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## Disclosure of Medical Error

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# Disclosure: Challenges and Opportunities

by Frank Federico, RPh

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The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) standard requiring that institutions have a process in place to disclose unanticipated outcomes to patients and families, has been in effect since July 2001. The initial reaction of the medical community ranged from a full embrace of the standard to circumvention. In 2002, JCAHO issued a new interpretation of the intent of standard RI.1.2.2.

At a minimum, the patient and, when appropriate, the patient's family are informed about outcomes of care that the patient (or family) must be knowledgeable about in order to participate in current and future decisions affecting the patient's care, and unanticipated outcomes of care that relate to sentinel events considered reviewable by the Joint Commission. The responsible licensed independent practitioner (LIP) or his or her designee informs the patient (and when appropriate, the patient's family) about these outcomes of care.<sup>1</sup>

This reinterpretation focuses on "reviewable" events, but the need for institutions to improve disclosure skills is unchanged. The increased emphasis on disclosure has spurred many organizations to develop or enhance training programs to assist clinicians who participate in these discussions. Many are learning that disclosure can be a difficult procedure *and* that patients expect communication about even the most insignificant of errors.

## Disclosure is Not New to Health Care

The American Medical Association's Code of Ethics states that "It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients...Concern regarding legal liability, which might result following truthful disclosure, should not affect the physician's honesty with a patient."<sup>2</sup> The American College of Physicians and other professional organizations have similar statements.

Disclosure of errors and unanticipated outcomes is a key element of the patient safety movement. The National Patient Safety Foundation Board of Directors approved a statement of principle stating that "the patient and the family or representative should receive a truthful and compassionate explanation about the error and the remedies available to the patient."<sup>3</sup>

Many of today's patients are more informed, ask more questions, and expect to be more involved in their health care decisions than previous generations. And patients

want their physician to acknowledge an error in some way, even if an error seems minor.<sup>4</sup> In a survey conducted on behalf of the National Patient Safety Foundation, as many as 95 percent of the respondents wanted to know about even the most insignificant error.

## Obstacles to Effective Disclosure

Among the many factors one must consider when dealing with disclosure is whether or not the clinician is aware of the error and the possible resulting harm. Obviously, a physician cannot disclose what he or she does not know. In some cases, the resulting harm may not be evident for some time, or is discovered only after a root cause analysis has been completed. What was first believed to be part of the disease process may be the result of an error. Sometimes a physician first learns of an error only when he or she is named in a claim or lawsuit.

A second challenge in properly handling disclosure is that many physicians have little training in dealing with mistakes or giving bad news. If the bad news is the result of what someone may have done wrong, the news is even more difficult to deliver. Cancer specialist Dr. Robert Buckman has written extensively about this issue.<sup>5</sup> He describes the difficulty clinicians face in giving bad news without guidelines to assist them. Professionals trained to provide leadership and support to patients in the diagnostic and treatment realm have difficulty acknowledging mistakes—especially since this is not an area in which they receive training during their educational preparation. Clinicians must be prepared to handle reactions such as patient anger and personal assaults on their competence. They must also realize that patients may not fully understand what is being disclosed nor the consequences of the injury. Ill-prepared clinicians may simply choose to avoid situations such as these and not deal with the patient.

## The Biggest Obstacle

Probably the biggest obstacle to physicians' willingness to disclose errors is the fear that disclosure will lead to a malpractice claim or lawsuit. The fear of being named in a lawsuit is significant. A survey of CRICO physicians completed in 2000, reported that 47 percent of the respondents were either highly or extremely concerned that they would be named in a lawsuit in the next five years. (In fact, of the physicians insured since 1976, 90 percent have *never* been named in a claim or suit, but the fear is real).<sup>6</sup>

Patients sue for many reasons, including mishandled communication. When, in the aftermath of an adverse outcome, the information provided to the patient or family is delayed or inconsistent, the perception of concealment gains credence. When patients (or their families) feel they need to take the initiative to uncover non-disclosed information, they turn to an attorney.

Plaintiffs often indicate that they file lawsuits out of anger at not being told the truth about the events that led to harm. Dr. Buckman points out that a patient who is told the truth is, generally, less upset than a patient who learns that bad news was withheld. Patients were significantly more likely to either report or sue the physician when he or she failed to acknowledge the mistake. From this, one may hypothesize that if clinicians disclose all pertinent information, patients will be less likely to sue.<sup>7</sup>

Vanderbilt University's Dr. Gerald Hickson interviewed mothers of infants who had experienced permanent injuries and death in Florida in an effort to learn what prompted families to sue. He found that 33 percent of the families perceived a cover up and 20 percent were seeking information.<sup>8</sup>

No one guarantees that disclosure will prevent a lawsuit. Even when a physician has been honest with a patient, if the patient feels that he or she is entitled to compensation, the patient will file a claim or lawsuit. Open communication, however, may be helpful in defending a suit because it shows respect for the patient, acknowledges pain and suffering, reduces feelings of abandonment, and keeps the patient informed. For example, seven years after the implementation of a disclosure policy, the Veteran's Administration Medical Center in Lexington, Kentucky found that it had among the lowest payouts for professional liability of any VA hospital in the country.<sup>9</sup> The success of the VA system is based a willingness to disclose to patients and offering compensation for harm that is the result of a negligent act. The results have been reasonable settlements, avoidance of costly payouts through the courts system, and reduced legal costs.



### Disclosure or Apology?

An apology and a discussion of outcomes and future treatment plans can be effective in mitigating a patient's anger. Patients, families, and juries look favorably on gestures that indicate a caring and empathic attitude. "I am sorry" can be interpreted as an expression of sympathy or as accepting the responsibility for what has happened. The apology must be sincere and include an explanation of why one is making that gesture. The apology should be directed towards the

patient's (or family's) pain and suffering and should not be not be a statement of fault. A phrase such as "I am sorry that this happened to you" is balanced and appropriate. Phrases, however, that include "I am sorry that *I did this to you*" are immediately overreaching and have significant potential for jumping to an incorrect conclusion.

Anecdotal evidence indicates that juries look more favorably on defendants who have disclosed as it demonstrates concern for the patient, empathy, and a patient-centered approach. Not disclosing may be interpreted as hiding information and placing the defendant in a less favorable position in the deliberations of the jury. As we work to improve our systems, we must keep in mind that there will always be bad outcomes. Some may be avoidable and others may not. By understanding the factors that affect a clinician's decision to disclose or not disclose, institutions will be better able to support these individuals and the patients they serve. ■

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# Error? What Error? The Role of Rationalization in Concealing Medical Error

by John Banja, PhD

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**W**hat elements need to be in place for a health care organization to maintain a patient-centered policy of disclosing harm-causing medical error? The most fundamental, and perhaps most challenging one, is the organization's securing the moral courage to implement such a policy.

