and humbly acknowledge errors
- Articulate the circumstances of the death
- Reassure and console
- Ensure self-care

The dialogues and dialectics of the reactive phase can be highly charged, irrational, qualitative, and subjective. All of the participants must be permitted to express
their emotions, but the situation will eventually be resolved by defusing uncertainty and ambiguity, ie, by conveying all of the quantitative and objective information that can be discerned. All of the participants will experience grief and will progress nonlinearly through its stages: shock, disbelief, anger, bargaining, depression, and, hopefully and eventually, resolution (acceptance, forgiveness, and peace). It is an extremely stressful process for a patient’s family and for a surgeon, and for the latter it incites fear of the unknown, the uncertain, and the ambiguous; self-doubt regarding competence, esteem, and reputation; and the possibility of litigation.

**SCRUTINIZE THE CARE PROVIDED PERIOPERATIVELY**

Surgical audits, ie, morbidity/mortality analyses and conferences, have been inherent to surgical educational programs in North America since the late 19th century. Critique of the care provided by disinterested and independent colleagues, peers, and invited authorities is an invaluable practice from educational, quality assurance, and risk-management perspectives. Ideally, the process empowers the participants to differentiate causality and to acknowledge and rectify errors of knowledge, technique, judgment, and ethics in the context of respectful argumentation and confidentiality.

All hospital and operating room personnel must be involved in investigating and debriefing the care provided to such a patient. That step is essential in discerning the facts surrounding an unexpected death. It will reinforce good practices, expose weaknesses in the system, and provide peace of mind if everyone involved did all humanly possible to care for the patient. Advising a family that a postmortem analysis is required is germane. The objective results of an autopsy may resolve uncertainty surrounding the death and help provide closure for both the family and the health care providers.

**HONESTLY AND HUMBLY
ACKNOWLEDGE ERRORS**

Normative ethical standards demand acknowledgment of errors, however agonizing that admission may be to a family and to a surgeon. The specter of professional liability litigation looms large in such settings. However, several authors have recently argued that such an admission may in fact defuse the situation and reduce the risk of litigation. It is advisable to acquire all objective data before holding detailed discussions with the family, including data derived from surgical pathological and postmortem analyses.

The thought of needing to admit mistakes strikes fear in the heart of all surgeons. Nightmares of litigation and the loss of prestige and livelihood are genuine concerns. However, if a medical error led to the death of a patient, normative ethical standards demand an admission of error. All patients desire some acknowledgment of even minor errors. Patient complaints and risk-management issues are more frequent for surgeons than for nonsurgeons. For moderate and severe mistakes, patients were significantly more likely to consider litigation if the physician did not disclose the error. Honesty and offering substantive help in filing claims when substandard care has been provided may diminish anger and a desire for revenge that often motivates litigation.

**ARTICULATE THE CIRCUMSTANCES OF THE DEATH**

A review of surgical textbooks indicated, Disease epidemiology, prognosis/prevention, progression, and medical interventions were generally well discussed in all textbooks. However, little helpful information was provided with regard to breaking bad news, advanced care planning, mode of death, treatment decision-making, effect on family/surgeon, and symptom management. Cancer chapters also addressed only a few of these concerns.

The process of breaking bad news is especially challenging for inexperienced medical and surgical residents. Clinicians should not speculate on causality in a manner that is legally destructive. Clinicians do not have an ethical imperative to speculate. Cogent guidelines (Table) for breaking bad news have been published recently. Those guidelines meld well with the following perspectives.

**REASSURE AND CONSOLE**

Communicating the unexpected death of a patient to family members requires that the leader take a team approach, choose a proper setting, prepare remarks, and be prepared to respond to grief.

**Team Approach**

A team approach should be used when communicating with family members. The team might consist of a surgeon, an anesthesiologist, a nurse from the operating room, a member of the chaplaincy, and a social worker. However, one individual should be designed as the spokesperson.

**Proper Setting**

The team should meet with the family in a location where quiet, privacy, and ample space are available to accommodate everyone. Distractions, such as pagers and cellular telephones, should be avoided. Seating and amenities, such as facial tissues and water, should be available.

---

**Table. Key Points in Giving Bad News**

| Select appropriate setting | Assess baseline knowledge | Discern level of information sought | Present information in clear language, repeat key points, and allow time for questions | Allow patient and family to respond and acknowledge their responses | Summarize and plan for additional discussions |

*a Adapted with permission from Buckman and Kason.*

©2008 American Medical Association. All rights reserved.

Downloaded From: http://archsurg.jamanetwork.com/pdfaccess.ashx?url=/data/journals/surg/9681/ on 03/30/2017
Prepare Remarks

Even though the time interval between the event and the communication with the patient’s family will undoubtedly be brief, careful thought should be given to what will be said. The fact that a meeting has been called will herald bad news. The designee who announces the meeting should indicate that serious issues will be discussed, which will also serve as a harbinger to family members.

