

Communicating With Patients and Families Following an Adverse Event

The past decade has seen a growing trend and greater demand for more transparency in health care. Part of this trend is reflected by the practice of health care providers making full disclosure to patients and/or their families following a medical error or adverse event. Institutional disclosure policies have become more prevalent since the release of the 1999 Institute of Medicine report, *To Err Is Human*, and the 2001 Joint Commission patient safety standards requiring the disclosure of certain “unanticipated outcomes of care.” This issue of *Health Care News In-Depth* looks at patients’ expectations about adverse events or medical errors, approaches to communicating with patients and their families following such events including the recommendations of GNYHA’s communication skills training program, and ethical and regulatory standards related to disclosure.

It is widely recognized that, following an adverse event or medical error in a health care facility, physicians and other involved health care practitioners should communicate openly with—or make “full disclosure” to—the patient and family who were affected. As such, and given the sensitivity of this type of communication, health care facilities have developed policies to guide their staff in making full disclosure. Although the primary goals of most policies are to enhance patient safety and fulfill an ethical responsibility to patients, an unexpected benefit experienced by some who have instituted “proactive” disclosure programs, which may include an offer of compensation, is a decrease in the number and cost of malpractice claims. Key to the success of these programs is the open, honest exchange of information that enables the early settlement of meritorious claims and the vigorous defense of non-meritorious claims.

The U.S. Department of Veterans Affairs as well as a number of hospital systems, insurers, and patient/provider coalitions are among the entities that endorse full disclosure and early offers. The University of Michigan Health System, for example, has a proactive disclosure and compensation program that is built on the principles of quick and fair compensation when “unreasonable medical care causes patient injuries,” vigorous defense of reason-

able care, honesty with patients, and learning from past mistakes. Those at Michigan responsible for the program say that over the years they have seen a reduction in the cost of malpractice claims, as well as in litigation expenses, as a direct result of this approach.

On the Federal level, in 2005 Senators Hillary Rodham Clinton and Barack Obama sponsored the National Medical Error Disclosure and Compensation Act, a national version of the “full disclosure and early offer” policy. The bill, which is expected to be reintroduced this year, was designed to enhance patient safety and to reduce, in part, medical malpractice litigation costs by encouraging early disclosure to patients and early offers of compensation. In return, the program would provide grant support and technical assistance for providers who disclose medical errors; providers would also receive legal protection for any statements of remorse made within the context of a pre-claim compromise negotiation.

In addition to the Joint Commission’s patient safety standards, several states—including New York and New Jersey—require disclosure to patients and, in some cases, their families in the event of an unanticipated outcome or complication of treatment. Finally, professional codes of ethical responsibility for physicians and other practitioners require honest communication and

disclosure of medical errors, and advise that, as stated in the American Medical Association’s Code of Medical Ethics, “Concern regarding legal liability . . . should not affect the physician’s honesty with a patient.”

What Patients Want

Patients involved in an adverse event or medical error want an explanation of what occurred and why. They want to understand the effect of the event on their health and their future and how the problem will be corrected—and they want assurances that they will not be held financially responsible for the costs associated with any resulting care and treatment. Patients typically want someone to take responsibility for what has occurred and want to know that the institution is doing something to prevent similar events from occurring in the future. Most, if not all, patients also want an apology.

THE POWER OF AN APOLOGY

Research has shown that an apology is one of the responses a patient and family often expect after they have experienced an adverse event or medical error. A “full” apology has been defined as “an acknowledgment of responsibility for an offense coupled with an expression of remorse.”¹ Research has also demonstrated that the *type* of an apology can be just as impor-

continued on reverse

EFFECTIVE DISCLOSURE FOLLOWING AN ADVERSE EVENT

Plan Ahead

- ☑ As soon as the institution is aware of an adverse event, begin to prepare for the disclosure conversation.
- ☑ Consult hospital policy on which staff and department(s) should be informed about the event and the planned discussion with patient and family.
- ☑ Make sure that the person who will be speaking to the patient/family has all the facts. Review the medical record in advance.
- ☑ Think about who should speak to the patient and who else should be present.

- ☑ Be mindful of cultural diversity and language barriers.
- ☑ Think about where to hold the conversation/meeting and keep in mind that this may be the first of several meetings.