Disclosure of harm-causing error, especially in a catastrophic case, can be an agonizing conversation for a health professional. Managing the anxieties and fears that disclosure provokes requires a profound commitment to patients' and families' right and desire to know. Such a commitment signals a willingness to "walk the talk" of professional codes of ethics.<sup>1-3</sup>

In addition to its moral commitment to disclosure, however, the organization will likely realize that a harm-causing medical error generally stems from multiple mistakes perpetrated by multiple people in an environment that "enabled" those errors to occur. Rare is the case that a serious, harm-causing error resulted from a single, isolated individual doing something inexplicably stupid or inept.<sup>4,5</sup> Consequently, because most harm-causing errors are the result of system failure involving multiple parties, the committed organization will institute a nonpunitive policy for acknowledging and reporting errors.<sup>6</sup> Indeed, the organization itself will assume responsibility for disclosing errors because that responsibility is understood as a logical and ethical response to error as systemic.<sup>7</sup>

Finally, the organization might very well believe that error reporting and disclosure ultimately reduce the costs of medical error, especially litigation costs.<sup>3,7</sup> While the idea that disclosing medical error reduces malpractice costs seems counterintuitive, a growing body of scholarly opinion suggests that health providers often underestimate their patients' ability to discern that something has gone wrong.

Likewise, clinicians also often fail to appreciate how concealing medical error provokes suspicion and anger among patients.<sup>7-9</sup> When patients who have been harmed by error don't receive satisfactory answers to their questions—e.g., when providers hedge, obfuscate, dissemble, and omit information—they and their families become angry and may well consider a malpractice action. Although difficult, disclosing the error in a timely and truthful fashion will—so these organizations believe—ultimately prevent many lawsuits or reduce the size of

compensatory settlements. But the literature abundantly suggests that the history of harm-causing medical error is largely one of secrecy and concealment and the above normative beliefs are not uniformly shared and practiced in health care facilities across the United States.<sup>10-13</sup>

While one might quarrel with the notions that error disclosure actually reduces malpractice costs, or that errors are more systemic than individual problems, the moral imperative of disclosure is iron clad. That is, patients do not assume the risks of harm from medical error in giving informed consent, and they have a virtually categorical right to know about their welfare as it is positively or negatively affected by the ministrations of health providers.<sup>2,3,13</sup> When patients are not told about harm-causing errors, they are doubly disappointed by the health care system: first, in having experienced an untoward event that occurred from error; second, in being deprived of their right to know about what happened.

## Rationalizing

How can health providers overlook their moral obligation to disclose harm-causing medical error? Well, one rather familiar strategy is to "look" in another direction. That is, rather than be morally attentive to the patient's right and desire to be informed, the health provider might very well search for reasons or rationalizations to justify concealment.<sup>14, 15</sup> In effect, the provider rationalizes, confabulates, or "re-creates" what happened so as to protect his or her welfare and allay his or her anxiety over the unpleasantness or fear that disclosing error arouses. Consider the following scenario:<sup>16</sup>

After failing to convince them otherwise, veteran cardiothoracic surgeon John Adams concedes to the requests of William Black's family to resect Mr. Black's right lung. Dr. Adams initially resisted because he deemed Mr. Black a poor surgical candidate. Mr. Black, 74 years old with end-stage tuberculosis that was aggravated by a long history of smoking and poor health habits, has had three lung operation over the past decade.

As soon as Dr. Adams begins the surgery, he realizes the operation will be extremely challenging due to an excessive build-up of scar tissue and the re-arrangement of Mr. Black's cardio-thoracic anatomy from the previous surgeries. As he is dissecting tissue, the surgical area becomes saturated with blood and Dr. Adams immediately realizes he has inadvertently lacerated Mr. Black's pulmonary artery. As he tries to stop the bleeding, Dr. Adams

Truthful [informed consent] conversations about risk that acknowledge the reality of an adverse outcome often assist patients and families to be better prepared emotionally if an untoward outcome occurs.

cannot believe his blunder since the structures of the artery were in relatively plain view. Worse, Adams cannot get the bleeding to stop and Mr. Black codes and dies on the operating table.

As Dr. Adams walks to the surgeon's lounge to collect his thoughts, three of his surgical colleagues are in casual conversation, and they notice his pained expression.

"John, are you all right?" Dr. Ford asks. Whereupon Dr. Adams tells his colleagues what has just occurred. He ends by saying, "And now I have to tell the family."

"Well, let's think about this for just a minute, John." Dr. Carter says. "This was a surgical complication. You told the patient and his family that the surgery would be difficult, and your patient's anatomy was complicated by his disease history and scarring from previous surgeries. Why, this could happen to anyone."

"Also, this fellow didn't help himself out, with his noncompliant history and his smoking and all that," adds Dr. Hoover. "And it sounds like the family wouldn't respect your initial refusal to operate. I mean, if there's anyone at fault here it's your patient and his family. They should have left well enough alone."

"In fact, John, you may have done them all a favor," Dr. Ford chimed in. "Sometimes what seems like an error is really a blessing in disguise. Even if the surgery was uneventful, this patient had an extremely poor prognosis and would have died an unpleasant death. Although we surgeons certainly don't like it, dying on the table is not a bad way to go."

"What good would telling the family that you made a surgical error do at this point?" Dr. Carter asks. "They'll only be more upset. I agree, with Dr. Ford, this was more a blessing in disguise than anything else."

"One more thing, John," says Dr. Hoover. "Are you absolutely sure that you lacerated the artery? I mean, couldn't there have been an aneurysm that hemorrhaged or a thinned out vascular wall that ruptured? You might not have done anything at all to cause this other than decide to operate."

Dr. Adams feels much better as he leaves the lounge to speak with Mr. Black's family. The words "complication ... blessing in disguise ... family will only be more upset" have an enormously calming effect on him. He enters the surgical waiting room and sees Mr. Black's family.

### Analyzing the Rationalizations

Humans react to anxiety by either shifting their attention away from those situational factors for which they are morally responsible or by reinterpreting the situation in a way that relieves them of their moral responsibility.<sup>15</sup> Consider the following counterpoints to each of the rationalizations in the above scenario:

*"It was a complication."* Authentic complications are adverse clinical events biologically or pathophysiologically attributable to the patient's disease. When associated with a health care intervention, such as sepsis following surgery, complications do not owe their occurrence to error. Those complications are inherently and essentially outside the control of any reasonable and prudent health provider, so that he or she cannot be held ethically or professionally accountable for them. Calling Dr. Adams' error a "complication" obliterates the distinction between reasonable or acceptable surgical technique and substandard practice. Per Dr. Carter's understanding of "complication," one might as well as call a wrong-side surgery a complication.

