

*Disclosing
Adverse
Outcomes
and
Medical Errors*

Institute for Healthcare Communication

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Objectives

- Understand rationale for openness
- Appreciate others' perceptions of situation
- Consider steps to take before, during and after an unanticipated outcome
- Acknowledge the ethical dimensions
- Practice the disclosure skills



Disclosure and Resolution

- Disclosure is telling the patient and family what happened
- Resolution is the feeling that the situation has been addressed as well and as completely as possible to everyone's satisfaction

Qualities of an effective resolution

- Ethical
- Psychologically healing
- Legal
 - Washington Apology Law
- Economical

Patients experience two types of disappointment

- The disappointing unanticipated medical outcome
- The disappointing way the healthcare providers behave after the unanticipated outcome
 - Research suggests patients are more forgiving of the first disappointment than of the second

(Hickson, 1992; Beckman, 1994; Vincent, 1994; Kraman, 1999; Gallagher, 2003)



Malpractice suits are not an inevitable result of unanticipated outcomes

- Reduce the impetus for the patient and family to go outside our relationship:
 - Rebuilding rapport and trust
 - Resolving disagreements
 - Negotiating fair settlements when appropriate

(Lester, 1993; Vincent 1994; Hamm and Kraman, 2001; Mazor, 2004;)



Unanticipated outcomes have 2 origins

Without error
Standard met
Not normally
preventable

With Error
Standard not met
Normally
preventable

Unanticipated
outcome



Balancing Patient's Right to Information With Organization's Confidentiality Privilege

- Confidentiality privilege not intended to hide the facts of their care from patients
- Confidentiality privilege allows organization to protect the deliberation process
- Once the facts and their most likely causes are determined, aren't the patient and family entitled to learn them
 - Informed consent before hand implies full disclosure after the fact

(Liang, 2002)



Outcomes may be unanticipated due to

- Uncorrected “unreasonable” expectations
- Biological variability
- Low probability risks & side effects
- Wrong judgments without negligence
- Medical or systems errors



What do we mean by medical/systems error?

- Medical / legal :
“Act of commission or omission with potential consequences for the patient that would be judged wrong by skilled and knowledgeable peers at the time it occurred.” (Wu, 1997)
- Failure of a planned action to be completed as intended or the use of an incorrect plan to achieve an aim (IOM)
- deviation from the standard of care



When to discuss potential or actual unanticipated medical outcomes

- BEFORE: prior to treatment
- DURING: as concerns arise
- AFTER: unanticipated outcome



BEFORE treatment begins

- Establish partnership
- Use shared decision-making acknowledging risks and benefits
- Make recommendation, confirm patient's agreement or continue discussion
- A signed informed consent form may be needed but the discussion is key



DURING treatment

- Elicit and respond to concerns
- Empathize with disappointments and doubts
- Demonstrate attentiveness & thoroughness
- Decide together on best approach



AFTER unanticipated outcome without error

Four aspects to address:

- Immediate clinical care of the patient
- Dealing with your own emotions, uncertainties and needs
- Developing clarity re: what happened
- Preparing for and having a discussion with patient/family



“AID” to disclosure and resolution

- Acknowledgment of adverse outcome
- Investigation and conclusions
- Disclosure
 - telling the patient what happened and following through until resolved

Team composition for initial discussion with patient

- PCP or attending present if medical error and/or significant harm
- Nursing or pharmacy and a supervisor if minor error
- If serious injury, a second person is essential to facilitate discussion, witness, support, and follow-up
- Consider need and value of involving a disclosure facilitator to oversee and guide the process



Role of disclosure facilitator

- Coordinates the AID process
 - provides support and guidance for the clinicians
 - maintains communication with patient family
 - identifies needs, questions and concerns
 - facilitates discussions, informal and formal
 - oversees until resolved

Before talking to the patient/family—Recognize and manage emotions

- Pause for self-reflection and ask for assistance
- Notice yours/their thoughts and emotions
 - How is emotional distress expressing itself?
- What help do you/they need and where can you turn to get it?



Initial acknowledgment or disclosure care was reasonable

- **ANTICIPATE** start with expression of sympathy
 - an “apology” for the situation
- **LISTEN** to understand the patient & family's upset thoughts and feelings
- **EMPATHIZE** and normalize without defensiveness
- *And then offer to **EXPLAIN***



Anticipate

- Anticipate emotions and questions
 - How did this happen?
 - What can be done about it now?
 - What does it mean for the future?
- Begin with an expression of sympathy
 - “I am very sorry that your family has been through so much this week.”
 - “I was sorry to learn that you had to return to the emergency room.”



Listen and Summarize

- Invite their story
 - *Tell me what happened...*
 - *and what have you been told so far?*
- Ask about their
 - Feelings
 - *How are you feeling at this point?*
 - Motivations
 - *How can I be most helpful to you now?*
 - Ideas
 - *What are your thoughts about ...?*



Empathize

Make sure the patient and family experiences:

- Being seen
 - Undivided, timely attention
- Being heard
 - Short summaries to assure understanding
- Being accepted and understood
 - *I can understand how it would appear that way.*
 - *No wonder you are feeling misled.*
 - *This is very different from what we were all expecting.*



Saying I'm sorry (know which one you intend)

- Expression of sympathy for situation.

"I'm very sorry that your family has been through so much pain this last week."

- Admission of responsibility

"I'm so sorry that I did not have the nurse bring those lab results directly to my office when she first got them and I might have gotten you into the hospital sooner."



Explain and answer questions

- Ask before explaining
 - *“Would it be helpful for me to explain ...?”*
- Describe facts and answer questions willingly
- Avoid being drawn into controversies that suggest liability by others

“It sounds like that was a frustrating experience up in diagnostic imaging.”



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If investigation concludes medical/ system error caused injury

Truth, transparency and teamwork
coordinated by the disclosure facilitator

Empathy for patient/family experience

Apology and accountability to prevent

Management of all aspects

- Exemplary patient care
- Emotional support for all involved
- Ongoing communication
- Offers of practical and financial help in recovery from injury



Who attends formal disclosure

- from facility side:
 - disclosure facilitator, attending physician, other staff whose behavior contributed to the harm, more senior administrator, risk manager and possibly attorney
- from patient side:
 - patient, patient's family and others as requested by patient
 - advocate, attorney, tape recorder?

Formal/post investigation disclosure meeting

- Disclosure facilitator helps prepare staff and invites and orients patient and family
- Either the TEAM or ALEE track is followed depending on investigation conclusions
- Individuals explain, demonstrate empathy, accept accountability and apologize in proportion to their contribution to the harm
- Clinician involvement should be largely concluded here. Compensation issue may remain

In Summary

Standard Met

- Anticipate, Adjust,
- Listen
- Empathize
- Explain

Standard not met

- Truth, Transparency, Teamwork
- Empathy for full impact
- Apologize and be Accountable
- Manage until resolved
 - Medical Care
 - Emotional Support
 - Ongoing communication
 - Practical and financial

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