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PEACE OF MIND | EXPERTISE | CHOICE | THE MEDPRO GROUP DIFFERENCE

Disclosure, Empathy and Apology:

Managing Unanticipated Outcomes in Healthcare

Objectives

At the conclusion of this program, you should be able to:

- Define an unanticipated outcome, and differentiate between the types of situations that can lead to unanticipated outcomes
- Describe the current ethical standards for disclosing unanticipated outcomes in healthcare settings
- Identify the difference between expressions of empathy and expressions of apology
- Explain the concept of the “second victim” of unanticipated outcomes and identify strategies to support second victim
- List the componence of the “communication and resolution “ approach to disclosure
- Identify the key steps in the disclosure process and who should participate
- Discuss the essential components of communication to assure the effectiveness of the disclosure

Definitions

Unanticipated outcomes include:	Outcomes of care that differ significantly from anticipated outcomes
	Medical errors caused by standard of care deviations
	Patient harm that results from medical mismanagement or system failures

A near miss is an unplanned event that does not result in patient harm, but has the potential to do so. — National Safety Council

Disclosure vs. admission of liability

Understanding the difference

Disclosure and empathy

"I'm sorry, Mrs. Jones, but your child became unresponsive and stopped breathing during the procedure. We had to resuscitate her. She is doing fine now, and we are going to closely watch her for the next several hours."

Admission of liability

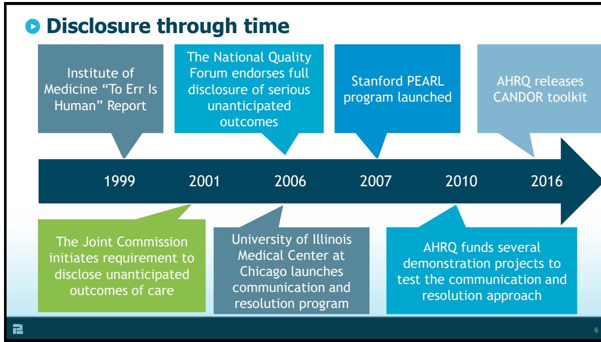
"I'm sorry, Mrs. Smith, but it is my fault that your child became unresponsive during the procedure. I must have given her too much medicine."

Discussion points

In my opinion:

1. There is value in proactively disclosing unanticipated outcomes.
2. Disclosing unanticipated outcomes just creates more problems and unnecessary stress.
3. I have no opinion about disclosing unanticipated outcomes.

Disclosure: Laws, standards, and expectations



Oklahoma State Law

2014 Oklahoma Statutes
Title 63. Public Health and Safety
§63-1-1708.1H. Statements, conduct, etc. expressing apology, sympathy, etc. – Admissibility – Definitions.
Universal Citation: 63 OK Stat § 63-1-1708.1H (2014)

A. In any medical liability action, any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence which are made by a health care provider or an employee of a health care provider to the plaintiff, a relative of the plaintiff, or a representative of the plaintiff and which relate solely to discomfort, pain, suffering, injury, or death as the result of the unanticipated outcome of the medical care shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest.

B. For purposes of this section, unless context otherwise requires, "relative" means a spouse, parent, grandparent, stepfather, child, grandchild, brother, sister, half-brother, half-sister or spouse's parents. The term includes said relationships that are created as a result of adoption. "Representative" means a legal guardian, attorney, person designated to make decisions on behalf of a patient under a durable power of attorney or health care proxy, or any person recognized in law or custom as an agent for the plaintiff.

The Joint Commission standards

"Though Joint Commission standards do not require disclosure, evidence suggests that patients benefit—and are less likely to pursue litigation—when physicians disclose harm, express sympathy and apologize."