*"It was the patient's fault."* Psychologists would pounce on this as a classic case of projection. The health provider unconsciously transfers his or her own sense of fault or guilt onto the patient. This allows the provider to maintain a self-understanding as that of a competent professional and blame the patient as the culprit.<sup>17</sup>

*"It was a blessing in disguise."* Interestingly, this interpretation only becomes apparent after the patient dies. Up until then, the prevailing understanding of "blessing" is that the surgery would prolong the patient's life or make it considerably more bearable. If death really was a blessing, however, the most beneficent treatment option would certainly not have been surgery.

*"Disclosure will upset the family."* Here the health provider decides what the family ought or ought not know. Although the literature overwhelmingly suggests that families want to know of error, the health provider transfers his or her own feeling of unpleasantness over having to disclose onto the family. They now become the ones who will be upset and their (imagined or hypothesized) distress offers a convenient rationalization to desist from disclosing.<sup>17</sup>

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*“Are you absolutely sure that you committed a harm causing error?”* This is an interesting rationalization since the usual or customary degree of certainty to which medical competence and medical judgments are held is a “reasonable” one.<sup>18</sup> If health providers had to be absolutely sure about everything they did before they did it, medical care would be largely impossible. Requiring absolute certainty about X’s having been a harm causing error involves a degree of surety that is not only highly unusual in health care but will often prove impossible to attain (e.g., “Are we absolutely certain that the patient’s having received 10 times the prescribed dosage of medicine caused her stroke?”) But that’s the point of the “Are you absolutely sure?” rationalization: by asking whether we are “absolutely sure” that error X caused the harm, we create the wiggle room needed to excuse ourselves from having to disclose the error. We conveniently forget that Dr. Adams realized his error immediately and was shocked by it. Because that memory is so painful, we look for ways to revise, dismiss, recreate, or “re-present” it.<sup>15</sup> This is human nature at work. It is understandable, but not, however, morally acceptable. That is why institutions that are committed to error disclosure need to implement strategies that counteract the temptations to rationalize away the disclosure of medical errors to harmed parties.

### Strategies to Counteract Rationalization

If a health care organization’s leadership does not strongly endorse a policy of error disclosure, the probability of its uniform and consistent implementation is low. Thus, if Dr. Adams’ discussion of Mr. Black’s surgery at his hospital’s morbidity and mortality conference is received by the hospital’s medical director, Dr. Reagan, in the same manner as it was received by Drs. Hoover, Ford, and Carter, one can probably assume the Black family was told something less than truthful.

On the other hand, if Dr. Reagan, along with the rest of the hospital’s executive administration, is convinced that medical errors must be managed ethically, an organizational protocol (what one hospital calls a “focused event team.”<sup>19</sup>) would be in place for analyzing an event such as occurred with Mr. Black. The team ought to be guided by the organization’s understanding of error as systemic, and in attending to the entire error trajectory examine whatever “organizational” events might have contributed to an error’s occurrence or its perceived impact on the patient or family.

While we might imagine any number of these—e.g., Dr. Adams had been showing signs of significant stress over the last few weeks which were noticed by staff but were not organizationally addressed; or the hospital has an unwritten rule whereby surgeons feel pressured to occasionally take on very difficult cases because the administration believes that surgical successes in such cases add to the reputation and market share prospects of the hospital—organizations would do well to consider how their system’s informed consent policy could lessen the impact of adverse outcomes such as happened to Mr. Black.

The goal is to encourage a comprehensive risk disclosure in the informed consent conversation. Despite decades of ethical and legal conversation encouraging more ample risk disclosures, they often tend to be terse and insensitive to what patients and families ought to know about the treatment plan and its likely outcome.<sup>19</sup>

If Dr. Adams says to Mr. Black and his family, “Because of the advanced nature of the tuberculosis and the previous surgeries, the surgery I’ll be doing will be complex and challenging,” then the Black family will probably have little idea what “complex” or “challenging” means. Without elaborations, they might think “complex” means that Dr. Adams will have to go a bit more slowly, be a bit more careful, take a bit longer, and so forth.

A better understanding might be reached if, instead, Dr. Adams says, “This surgery will be quite complex. There may be a lot of scar tissue in Bill’s chest from his tuberculosis and his previous surgeries. That scar tissue can make it hard for me (or any surgeon) to determine what to cut, how much to cut, what not to cut, where to go next, and so forth. Also, because Bill has had previous surgeries, his chest anatomy may appear very differently from the norm. It’s kind of like driving an automobile in a dense fog; a lot of the time you can’t be certain where you are. And, last but not least, this surgery is further complicated by the extent of Bill’s disease. He’s a sick man, and a surgery like this is traumatic under the best conditions. I’m certainly going to do the best job I can, I just want you to realize what we’re up against.”

Many physicians resist these kinds of discussions because they fear that making families feel uncomfortable will result in those families losing trust in them or thinking less of them. In fact, some studies indicate just the opposite.<sup>20</sup> Truthful conversations about risk that acknowledge the reality of an adverse outcome often assist

The most significant contradiction in the error disclosure movement today may well be encouraging organizations not to blame individuals who err, but then exposing those very persons to the threat of malpractice.

patients and families to be better prepared emotionally if an untoward outcome occurs. Consequently, the physician who goes the extra step with these reality checks may less likely be the target of a family's enmity when such an outcome materializes than the one who gives a rosy prognosis despite knowing that the situation is actually quite grim.

In Dr. Adam's case, a comprehensive disclosure of risks and surgical complications might have had a considerable buffering effect on the family's reception of a subsequent admission of error. Had the family been aware of the difficulties of the operation, Dr. Adams admitting that he "probably cut a blood vessel and despite the staff's best efforts, the bleeding could not be stopped," might be perceived as a further expression of his honesty and integrity, rather than an admission of negligence.

### The Great Contradiction

Finally, if the temptation to rationalize is ever to be significantly reduced, the enactment of either an enterprise medical liability compensation system or a no-fault system for medical injury should accompany the movement towards nonpunitive and blameless health care organizations.<sup>21-23</sup> The most significant contradiction in the error disclosure movement today may well be encouraging organizations not to blame individuals who err, but then exposing those very persons to the threat of malpractice litigation that attaches to each and every harm-causing error disclosure.

Even though health care organizations might progressively convince themselves that disclosure is the best ethical and economic policy—i.e., that in the long run, disclosure costs less than risking an extremely expensive malpractice suit resulting from concealment—the health provider whose liability is directly implicated as an "error operator" might attach more significance to the way his or her professional history is represented in the National Practitioner Data Bank than to the long term financial welfare of his or her hospital. Reducing that anxiety through some variety of tort reform<sup>24</sup> can preserve the harmed party's right to recover, acknowledge the sys-

temic nature of medical error by targeting the organization as ultimately responsible, and significantly diminish the temptation to rationalize away medical error. ■

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## Disclosing Medical Errors: How Will It Affect Future Litigation?

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**D**isclosure to patients of medical errors or ‘near misses’ is the most recent mandate given to the health care industry by the Joint Commission for the Accreditation of Healthcare Organizations. How disclosure is done, what impact it has both on the culture of the organization as well as on the patient directly, and how it impacts future malpractice litigation are all areas of concern for the health care provider and entity.