When the meeting begins, everyone should be introduced and the family should be asked whether they wish everyone to be present. The spokesperson for the team then compassionately expresses with sincere sorrow that the patient has died, which will elicit a grief response from family members. Time should be allowed for them to absorb that information. The spokesperson should honestly and factually communicate the circumstances surrounding the death and assure the family that the operating room team did everything possible to resuscitate the patient. If the cause of death is suspected but not fully understood, the family should be reassured that a thorough investigation will be conducted and that the results will be communicated to them as soon as possible. If feasible, the spokesperson may provide an idea of the most likely conditions to be analyzed. The spokesperson should answer all questions as clearly and compassionately as possible; however, if any of the facts are uncertain, those reservations should be expressed. It is unwise to give inaccurate information.

Prepare to Respond to Grief

Grief can be expressed in a variety of ways; however, when an unexpected death occurs, family members may experience more pronounced and severe grief reactions than an unexpected death occurs, family members may experience more pronounced and severe grief reactions than they might have experienced had the death been expected.34 The initial phase of grief may be manifested as shock, denial, and/or disbelief. Because loved ones have not had time to prepare, their minds will work overtime to insulate themselves from reality. They may quickly move to the next phase of grief, characterized by highly emotional reactions (crying, anger, and accusations). They may have a desire to see and touch the body of the deceased. The surgeon and the hospital personnel need to be as helpful and accommodating as possible at that juncture, which communicates their genuine understanding of and compassion for the family’s grief. Normally, grief will eventually give way to the phase of acceptance and peace. The length of time required for that progression varies greatly.35

ENSURE SELF-CARE

Surgeons enter the practice of medicine to restore health and wholeness to patients. They desire to relieve suffering and cure disease. While always difficult, death is often easier to accept when the patient experiences declining health due to an incurable illness. By contrast, the stress associated with the unexpected death of a patient can be overwhelming.33-36 Under those circumstances, self-care is not only desirable but mandatory for personal and professional survival.

Self-care is not usually a part of a surgeon’s education and is generally low on the surgeon’s list of priorities.33 The rigors of medical school and residency require a bravado and an almost superhuman commitment to work, which may result in suppression of personal needs and effacement of self-interest. Surgeons often lead unbalanced lives in terms of work commitments, family relationships, and personal recreation, rest, and reflection.34 They frequently strive for perfection, deny their personal needs and feelings, assume total responsibility for a patient, and are altruistic to the point of denial. Surgeons responding to the strong emotions of critically ill patients and their family members frequently experience strong emotions of their own.35 One can only imagine the emotional responses of surgeons experiencing the unexpected death of their patients.

Surgeons are frequently characterized as driven, controlling, intense, and obsessive-compulsive individuals, who are willing to postpone short-term gratification for long-term goals; who exhibit a superhuman commitment to work, duty, and obligations; who overvalue science and technology; and who undervalue self-care. It is dichotomous that the attributes and characteristics of all competent health care providers are the same attributes and characteristics that may be detrimental to their personal and professional welfare. That surgeons strive for balance between their current situation and their own psychological disposition is imperative. The Aristotelian ideal of the golden mean should be followed. Surgeons must give attention to their body, mind, and spirit, which can include professional goals and responsibilities. Nutrition, hydration, hygiene, rest, socialization, spirituality, and recreation are fundamental human needs. Surgeons and health care providers neglect them at their peril. Prescriptively, what can a surgeon do to provide self-care? Pfifferling36 offered 6 suggestions for balance in a physician’s life:

- Set priorities
- Learn to value who you are
- Understand your own needs
- Learn to say, “I do not know”
- Learn to say “no”
- Take a vacation

Turnbull37 offered 10 steps to staying sane:

- Maintain a sense of optimism
- Work on your friendships
- Focus on special individuals in your life
- Plan for retirement
- Take care of the “old equipment” (yourself)
- Keep a sense of humor
- Do something you like
- Be comfortable with assertiveness
- Believe you can change
- Get help if you need it

Whatever physicians do to take care of themselves, they need to do it consistently and do it frequently. This will help them prepare physically, emotionally, and spiritually for that rare occasion when a patient unexpectedly dies.

In summary, we respectfully argue experientially and advise prescriptively that the imperatives of both fam-
ily- and surgeon-centered care must prevail when the unexpected intraoperative death of a patient is confronted. The acronyms CARE and SHARE to describe the proactive and reactive phases of response to such a situation, respectively, will help to establish a positive therapeutic relationship, reassure and console the family, and defuse the angst for everyone involved. Application of these principles will reaffirm concern, compassion, and respect for the patient and the family and will ensure the personal and professional viability, credibility, and competence of the surgeon.

Accepted for Publication: April 27, 2006.
Correspondence: Charles B. Rodning, MD, PhD, Department of Surgery, College of Medicine and Medical Center, University of South Alabama, 2451 Fillingim St, Mobile, AL 36617 (crodning@usouthal.edu).


Financial Disclosure: None reported.

Additional Contributions: Betty J. M. Pledger typed the manuscript.

REFERENCES

4. Leach DC. Competence is a habit. JAMA. 2002;287(2):243-244.