Source: The Joint Commission. *Quick Safety Issue 29: Advancing patient-provider communication and activating patients*. 2016. Retrieved from https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-29-advancing-patientprovider-communication-and-activating-patients/

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Other disclosure policies and guidance

AMA Code of Ethics	"Withholding pertinent medical information from patients in the belief that disclosure is medically contraindicated creates a conflict between the physician's obligations to promote patient welfare and to respect patient autonomy." (Opinion 2.1.3)
The American College of Obstetricians and Gynecologists	"The disclosure and discussion of adverse events are critical to create and maintain high-quality health care and to preserve the integrity of the patient-physician relationship."
The Leapfrog Group	"Leapfrog asserts that regardless of its environment, setting, or type of patients it treats,100% of hospitals should comply with all nine elements of Leapfrog's Never Events Policy."

Sources: AMA Code of Medical Ethics. (2016, June). Chapter 2: Opinions on consent, communication & decision making. Retrieved from https://www.ama-assn.org/delivering-care/ethics/withholding-information-patients; Disclosure and Discussion of Adverse Events. ACOG Committee Opinion. Retrieved from https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Patient-Safety-and-Quality-Improvement/Disclosure-and-Discussion-of-Adverse-Events; Leapfrog Never Events Report. (2019). Retrieved from https://www.leapfroggroup.org/never-events-report-2019

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Disclosure organizational plan

ECRI	Culture of safety
	"Disclosure culture"
	Clinical crisis management plan
	Disclosure policies and procedures
	Educate staff
	Prepare staff for disclosure conversations
	Support staff
	Document and communicate disclosure
	Service recovery

Source: ECRI Institute. (2018, May). Disclosure of unanticipated outcomes. *Healthcare Risk Control (HRC)*.

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The expectation gap

"Studies using hypothetical designs have suggested that a gap exists between clinicians' and patients' views of what is appropriate incident disclosure. Clinicians tend to consider unexpected clinical outcomes as less serious and therefore less in need of disclosure than do patients. Clinicians also err on the side of caution, whereas patients expect openness and admission of responsibility. Such breakdowns in the disclosure process exacerbate the distress patients experience from the event itself."

Source: Ledema, R., et al. (2011, July). Patients' and family members' views on how clinicians enact and how they should enact incident disclosure: The "100 patient stories" qualitative study. *BMJ*, *343*, d4423. Retrieved from http://www.bmj.com/content/343/bmj.d4423

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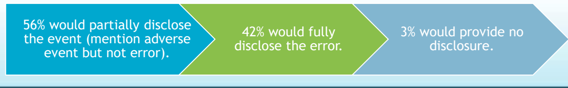
Full vs. partial disclosure

Full disclosure includes:

- Disclosure of all harmful incidents
- Acknowledgment of responsibility and apology (when a known error has occurred)
- An explanation of why the event happened
- How the effects of the event will be mitigated
- Steps the healthcare provider/organization will take to prevent similar occurrences

In a survey of more than 2,600 medical and surgical physicians who were given scenarios depicting serious errors:



Sources: AHRQ, *Patient safety primer: Error disclosure*; Gallagher, T. H., et al. (2006, August). Choosing your words carefully: How physicians would disclose harmful medical errors to patients. *Archives of Internal Medicine*, *166*(15), 1585-1593. Retrieved from http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/410785

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Barriers to disclosure

Austin Journal of Pathology & Laboratory Medicine (2014)
Tangible sanctions for physicians
Punitive workplace policies, damage to reputation and career, fear of litigation, legal/financial damages assessed by the courts
Healthcare norms and attitudes toward medical error
Fear of retaliation or career damage from reporting unanticipated outcomes; uncertainty of role in reporting; concerns about loss of authority, damaged reputation, and criticism; effect of disclosure on patients' idealized perceptions of healthcare providers; different notions of what constitutes an error
Causal uncertainty surrounding the error trajectory
Lack of definitive answers about what occurred, how it occurred, why it occurred, and who played a role; uncertainty about the responsibility for disclosure; lack of accountability for systemic origins of errors; questions about preventable errors vs. nonpreventable illness complications
Physician weighing of harms and benefits of disclosure
Uncertainty about duty to disclose near misses or errors that are caught and corrected prior to harm, fear of unwarranted patient distress, concern for patient understanding of unanticipated outcome

Source: Entwistle, M., & Kalra, J. (2014, October). Barriers to medical error disclosure: An organizing framework and themes for future research. *Austin Journal of Pathology & Laboratory Medicine*, *1*(2), 6.