To think that every disclosure conversation will go as well as planned, and that malpractice litigation will never result from these errors or occurrences is unrealistic. But, since studies have shown that the primary factor in a patient’s decision to pursue a malpractice case is lack of communication from the provider on an unexpected outcome or undesirable result, one could speculate that having any conversation with the patient at all would decrease the chance of litigation, and may even alleviate any concerns (emotional, psychological, or financial) and thus prevent litigation.<sup>1,2</sup>

### Mock Trial Results

In studying a case scenario with a disclosure component, a mock trial was held based on simple facts involving a medication error (a nurse administered one medication to the patient when another was ordered).<sup>3</sup> The patient was discharged with residual damages in a decreased health condition, but the physicians felt strongly that the residual was due to the patient’s underlying medical condition and not from the medication administered. Because the case had been previously resolved, the end result was known when the research was undertaken.

The case was presented to two separate sets of potential jurors, who had been screened to be demographically similar to a potential jury in the venue of the dispute. The first jury heard the facts of the case and then live testimony from a “charge nurse.” She stated that, while the physicians felt that the medication error did not cause the patient harm, nor did it change the patient’s treatment plan, she felt it was appropriate and necessary to share the occurrence with the patient, even though that was contrary to the hospital policy. She explained what had happened, that they would watch the patient closely for any residual effects from the medication, but that the patient also had a duty to alert the hospital staff if he felt any change whatsoever. The patient still chose to file the malpractice action, alleging that the residual damage was related to the medication erroneously administered, rather than his underlying condition.

The second jury heard the same set of facts, but with testimony from the “charge nurse” that the patient did not need to be informed of the medication error, since the treating physicians had determined that the error would not change the patient’s condition, and that, essentially, the patient was unharmed. Consequently, the patient only learned of the medication administration when another provider in treatment of his continuing medical needs reviewed his medical records.

The differences in jury deliberations and finding were dramatic. The first group believed that information was shared with the patient and they debated causation of the residual damage and its impact on the patient’s continuing medical needs.<sup>3</sup> While the jurors in the first group did find liability, their view of the damages (in the form of future wage loss and medical costs) was dramatically lower than the other group. In fact, the dollar amounts awarded were less than that amount actually paid on the case. The jurors extensively discussed the disclosure, finding validation and honesty on the part of the hospital and providers due to the disclosure conversation. The discussion among the jurors was calm and rational, discussing how the matter affected the patient, and how they felt that the providers had “done the right thing” disclosing the error.

The second group, reviewing the scenario in which no disclosure was made, immediately focused on a “conspiracy theory” within the hospital, and really never even reached causation in their deliberations.<sup>3</sup> It was sufficient for them to find wrongdoing by the hospital staff and providers (the medication error) and the “cover up” (lack of disclosure). Their deliberations focused on punishing the hospital and staff, forcing them to “learn the lesson” of disclosing information with patients in the future, and then awarded damages far exceeding that awarded by the first jury panel.

This second jury group simply found sufficient basis to award large damages solely on the existence of perceived injury, rather than needing to determine or debate the causal link between the amount of residual damage to the patient and his underlying medical condition. This deliberation, much different than the first, was emotional and accusatory against the hospital and health care providers.<sup>3</sup>

Subsequent jury research confirms the findings in this case and suggests that patients now have an expectation that they will learn more information from their providers than may typically have been presented to them in the

## ABOUT FORUM

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past.<sup>4</sup> The consumerism of health care, illustrative in all of the media attention given to medical errors and the increasing sophistication of the Baby Boomer patient, means that the patients are more savvy and educated than generations before, and are wanting, even demanding, to be involved in all aspects of their care (and often the care of their family members). The mystique that may have allowed the surgeon to gloss over the explanation of a surgery in the past has been replaced by the knowledge of the media generation, who often access information (including surgical procedures, medication usage and dosing, treatment complications, and the like) on the Internet, via television shows, or in consumer-focused magazines.

### Disclosure As a Defense

Why does disclosure work? Because it meets the expectations of the jurors. Nearly 90 percent of jurors felt that there should be an admission following a medical error or mistake and that this disclosure should be done regardless of whether the error or mistake resulted in any harm to the patient.<sup>4</sup> The disclosing provider is seen as very credible, and may indeed become a key witness at trial for the defense (but in the opposite way anticipated by many pessimistic counsel).

Indeed, organizations that have practiced open disclosure approaches with their patients have found that it actually decreases their litigation.<sup>5</sup> Often, the conversation with the patient results in a bill waiver or reduction, or facilitation of another medical resource (a continued stay, social services, discharge planning) to address the patient's resulting medical condition. Once these concerns are resolved, the patient has less incentive to pursue litigation against the providers or facility. In fact, children's hospitals have found this across the country over the years, simply because they often spend much more time communicating with concerned parents over their child's condition than a physician in an acute setting may spend discussing a care or treatment plan with an adult patient.<sup>5</sup> ■

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# Disclosure from a Risk Manager's Perspective: A Conversation with Jeff Driver

By Frank Federico, RPH, and Tom Augello

Frank Federico is Loss Prevention Specialist/Manager, Office Practice Evaluations for Risk Management Foundation of the Harvard Medical Institutions; Tom Augello is Senior Editor, RMF

**H**ealth care institutions are increasingly committed to disclosing unanticipated outcomes to patients. An aggressive and supportive disclosure practice commonly relies upon the risk manager to make that practice an improvement-focused process. To explore the barriers and gateways risk managers are facing with this expanding responsibility, RMF spoke with Jeffrey Driver, J.D., President-elect of the American Society of Healthcare Risk Management (ASHRM). Driver is Chief Risk Officer and Director of Regulatory Advocacy at Beth Israel Deaconess Medical Center (BIDMC), in Boston, and was a contributor to the ASHRM White Paper on Disclosing Unanticipated Outcomes.

*Forum: In 2001, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) introduced a standard on disclosure. Was that necessary?*

**Driver:** I think it's fair that JCAHO has come out with this standard. Prompt and thorough disclosure is the mainstream view, but we need a process in hospitals to support that.

*What have we learned in the past year?*

Since the implementation of the disclosure standard, we are formalizing something we've been doing all along, but now we talk about it more. We've gotten clearer on some of the principles and concepts.

*Has this practice led to increase in costs or claims?*

Of the 1,000 risk managers polled during a recent conference call, only 25 percent said the JCAHO disclosure standard had an increased financial impact. The majority said it had not increased financial impact, yet, but also indicated it's too soon to say. Within BIDMC, I do not see more cases being opened as a result of the disclosure practice.

*Is there more than one type of disclosure?*

Yes. One type is the disclosure that happens with the patient. That is difficult because it's terrible news to deliver and, unlike other terrible news that clinicians deliver, this has something to do with their practice. That's a challenge.

