DISCLOSURE

“When Bad Things Happen”

Pauline Barry, BSN, MPS, CPHRM
Assistant Vice President
Risk Management and Client Services
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

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

DR. WARNER IS A GOOD GUY!
IT WOULD BE WRONG TO SUET HIM!
DR. WARNER IS A GOOD GUY!...
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