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Second victims

Don't forget "second victims"

Unanticipated outcomes can have three victims:

- Patients/families (first victims)
- Healthcare providers (second victims)
- Healthcare organizations (third victims)

Second victim

A healthcare provider who is involved in an unanticipated patient outcome and feels traumatized by the event. The provider may experience feelings of blame, anger, shame, failure, depression, inadequacy, and distress.

Sources: Seys, D., et al. (2013, May). Supporting involved health care professionals (second victims) following an adverse health event: A literature review. *International Journal of Nursing Studies, 50*(5), 678-687. Retrieved from www.sciencedirect.com/science/article/pii/S0020748912002283; Agency for Healthcare Research and Quality. (2016, July). *Patient safety primer: Support for clinicians involved in errors and adverse events (second victims)*. Retrieved from https://psnet.ahrq.gov/primers/primer/30/support-for-clinicians-involved-in-errors-and-adverse-events-second-victims?q=second+victim

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TJC *Journal on Quality and Patient Safety*

Results from a survey of more than 3,000 physicians in internal medicine, pediatrics, family medicine, and surgery

Following errors, physicians reported:	%
Increased anxiety about future errors	61
Loss of confidence	44
Problems sleeping	42
Reduced job satisfaction	42
Harm to their reputation	13

Only 10 percent of participants felt that their healthcare organizations adequately supported them in coping with error-related stress.

Source: Waterman, A. D., et al. (2007, August). The emotional impact of medical errors on practicing physicians in the United States and Canada. *The Joint Commission Journal on Quality and Patient Safety, 33*(8), 467-476.

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Second victim support: Organizational strategies

- Support a culture of safety that encourages transparency, respect, and honesty.
- Survey staff and conduct an organizational assessment to determine how best to support healthcare providers involved in unanticipated outcomes.
- Develop written policies for second victim support and resources.
- Implement a comprehensive program to support providers before, during, and after disclosure of unanticipated outcomes, including rapid response provisions.
- Establish confidentiality standards for information shared as part of second victim support programs.
- Educate and train providers on the organization's disclosure policies so they are prepared to handle a disclosure scenario.

Sources: University of Missouri Health System. (2010, December). Building a clinician support program: Assessment worksheet/planner. Retrieved from www.mitsstools.org/uploads/3/7/7/6/3776466/building_a_second_victim_support_programdecember3.pdf; Conway, J., et al. (2011). *Respectful management of serious clinical adverse events* (Second Edition). Institute for Healthcare Improvement. Retrieved from www.ihi.org/resources/Pages/IHIWhitePapers/RespectfulManagementSeriousClinicalAEsWhitePaper.aspx

Second victim support: Program considerations

- Unit- or department-based support systems
- Rapid response teams
- Peer support/mentoring
- Employee assistance programs
- Easily accessible support contact/hotline
- Professional review/feedback
- Expert consultants (e.g., risk managers, patient safety experts, behavioral health professionals)
- Support materials (e.g., tips for coping with stress, self-care guidance, crisis management advice)
- Professional counseling

Sources: AHRQ, *Support for clinicians involved in errors and adverse events (second victims)*; Conway, et al., *Respectful management of serious clinical adverse events*, Institute for Healthcare Improvement.

Litigation support

MAINTAINING YOUR BALANCE

Source: MedPro Group Patient Safety & Risk Solutions: Litigation Support: Maintaining Your Balance (2016). Retrieved from https://www.medpro.com/documents/10502/359074/Litigation+Support+Booklet.pdf

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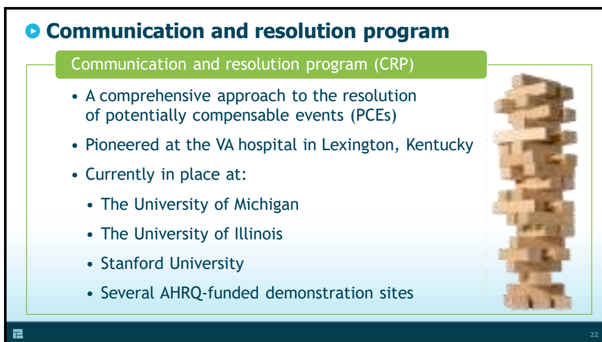
Communication and resolution programs