The other type is disclosing to your supervisor or to your administration that you've made a mistake. That has potential consequences for the person reporting. They are worried about "Will I be suspended?" "Will I lose my income?" "What will happen to my license?" "Will they fire me?" These are tough personal consequences that folks consider and, depending on their environment, impact their decision to disclose.

Patients want answers quickly, but the immediate answer may not be the correct answer. Disclose the facts, as you know them, when you know them. And if you don't know them, let the patient know that.

*How can risk managers support disclosure to patients?*

I sometimes hear the view that risk managers and lawyers advise clinicians to not disclose anything. In fairness, when risk managers used the statement, "Don't say anything," it was because they were worried that a clinician would not be in a position to handle, properly, the communication after the event. So the initial statement was "Don't say anything," and the next words were—but were not always articulated—"until we

know more." I don't know of any risk manager who would ever suggest, "we're going to hide this," because you can't and shouldn't.

*Are risk managers conflicted by managing the institution's financial risk and, at the same time, sharing information with patients that may result in lawsuits?*

Risk managers need to acknowledge that they do have this conflict of interest by the nature of their position. They are responsible for keeping losses down, and obviously, they are concerned about disclosure bringing on a lawsuit. On the other hand, risk managers have a responsibility to make sure that patients have all the information that should be available to them.

*Do clinicians need to be trained in how to handle a disclosure?*

Yes, because it is a relatively rare circumstance that clinicians get into a true disclosure situation. The training I do is to try to put little flags in their heads, so that if a disclosure situation does come up, they know to call the risk manager. We then move in with "just-in-time" disclosure training and consulting on a case-by-case basis.

If you broaden that training to communication skills in general and especially if you talk about informed con-

sent—because there is a natural connection between disclosure and consent—I think that would be worthwhile.

#### *How are consent and disclosure linked?*

The importance of the consent process, and the relationship to disclosure, is something that I always like to talk about proactively with physicians. If the consent process includes a good discussion about the risks—the major and the minor risks—that’s going to benefit us on the tail end when we have to go back to the patient and say “Remember how we talked about the minor risk of \_\_\_\_\_? Unfortunately that has happened and here’s what we are going to do to take care of that.” That is not an unanticipated outcome—not even in the patient’s mind—because he or she was warned in advance of that potential complication. That’s the importance of consent process, it sets up reasonable expectations and moves complications from the unanticipated dimension to the anticipated or expected result.

#### *How big a role should the risk manager take in the patient disclosure process?*

Well, first of all, we only get involved in those disclosure issues that come to our attention. If a physician does not bring an issue to our attention, then we can’t consult with and advise him or her. So, we rely on our relationship with our physicians to make them comfortable bringing disclosure events to us. That comfort level goes hand in hand with a hospital policy about nonpunitive reporting of adverse events.

Once we know about the need to disclose, the risk manager is a communications coordinator. Generally a risk manager is there to help a physician, nurse, or hospital administrator work through a difficult communication about an unanticipated outcome, but we don’t make the decision about disclosing.

#### *Would you recommend disclosing all errors, even those with no resulting harm?*

The degree of “error” is quite broad. For example, should the patient need to know that there was a transcription mistake that happened to be caught by the unit secretary? By analogy, do the passengers on an airplane need to know every blip that happens during their flight? I know that when a pilot has announced something like

“Sorry folks, we have an all new maintenance crew and it is taking a while;” that was very unnerving to me. It’s the same thing with health care. We can’t be telling patients about every minor event that happens because that would be unnerving to them and they will lose trust and get scared. So, generally, the answer is no, we do not tell them about errors with no adverse outcome or unanticipated outcome.

#### *Are the clinicians clear on what should or should not be disclosed?*

A discussion that occurred at a recent M&M meeting nicely demonstrated a difference of opinion on whether or not to disclose. A patient, through an administrative error, had not received insulin for a long period of time and was in a semi-comatose state. When I asked if this delayed the patient’s improvement, I heard back “yes” and I heard back “no.” But, the chief of staff said no disclosure because no harm was done, and no unanticipated outcome occurred.

One of the younger physicians challenged that point of view and said, “I favor disclosing because families go into the medical records and it’s obvious what happened, and then they come back to us and ask ‘why didn’t you tell us this?’”

Sorting this out, the minor errors that are kind of inherent in a process, I would not disclose. But, errors that, while they had no impact or no unanticipated outcome, are disclosed in the medical record or to regulatory agencies should be disclosed to the patient so that there are no surprises.

#### *Who should disclose an error to a patient or family?*

The risk manager should not be involved in the disclosure discussion, better that it be the clinicians, those who have the relationship with the patient. If the event involves a significant injury, I advise to have a witness present, generally, a nurse who is caring for the patient. This person also helps in follow-up communications, because, after the disclosure, the patient may have additional questions.

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### *How do you handle resistance, from clinicians, to having this discussion with a patient or family?*

We have had situations where the physician said, "I do not believe anything was done wrong here.... I am not talking with this patient, and I don't want anyone else talking to this patient." We handle these situations by working through the chain of command to impress upon the clinician what needs to be done. The department chief or the chief of staff of some of the hospitals, or the chief medical officer, may become involved.

### *What information should be disclosed?*

Patients want answers quickly, but the immediate answer may not be the correct answer. Disclose the facts, as you know them, when you know them. And if you don't know them, let the patient know that. Inform the patient that you will be coming back with those facts as they become known.

Risk managers know that none of these situations is that simple. It is only through a root cause analysis or failure mode and effects analysis that we can drill down to what actually caused an adverse or unanticipated outcome.

### *How do patients react when told "We're continuing an investigation."?*

Patients may be skeptical to begin with, so we avoid using words such as "investigation" or "inquiry." Instead we say "We are looking into this." Most patients, while emotionally impatient, will understand that you need time to conduct a review.

### *How do you handle a negative patient response to disclosure?*

There are cases after an adverse event in which the relationship goes south very quickly. Basically, if there has been a situation involving a physician and a patient and all trust has been lost, then it's really not going to serve anybody's interest for that physician to continue on caring for the patient because everything the physician does is now suspect. So, we will move to a formal discharge with the patient's cooperation, find a new physician, or even transfer the patient out of the hospital if he or she feels uncomfortable with the hospital, too.

### *Is there a place for some earlier intervention with the patient?*

Anything you can do to help the family during a very difficult time is going to help you in the long run. In addition to offering money to the patient/family to cope with immediate issues, you can offer other gestures: providing nursing care in the home, housekeeping ser-

VICES, rides to and from a doctor's office, free visits, or writing off bills. Other gestures include recognizing the patient or family by contributions to charities, plaques on walls, or a dedicated lecture.

You have to be careful on how that's framed and you should do that in writing, not orally, so that there's no ambiguity about exactly what the hospital's position is. It's okay to do those things, but you have to be clear on why you are doing them.

