



DISCLOSURE

“When Bad Things Happen”

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OBJECTIVES

- Develop an understanding of what comprises an unanticipated outcome and its impact on patient and families
- Review the ethical and regulatory obligations of disclosure
- List the common barriers to effective disclosure
- Discuss the elements of an effective disclosure program



DEFINITIONS

- **Adverse Event:** An injury that was caused by medical management rather than the patient's underlying disease.....may or may not result from an error.
- **Medical Error:** The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.
- **Preventable Adverse Event:** An injury or complication that results from an error or systems failure.
- **Unpreventable Adverse Event:** An injury or complication that is not due to an error or systems failure and is not always preventable at the current state of scientific knowledge.

▪Source: ASHRM definitions

PHYSICIAN DISCLOSURE TRENDS

Hypothetical Error

- 97% would disclose **minor** error resulting in patient harm
- 93% would disclose **major** error resulting in patient harm

Actual Error

- 41% had disclosed an actual **minor** error resulting in prolonged treatment and discomfort
- 5% had disclosed actual **major** error resulting in disability or death

▪ Source: Journal of Gen Intern Med. 2007 July; 22(7): 988-96.



BARRIERS TO DISCLOSURE

▪ **Psychological barriers**

- Fear of retribution
- Fear of ineffective communication style
- Belief that disclosure is unnecessary
- Belief that outcome was inevitable

▪ **Legal barriers**

- No protection for information disclosed
- No protection for information in medical record
- Absence of disclosure criteria
- Disclosure of no benefit during claims/litigation process



REGULATORY REQUIREMENTS

CMS (Sec.482.13 CoP)

- Protect & promote each patient's rights
- Prompt resolution of patient grievances
- Timely referral of patient concerns regarding quality of care
- Right to receive care in a safe setting

JOINT COMMISSION (R1.Ethics, Rights & Responsibilities)

- Pts. & families are informed about outcomes of care, including unanticipated events
- Respect to pts. rights to & need for effective communication
- Address the resolution of complaints from patients & families
- Right to be free from neglect

**Disclosure is an ethical obligation, not
just a regulatory one**



TO ERR IS HUMAN...

Why Patients Sue:

- Anger
- Surprise
- Distrust

To Admit it is Another Thing



FACT

Most medical errors are not attributable to individual negligence or misconduct. Rather, they are the result of a system of malfunctions – often related to communication.

The safety of the health care system cannot improve if there is a veil of secrecy surrounding what happens in facilities.



WHEN THINGS GO WRONG

Voices of patients and families

EFFECTIVE DISCLOSURE

Effective disclosure is not measured by whether or not a patient sues but provides opportunities for:

Patients and families

Physicians and other caregivers

To....

DISCLOSURE PROCESS

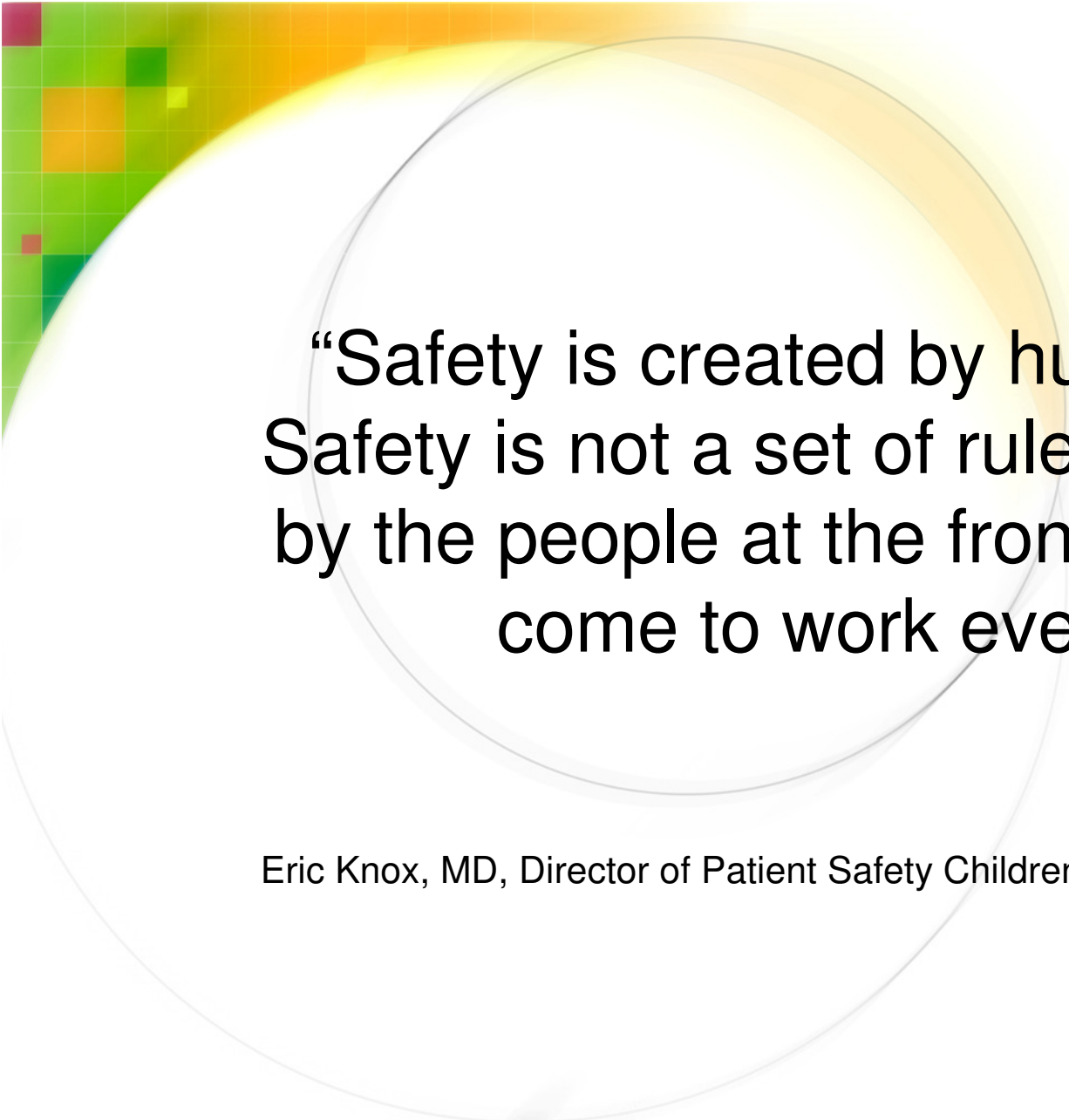
- Review the facts
- Decide who should do it
- Select an appropriate setting
- Decide when to do it
- Present the facts

DISCLOSURE PROCESS (cont.)

- Express empathy
- Describe the next steps
- Establish a follow-up
- Take care of the discloser and caregivers
- The outside world

DOCUMENTATION

- Time, date and place of discussion
- Names of those present
- The discussion of event
- Patient reaction & level of understanding
- Any offer of assistance & response
- Questions asked by patient & family and responses
- Notation that further information will be provided as it becomes available
- Next steps to be taken by patient and providers
- Any follow up conversations



**“Safety is created by human beings.
Safety is not a set of rules. It is created
by the people at the front lines as they
come to work everyday.”**

Eric Knox, MD, Director of Patient Safety Children’s Hospitals and Clinics, MN