Elements of a communication and resolution program

- Immediate reporting of unanticipated outcomes to risk management staff
- Rapid investigation and evaluation of the PCE
- Full disclosure
- Full apology (if appropriate)
- Full compensation (if appropriate)

The University of Illinois Medical Center approach

- **Reporting**: Notifying patient safety or risk management personnel about unexpected outcomes involving patient harm
- **Investigation**: Undertaking a rapid, detailed investigation using standard RCA techniques to determine whether an error was made
- **Communication**: Creating programs for providing ongoing communication with patients/families after an unexpected outcome without regard to the cause of the event
- **Apology and remedy**: In the event of an error, providing an apology and an appropriate remedy
- **Improvement**: Linking process improvements identified in the RCA with patient/family involvement

Source: Mayer, D., et al. (2011, September 12). Medical error calls for honest disclosure. *American Medical News*. Retrieved from www.amednews.com/article/20110912/profession/309129949/5/

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Stanford's PEARL

Process for Early Assessment and Resolution of Loss (PEARL)

- Designed to address significant, unanticipated, or adverse medical outcomes
- Based on principles of open communication, transparency, and integrity
- Helps patients understand their care by addressing complex medical concerns in a comprehensive, compassionate, and confidential manner

Between 2009 and 2014, Stanford's frequency of malpractice lawsuits dropped by 50 percent compared with the frequency from 2003 to 2008. Further, a 40 percent decrease occurred in the average cost of individual malpractice claims.

Source: How Stanford Hospital cut malpractice lawsuits in half. Retrieved from www.advisory.com/daily-briefing/2016/02/03/how-stanford-health-care-cut-malpractice-lawsuits-in-half

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AHRQ's CANDOR process

Communication and Optimal Resolution (CANDOR)

- A process to help healthcare organizations and providers respond in a timely, thorough, and just way to unanticipated outcomes.
- Based on expert input and lessons learned from an AHRQ Patient Safety and Medical Liability grant initiative launched in 2009.
- Process and materials tested and applied in 14 hospitals across 3 U.S. health systems.
- Includes eight different modules that cover topics such as obtaining organizational buy-in; gap analysis; event reporting, investigation, and analysis; response and disclosure; second victim support; resolution; and more.
- Each module contains PowerPoint slides with facilitator notes. Some modules also contain tools, resources, or videos.

Source: Agency for Healthcare Research and Quality. (2016, May). Communication and optimal resolution (CANDOR) toolkit. Retrieved from www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/candor/introduction.html

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The disclosure process

Discussion points

In my career:	I have disclosed an unanticipated outcome.
	I have never found it necessary to disclose an unanticipated outcome.
	I should have disclosed an unanticipated outcome, but I did not.

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Disclosure is a continuum

Five-Star

Loyalty

Disclosure

Follow-up

Resolution

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Five-Star culture

- Treating staff, colleagues, physicians and patients at the highest level of service – internal and external
- Providing an unprecedented level of service
- Leaving a lasting positive fingerprint
- Consistent…pervasive…even on the worst days

When does the disclosure process begin?

Disclosure should begin with the informed consent process. Informed consent is:

- An opportunity for patients/families to develop reasonable expectations for their treatment results
- An excellent reference point to begin the disclosure discussion (e.g., “*Remember when we discussed the possibility of [x] outcomes*?”)
- Your opportunity to build a strong provider-patient relationship that can support future disclosure discussions

Is honesty always the best policy?

Error Without Harm

- The facts are in the health record.
- Disclosure can be used as a “relationship builder.”
- There is a risk in *not* disclosing.

Is honesty always the best policy?