### *Is disclosure different when the health care providers involved are not physicians?*

I usually have the physician communicate on behalf of the hospital. I do that because that relationship is much stronger than any relationship that the patients developed with a hospital-based clinician, nurse, or pharmacist. Generally, I don't bring employees into the disclosure meeting

### *Any comments on how one should apologize?*

An apology on its own, or an expression of sympathy or understanding, should be offered. However, it's what comes after the apology that can lead to trouble, for example, "I apologize. I'm completely at fault; I feel horrible that this happened; I hadn't slept and we were short staffed." It's all of that attached verbiage that gets clinicians in trouble.

I suggest the process "apologize and stop." If it is a situation in which clearly something has gone wrong, then you want to apologize up front. You should show that you care and explain what you're going to do immediately to address the situation. Basically, you put in the apology, you give it time to rest, and then you move forward to the follow-up care. ■

# Disclosure: A Visiting Journalist's Perspective

by Rae Lamb

Rae Lamb is a health care correspondent for Radio New Zealand, and a Harkness Fellow in Health Policy based jointly at the Harvard School for Public Health and the Institute for Healthcare Improvement.

**O**n a cold Sunday in January 2001, I traveled to New York to attend a regular monthly meeting of the patients' advocacy group, Persons United Limiting Substandards and Errors (PULSE). Most of the 20 people there (or a family member) had had a bad health care experience. Call it an adverse event, unanticipated outcome, medical error, or some other less threatening term; all had sad, often tragic, tales to tell. But most strikingly, much of their anger—and they are angry—continues to be about how they were treated after the event.

As one woman tells me: "If he (the physician) had called me and apologized, he would have made me feel like I was a human being, that he really cared about me and my son. I know people make mistakes and I would have forgiven him for it." Instead she pursued a multi-million dollar medical malpractice case (which was ultimately shelved when she missed a legal deadline).

Much of the literature on disclosure argues that ethically, legally, and practically, telling patients about medical error is the right thing to do. The professional codes of physicians, nurses, and many other health care providers also demand truthfulness and openness with patients.

So why then is it so difficult to do "the right thing"?

As one man at the PULSE meeting sums it up, the issue is black and white. "The right way (to handle it) would be to be forthcoming initially. To say 'there was an error, an unfortunate error, we are very sorry it happened and let us try to see what we can do for your family'" He adds, "When you try to hide records, deliberately avoid the issues... then I think it becomes criminal. At that point, I don't want to talk to you. I'll get a third party, a lawyer, involved."

## Doing the Right Thing

Despite America's litigious environment, some hospitals are making brave attempts to "do the right thing." After talking to the PULSE members, I visited Minneapolis' Children's Hospital that adopted a policy of complete disclosure two and a half years ago. Now, Chief Operating Officer Julie Morath says the practice of disclosing errors to patients (usually the parents) is becoming accepted, a belief substantiated by staff and patient representatives I spoke to. A staff nurse and union representative told me that, following a case in which a patient was severely harmed: "The entire truth, everything we knew, was told to the family."

A physician talked of how difficult it was to call a family at 4 a.m. to tell them he had misread the results of the child's lumbar puncture to test for meningitis. Fortunately, no harm resulted, but the physician did not know that when he disclosed the error. He says: "Now that I live part of this culture where truth telling is important, I just keep thinking it must be so hard to keep trying to hide the truth."

Disclosure is not work for the faint hearted. For many hospitals, the issue has become even more salient with the recent introduction of the JCAHO safety standards requiring processes for the disclosure of "outcomes of care" to patients and their families. For many, this means trying to establish what their practices are, and to translate these into written policies to show JCAHO assessors.

Clearly strong and unequivocal leadership is required. During the last six months, I have been told repeatedly that hospital executives want "to do the right thing" but their lawyers or insurers are resisting. Julie Morath says, "Initially I thought we were going to have to sedate [our lawyers], they got very anxious about the implications. But we see it as our obligation, our values and standards, our promises to our families. Our legal counsel provides counsel about the risks and limitations, but ultimately the decision about how we behave is ours and our board did endorse this knowing that there were risks in what we were about to do."

I am told another barrier is the independence of physicians and the fact they often have different malpractice insurers from the hospital. Risk managers say they want to disclose more commonly, but face physician resistance; physicians say the problem is the lawyers and risk managers.

Seasoned American health journalists I have spoken to have little time for such excuses. They tell me the hospitals might as well disclose as most things will come out anyway, particularly through the legal discovery process. ■

# Health Care, We Have a Problem

by Nancy Conrad

Nancy Conrad is co-founder and co-chairman of fundraising of the Community Emergency Healthcare Initiative.

## Editor's Note

In July 1999, Charles P. "Pete" Conrad, the third human to walk on the moon, was injured in a motorcycle accident, and died later that night in the emergency department of a hospital in Ojai, CA. He was 69 years old.

**M**y involvement in the patient safety movement began as the result of my husband's death that, I believe, involved medical error.

I began this process in anger, but I have tried to educate myself and to make something positive out of a devastating experience. I am starting to understand how difficult it must be to be a physician, to be an island of excellence surrounded by oceans of chaos. I realize it's tough duty, with unreasonable expectations of perfection.

The IOM has demystified medicine.<sup>1,2</sup> The public now knows—Health Care, We Have a Problem. Statisticians can argue all day about how big the problem is, but the point is that the avoidable harm or loss to a single life is one too many. Years of trying to "fix" individual physicians have not solved the problem. Blame and shame are dead end streets. We have to face the bigger challenge of trying to fix the system. When you stop to think about it, what we are trying to do in health care improvement is really no different than sending Pete to the moon. When NASA began, it had no clue how to solve all the problems it was confronted with: imagine trying to change a bomb into a vehicle safe enough for men to ride in on a journey 240,000 miles from earth. Daunting, but not out of reach. Patient safety is not out of reach.

Approximately 450,000 people sent Pete to the moon. Every one of them felt a responsibility and a pride in his or her work. In the days when NASA was working on the Apollo lunar missions, reporters everywhere were trying to interview folks who worked there. One guy at the Johnson Space Center in Houston who was interviewed and asked what he did at NASA replied that he was sending a man to the moon. What the reporter didn't realize is that the man he was interviewing was a janitor.

Like the janitor at NASA, everyone involved in health care—physicians, nurses, administrators, insurers, and patients—needs to participate and take pride in a commitment to a common goal. Pete's return for his hard work was the joy of accomplishment, and the thrill of being one of 12 men who landed on the moon. Like Pete, we are all stakeholders navigating in uncharted space with issues and problems we've never before confronted. For us, the return on investment is just as monumental. Our return is thousands of lives that will be saved.

Here are some of the lessons I have learned since becoming involved in patient safety improvement:

- the solution will lie in the development of systems that minimize errors and harm,
- health care is a partnership,
- there is a difference between error and harm, and
- problems related to patient safety are truly an enormous opportunity to improve the quality of care.

## Why is Disclosure Important?

Like any partnership, health care requires trust, communication, and honesty. And, like any other partnership, business or personal, things can go wrong. The question is: how do you keep trust, communication, and honesty in tact when bad things happen?

What has been learned from those studying disclosure of adverse events is that most patients want to know three things: 1) how it happened, 2) that the care gives sincerely care, and 3) that steps will really be taken so that it doesn't happen again.<sup>3</sup> This does not mean that a patient will not sue, but disclosure may minimize the chance of litigation.

Patients and families have a right to know the truth—after all, whatever is happening or has happened is, in the end, all about them. Patients will need the truth to make informed decisions about their care; when a patient dies, families need the truth to help them with closure.

Information should come directly and in person from the individual most responsible for the patient's care. In most cases, that is the physician. I realize physicians must disconnect the heart and the head to "be at the pointy end." But, when it comes to disclosure, that 18-inch journey between heart and head needs to be reconnected. A little empathy can go a long way. Conveying compassion, extending sympathy—just saying "I'm sorry"—are simple human emotions that patients so appreciate when in they are in difficult situations.

What we as patients and you as caregivers need to do is address what is really important—the harm that we can prevent by working together as better partners. Pete used to say, "mistakes in my world can really spoil your whole day." (Can you just imagine if something was wrong with one of the rocket systems and no one honestly disclosed the problem?) Well, mistakes in patient care can also spoil someone's whole day.

NASA employs a system of reporting accidents and incidents that succeeds because it is surrounded by a cloak of anonymity. The goal is prevention, not punishment. Dr. Charles Denham, a physician actively involved in supporting patient safety efforts, taught me that many adverse events can be prevented by recognizing the four “A”s: awareness, accountability, ability and action:

- *awareness* that the majority of problems are due to systems failures,
- being *accountable* for our roles in those systems,
- creating the *ability* to intervene, and
- aligning the incentives and conditions to prompt positive *action*.<sup>4</sup>

As stakeholders and partners in health care, patients and health care professionals need to take responsibility to minimize the inherent risks. Patients need to recognize that no system is perfect—errors can occur, adverse events happen. Some outcomes are unanticipated and they disturb everyone involved. Patients and caregivers need to work together to avoid fear, and misunderstandings. Caregivers can help patients so much by giving honest, concise information in words we can understand. And, please, let us ask questions, let us participate in our well-being and the well-being of our families.

#### Allowing Candid Disclosure

Now, I am sure all this flies in the very face of everything a lawyer will tell you. I hope that we can establish a working environment in which health care professionals can discuss their experiences candidly without fear of any legal liability that might follow honest disclosure. Since many patients seem to sue just to get at the truth,<sup>5</sup> then improved physician-patient communication might be one of the most effective methods of preventing malpractice claims. I strongly suspect that those physicians who make a full disclosure following an unanticipated outcome will not experience a rise in litigation, but will build trust in their communities and, as a consequence, will be rewarded with more of the patient “market share.”

We have discussed the need to know how events have happened, and the need to hear “I’m sorry.” The third element of disclosure is taking responsibility to see to it that what happened to you never happens to anyone else.

As a result of the failure of the systems of care that may have led to Pete’s death, I have decided to take on the mission of improving the delivery and quality of care

where Pete’s life ended... in the small rural emergency department. Our rural and frontline emergency departments are the lifeline in their communities, and are almost universally strapped for resources.

Dr. Charles Denham, his team at the Texas Medical Institute of Technology, and I have created the Community Emergency Healthcare Initiative. This effort is specifically designed to help small and frontline community emergency medicine teams deliver better care. We have focused on these hospitals with a team of performance experts, a team assembled not for academics but rather driven to grab the low hanging fruit with practical solutions. Our goal is to create a growing network of small emergency departments who will work together to get better. We will hand pick 30-50 hospitals per year, looking for teams with the “right stuff:” the desire to be better, the courage to do what it takes, and the drive to get the job done. We plan to employ methods and systems learned from aerospace and aviation such as space flight resource management, crew resource management, human factors, trajectory forecasting, flow, avionics, cognitive psychology, and others that have direct applicability in health care.

Although many great things are happening to improve the delivery of health care, we can do much more. Pete Conrad spent his life putting himself at risk to accomplish great things. Perhaps this is a lesson we can all learn from him. My goal is to help consumers become active stakeholders in the health care partnership. ■

*Segments of this article were excerpted from Nancy Conrad’s presentations to the 2001 Salzburg Seminar on Patient Safety and Healthcare Improvement, and the Partnership Symposium 2001—co-sponsored by Premier Inc., VHA Inc., and the National Patient Safety Foundation at the American Medical Association.*

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# Disclosure Skills Training

by Geri Amori, PhD, ARM, CPHRM, FASHRM

Geri Amori is an Associate at Health Care Negotiation Associates in Lexington, Massachusetts, and Past President of the American Society for Healthcare Risk Management.

As part of the process of disclosure skills training, we ask participants to visualize the first time they, as teenagers, suddenly recognized they would return home past curfew. The next part of the exercise suggests that participants recall the conversation when confronted by the waiting and, perhaps, angry parents. Audience members recognize the tightness of throat and difficulty they recall having to admit error and risking the potential for reactions that may be difficult to predict and control.

Absent training, these types of conversations leave the person engaged in them dealing with a continuum of emotions and alternatives to choose from, with no guidance to the relative efficacy of any choice. This visualization exercise also prepares participants to recognize specific techniques and approaches that can be used when breaking bad news, e.g., disclosing a medical error. To expect that these skills should be natural for any provider is unreasonable. Written guidance, although helpful, is not likely by itself to result in the development of consistent behaviors that can be applied in the clinical setting.<sup>1</sup>

## Does Communication Skills Training Work?

Some health care experts assert that communication skills training is unnecessary, that, instead, an uncomplicated longitudinal history of relationships with patients—a situation severely limited by managed care—is the key factor to improved communication. Although a worthy proposition, the evidence refutes this contention;<sup>2</sup> even experienced physicians have readily admitted that they lack certain communication skills.<sup>3</sup> Furthermore, communication skills training has been shown to alter physician beliefs and attitudes about patient communication, leading to more involvement with patients (with, surprisingly, no increased visit length).<sup>4, 5</sup>

Although most people accept that communication behaviors are skills and can be taught, questions remain about the most effective ways to teach them. Participants enter communication training with differing amounts of innate talent; each has a different style of learning and needs.<sup>6</sup> Consequently, the designers of communications training have attempted multiple approaches to skill acquisition with varying degrees of success.