"Admitting mistakes can be difficult and can force physicians to confront their own perceptions of inadequacy, fallibility, and guilt. It can be easier to avoid acknowledging mistakes, especially when the event or potential error has a perceived minimal or no-harm effect. However, there are several reasons why minimal and even no-harm errors should be disclosed to the patient."

Source: Chamberlain, C. J., et al. (2012, March). Disclosure of "nonharmful" medical errors and other events: Duty to disclose. *Archives of Surgery*, *147*(3), 282-286. Retrieved from http://jamanetwork.com/journals/jamasurgery/fullarticle/1107400

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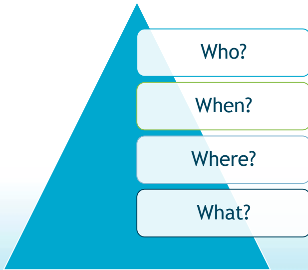
Communication of an unanticipated outcome



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Disclosure — Who should participate?

- The physician or other practitioner who is primarily responsible for the error or is familiar with the unanticipated outcome
- A representative from the healthcare practice or hospital, depending on the event
- The patient and family (consider the patient's desires and federal/state privacy regulations)
- The person who will be responsible for following up with the patient/family

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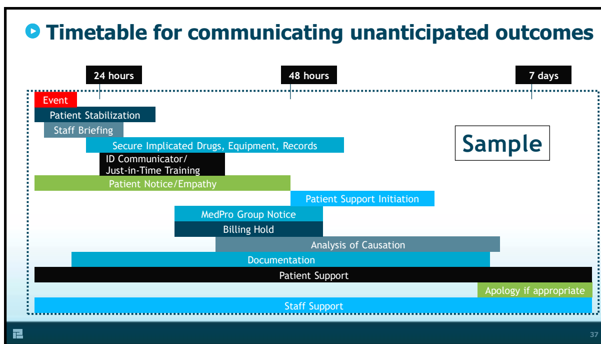
Disclosure — When should it happen?

- As soon as practical following the event
- As soon as basic facts about the event are known
- As soon as the patient and/or family is able to receive the message



Disclosure — Where should it happen?

A quiet, comfortable room that provides privacy

- Make sure the room is not scheduled for something else
- Hang a "Do Not Disturb" sign on the door

Do not Disturb!

Disclosure — What should happen?

Provide simple, concise facts in layman's terms.

Discuss current medical status of the patient and anticipated treatment.

Be empathetic. Offer an apology only after all facts are known and error is identified.

Acknowledge that the information currently available is incomplete, and commit to further meetings with the patient/family as more details are known.

Disclosure — What else should happen?

Solicit feedback from the patient/family throughout the disclosure discussion.

Indicate that this can be an ongoing conversation, and provide the patient/family with the name and phone number of a contact person.

Ask whether the patient/family has any immediate unmet needs.

Another consideration

"Some studies suggest that patients may have an interest in extending disclosure discussions to encompass plans for and evidence of practice improvement, with some interviewees indicating interest in contributing to the monitoring of improvement processes over time."

Source: Ledema, R., et al. (2011, July). Patients' and family members' views on how clinicians enact and how they should enact incident disclosure: The "100 patient stories" qualitative study. *BMJ*, *343*, d4423. Retrieved from http://www.bmj.com/content/343/bmj.d4423

Don’t forget to document the disclosure process

Healthcare providers and staff involved in the medical error may require support counseling.

Document the disclosure process, including:

- The time, date, and place
- Who was present
- The information that was communicated
- The patient’s/family’s understanding of the event, any questions presented, responses to questions given
- Who is responsible for follow-up
- The plan of action going forward

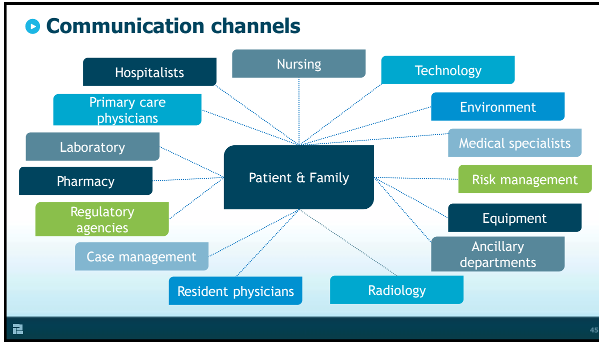
Stop patient billing until the details of the unanticipated event are analyzed.

More disclosure advice

Consult your claims or insurance representatives when early resolution is indicated (as it relates to a medical error with damages).

A discussion of monetary settlement is not recommended at the first meeting with the patient/family.

Avoid absolute statements, such as “We’ll take care of everything.”



The failure to communicate is a catalyst for converting patients to plaintiffs.

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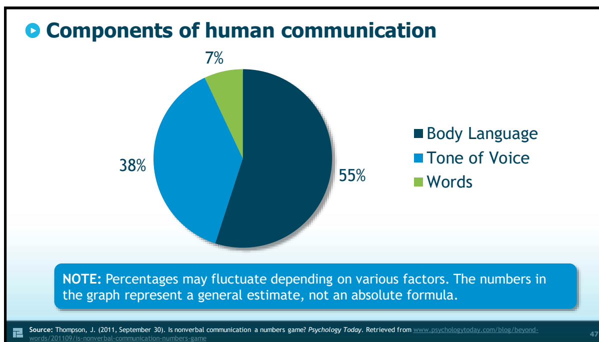

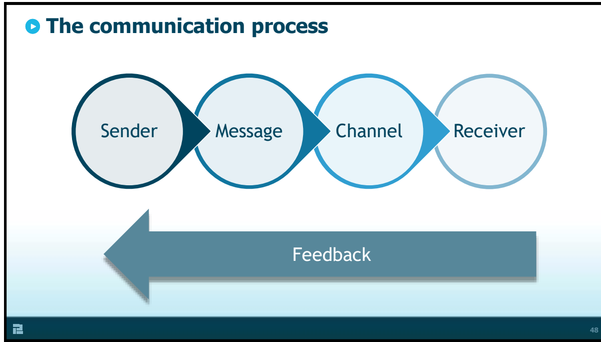

How important is good communication?

A healthcare provider might increase the risk of litigation if he/she:

- Has poor listening skills
- Delegates critical informed consent communication
- Fails to be timely in sharing information with the healthcare team
- Becomes defensive when a patient inquires about diagnostic and treatment options
- Lacks empathy when disclosing unanticipated outcomes

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Source: Spector, R. A. (2010). Plaintiff's attorneys share perspectives on patient communication. *Journal of Healthcare Risk Management*, 29(3), 29-33.

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Communication tips

- Establish direct eye contact.
- Sit rather than stand (sitting is preferred).
- Use “I” instead of “we.”
- Speak slowly.
- Use layman’s terms.
- Be brief (avoid the tendency to overexplain).
- Try to anticipate questions the patient/family may have.

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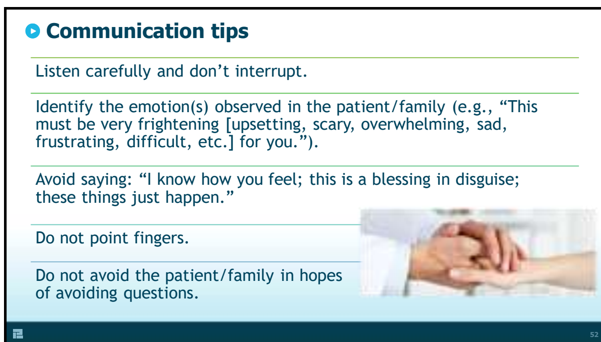

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Disclosure case scenarios

Case example #1 — Medication error disclosure

Mrs. Johnson receives the wrong medication.

She has no current adverse symptoms.

Future symptoms are unknown.