The ideal timing for skills building would seem to be during medical training, with multiple opportunities for practice and feedback over a long period of time. Skills-

based laboratories have been deemed successful as part of medical school training.<sup>7</sup> Residency training programs in communication skills have yielded findings that trainees retain skills for more than two years after training, particularly reflective listening.<sup>8</sup> In addition, some programs have determined that intense communication skill training may be essential to the development of the “competent physician.”<sup>9</sup>

Nonetheless, skills developed during medical training must be retained and enhanced to meet the evolving demands of health care delivery. Studies have shown that traditional communication skills training programs can affect targeted skills, such as listening, or the development of open-ended questions; however, the evidence supporting the ability to readily apply those skills in the clinical setting has not been established.<sup>10, 11</sup> Trainees need specific techniques for specific situations; we cannot assume that general training will lead to more effective disclosure communication.

## Techniques and Timing of Disclosure Skills Training

Physicians have been shown to be more accepting of communications training when the need is felt, the training is easy to access, and the feedback is immediate.<sup>12, 13</sup> Since the release of the JCAHO standard requiring disclosure of unanticipated outcomes in 2001, the interest in disclosure training has greatly increased. Given the specific nature of disclosure skills and the types of behaviors that are being taught, a just-in-time, one-day training using specific techniques is effective. Arguably, the changes reported may not be as pervasive or dramatic as could be achieved in a longer training program, but self-assessed changes have been reported as long as three months after one-day workshops.<sup>14, 15</sup>

## Training in Disclosure Skills Using Role-Play

In the multiple programs this author has provided, role-play has emerged among the most effective tools. Disclosure training using this technique should:

*Include a basic didactic session.* This should speak to the implications of body language, medical literacy, cultural differences, and basic listening skills as factors influencing interpretation of the information and the potential for misunderstanding. This helps prepare for normal reactions of patients and families when hearing news that could be emotionally devastating personally as well as influence their trust in the organization and provider.

*Feature three to four “neutral” scenarios.* The scenarios should be designed to bring out different aspects of the disclosure discussion, not scenarios introduced to work out a targeted individual’s unfinished experience. The learning points should not be left to chance.

*Use actors in lieu of participants for the patient or family member whenever possible.* When given the opportunity, the medical professional, untrained in acting, will tend to play the stereotype of the patient they are portraying. The finest training we have conducted involved an actor who was formerly a development officer for a small hospital. As a professional actor, he was able to portray patient emotions and responses in a believable manner.

*Provide feedback or coaching immediately.* The trainer must tailor the opportunity to the situation. The one point that cannot be sacrificed is that feedback must be immediate and all participants must be included in the difficult decisions about increasing the efficacy of the encounter. In this manner it becomes a group learning experience.

*Recognize volunteers for their vulnerability.* The willingness to sit before a group and exercise difficult skills in a difficult situation must be recognized and applauded.

*Close on a positive note.* Role-play can be unnerving. If the trainer exudes a compassionate approach to the training, the participant is more likely to leave understanding that disclosure will be difficult and he or she will not always be as effective as they could be. There is always room for improvement. ■

Physicians have been shown to be more accepting of communications training when the need is felt, the training is easy to access, and the feedback is immediate. Since the release of the JCAHO standard requiring disclosure of unanticipated outcomes in 2000, the interest in disclosure skills training has greatly increased.



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## Responding to a Medication Error

A newborn transferred from a community hospital to rule out a GI bleed suffered an IV infiltrate.

by Frank Federico, RPh

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### Clinical Sequence

A one-day-old boy was transferred from a community hospital to a larger city hospital to rule out a GI bleed. An IV line in his right foot was used to infuse calcium gluconate. Over the next two days, one entry into his medical record during each shift indicated that the IV was running well. On the third day, during the overnight shift, the nurse noted an IV slough with a darkened area at the IV site.

The patient was transferred to the ICU later that day. A transfer note specified the time the infiltrate was noted and commented that the IV site had been checked prior to transfer; however, those details did not appear in the patient's chart. In addition, the nursing flow sheets from the shift when the infiltration was discovered, and the one preceding it, contained scratch-outs and re-writing over the original IV infusion numbers.

When they came in that morning, the parents discovered their son's injury and were upset that the staff had not notified them. When they questioned the staff, the injury was characterized as a blister. In addition, they were told by one of the physicians that the IV medication was very caustic and was usually given for babies with heart problems. The parents had not been told their son had heart problems, and, indeed, he did not. One physician suggested that the problem originated in the community hospital. Another physician told them that the infiltrate should not have occurred and that he would not blame them if they took their child out of the hospital immediately. Two days later, when the child was discharged, his parents were surprised by the extent of his injury.

### Claim Sequence

The family eventually brought suit against the nurse who cared for the baby when infiltration occurred. Their allegations included failure to monitor the IV resulting in considerable scarring and subsequent loss of motion as the patient grew.

### Disposition

The suit was settled in the low range (<\$99,999).

### Discussion Points

**Fingerpointing:** The parents' trust in the institution and its clinicians eroded when physicians and nurses blamed one another for the injury. One physician blamed the staff at the transferring institution.

Discuss with your health care team members the factual details and sequence of what occurred and attempt to reconcile any opposing perceptions of what occurred. Coordinate your response. Determine how the details of the event, the outcome, and the treatment plan, will be explained to the patient and family. Decide which member of the health care team will discuss the event, and with whom (patient and/or family member).

**Inadequate follow-up:** The clinicians did not initiate, nor did they recommend, any treatment for the patient.

The first priority should be to attend to the patient's medical needs. When appropriate, obtain medical consultation and arrange for consultants to forward necessary follow-up information.

**Inadequate Disclosure:** The caregivers did not tell the parents about the infiltrate before they came to the hospital to see their son. When the parents discovered the injury, they were told that the injury was minor.

Discuss the adverse event with the patient, and when appropriate, the family as soon as possible. Consider the time and place to meet with the family. Apprise them of the situation and help them understand the implications. Offer emotional support. Answer their questions factually and directly, but do not speculate about what might have gone awry.

**Incomplete Documentation:** A review of the medical record revealed poor documentation of care rendered, e.g., lack of or poor documentation of monitoring of the IV site, no documentation of the discussion with the family, and alteration of the record.

Corrections to the medical record must follow guidelines to preserve integrity. Writing over numbers gives the appearance of a cover-up. The proper method is to draw one line through the information that needs to be corrected, writing the word "error" above it, and re-writing the correct information. When documenting an adverse event, assign the most involved and knowledgeable member(s) of the health care team to record factual statements of the event in the patient's record. Also record any follow-up medical care completed, planned, or needed. As in many cases, the injury may not have been prevented, but the extent may have been mitigated. The lack of documentation of the IV checks made this case difficult to defend.

**Inadequate Communication:** The baby was discharged in good condition with the exception of the IV infiltrate on his foot. The parents were very angry about an injury that they thought could have been prevented.

If appropriate, acknowledge and apologize for the patient's distress. Accept responsibility for follow-up of serious complaints, but do not admit liability, accept blame, or assign blame to others. Do not criticize the care or responses of other providers.



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