Medication error disclosure — Scene #1

Medication error disclosure — Scene #1

- No introductions take place
- Only mentions “some type of error”
- “Can be difficult to understand the prescription”
- Physician and pharmacist leave no time to answer questions

Medication error disclosure — Scene #2

Medication error disclosure — Scene #2

Strategies

- Meet with the healthcare team first to discuss and practice the disclosure.
- At the meeting with the patient/family:
  - Introduce all parties at the disclosure.
  - Explain the error and possible sequelae.
  - Empathize with the patient's emotions.
  - Reassure that corrective actions will take place.

Case example #2 — Wrong diagnosis disclosure

Carol had a chest X-ray 2 years ago and was diagnosed with pneumonia.

Now Carol is informed that she also had a lung lesion at the time of the chest X-ray. Yet, this information was not previously communicated to Carol.

Upon follow-up testing, the tumor is obvious.

The surgeon explains the missed diagnosis of cancer and says surgery must be scheduled immediately.

Wrong diagnosis disclosure — Scene #1

Wrong diagnosis disclosure — Scene #1

- Chest X-ray read incorrectly
- Missed lung lesion not communicated to patient
- Physician communication style
- Physician rushing off
- "Pull yourself together before you leave"

Wrong diagnosis disclosure — Scene #2

Wrong diagnosis disclosure — Scene #2

Strategies

- Sit down when communicating.
- Make eye contact and be mindful of your body language.
- Give short, simple explanations.
- Be prepared for patient confusion and anger.
- Spend as much time as necessary with the patient to discuss the event and answer questions.

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Self-assessment

Self-assessment checklist — Policy

	Yes	No
My organization has a mechanism for all providers and staff to report incidents.	☐	☐
My organization has a process for reviewing cases to identify all unanticipated outcomes.	☐	☐
My organization has a disclosure policy.	☐	☐

Self-assessment checklist — Policy

My organization's disclosure policy addresses:	Yes	No
Who will disclose unanticipated outcomes	☐	☐
What information should be disclosed	☐	☐
When to conduct the disclosure conversation	☐	☐
How to manage ongoing communication with the patient/family	☐	☐
How financial issues regarding the event will be managed	☐	☐
What events trigger regulatory reporting	☐	☐
How the organization will manage ancillary issues that arise, such as regulatory and litigation inquiries	☐	☐

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Self-assessment checklist — Process

	Yes	No
My organization includes disclosure education in new employee orientation, including the confidential nature of disclosure management.	☐	☐
The designated individual in my organization is notified immediately when an unanticipated outcome occurs and is known.	☐	☐
All involved providers and staff are interviewed after an unanticipated outcome to accurately determine the sequence of events.	☐	☐
My organization has a protocol in place for managing any outside inquiries related to unanticipated outcomes.	☐	☐

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Self-assessment checklist — Documentation

	Yes	No
Clinical documentation is completed as soon as possible after the unanticipated outcome.	☐	☐
Clinical documentation includes:		
Date, time, and place.	☐	☐
Detailed, objective narrative of the facts of the event.	☐	☐
Details about any conversations with the patient, family, or other providers.	☐	☐
Additional steps to be completed and who is responsible.	☐	☐

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Final thoughts

When disclosing, remember to . . .

- Identify the facts.
- Use a communications checklist to prepare yourself.
- Consult your professional liability carrier to review possible indicators for early resolution.
- Offer support counseling to healthcare providers and staff involved in the event.
- Realize that it's okay to say "I'm sorry."

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In summary

When done properly, disclosure can reduce the impact of unexpected outcomes on patients AND healthcare providers

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MedPro Group resources

Checklist: Disclosure of Unanticipated Outcomes

Guideline: Disclosure of Unanticipated Outcomes

Healthcare's Second Victims: A Problem That Should Not Be Ignored

Risk Q&A: Coping With Stress After an Adverse Patient Outcome

Risk Strategies for Disclosing an Unanticipated Outcome

Other valuable resources

Source: MedPro Group Patient Safety & Risk Solutions: Risk Resources on Disclosure of Unanticipated Outcomes (2019). Retrieved from https://www.medpro.com/documents/10502/2824311/Risk+Resources_Disclosure+of+Unanticipated+Outcomes.pdf

What questions do you have?

Thank you!

Disclaimer

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