What to Disclose

- ☑ Defend the actions of the staff and the institution when care was reasonable and appropriate. Accept responsibility or fault on behalf of the institution if it is clear, after discussion with legal counsel.
- ☑ Explain clearly only the known

facts. Be prepared to review the medical record with the patient.

- ☑ Use a layperson's language, not medical terms.
- ☑ Apologize and express sympathy, accepting responsibility as appropriate.
- ☑ Remember that the patient's reaction often depends on how the information is disclosed.
- ☑ Anticipate questions that may be raised; be prepared to respond.
- ☑ Assure the patient that you will provide additional information as it becomes known.

Documentation, Next Steps, What to Expect

- ☑ Factually document the conversation in the medical record.
- ☑ Let the patient and family know that future discussions will take place as necessary; provide contact information.
- ☑ Explain the steps that have been or will be taken to prevent similar events from occurring.
- ☑ Be prepared for patient/family responses and strong emotions.
- ☑ Give patients ample time to express their feelings.

tant as the act of apologizing itself with regard to settling legal disputes.² When liability is clear, an apology of *only* sympathy (“I am sorry this happened to you”), also known as a “partial apology” and one that does not indicate the provider is accepting any responsibility for what has occurred, may negatively affect the injured party’s perception of the physician or institution and can decrease the likelihood of resolving the matter without litigation. A “full” apology—an apology accompanied by responsibility (“I am sorry we did this to you”)—on the other hand, in which the practitioner or someone on behalf of the institution accepts responsibility for having caused the event, has been assessed as more effective and meaningful to the patient involved and has more often led to rebuilding trust between the physician/facility and the patient. It may also lead to a resolution of the matter without litigation. Additionally, a full apology and one that acknowledges the physician’s and/or institution’s responsibility often includes a fair offer of compensation.

To date, 31 states have enacted “apology protection” statutes that protect apologies and other statements of remorse from admissibility in civil suits.

BARRIERS TO EFFECTIVE DISCLOSURE

While providers can be adept at communicating complex medical information to patients, communicating bad news or information about errors or adverse events for which a per-

son may bear some responsibility is never easy. This difficulty is compounded by the strong emotions of those involved, which may hamper the objectivity of both the provider and the patient. Other barriers to disclosure include the culture of the organization, fear of litigation—disclosure can be mistakenly interpreted as an admission of liability if not done properly—and liability insurance company policies that, for the most part, providers have generally interpreted as discouraging of full disclosure and apology.

GNYHA Communication Skills Training Program

GNYHA has sponsored an ongoing communication skills training program for its members based on the premise that better communication leads to improved patient outcomes of care and ultimately improved patient satisfaction, which in some cases could result in reducing the costs associated with medical malpractice claims. The goals of the training are to help staff develop and improve effective communication skills necessary to accomplish effective disclosure; to prepare a core group or team of skilled staff who can assist others in preparing for such communications with patients and families; and to help create a more

supportive environment in hospitals for physicians and other caregivers following an adverse event. Some of the key communication skills covered in GNYHA’s training are:³

Active Listening. Show you are listening through body language, eye contact, asking questions, reflecting what’s been said, acknowledging feelings, and identifying and responding to patient and family needs.

Talk Openly. Provide the patient and family with basic information—that you know to be true—in understandable terms. Describe what additional questions need to be answered. Don’t avoid describing the error. Providers need to show feelings they are experiencing as a result of the error and its impact on the patient. Apologize or express sympathy, and accept responsibility when appropriate.

Invite Participation. Include the patient and family in fact-finding.

Explore and Discuss Next Steps. Explain plans to provide more information to the patient and family and ask what they would like to see happen. Provide contact information for follow-up questions or meetings.

For more information, see the GNYHA Quality and Patient Safety Resource Center on GNYHA’s Web site, at www.gnyha.org, or contact Lorraine Ryan at GNYHA. ■

REFERENCES

1. Aaron Lazare, M.D., “Apology In Medical Practice,” *JAMA* 296, no. 11 (September 20, 2006): 1401–04.
2. Jennifer Robbenolt, “Apologies and Legal Settlement: An Empirical Examination,” *Michigan Law Review* 102, no. 460 (December 1, 2003).
3. “Communicating About Medical Errors and Adverse Events: Introductory Training,” GNYHA-sponsored training, 2005. Accessible in the Resource Centers section of the GNYHA Web site (www.gnyha.org), under “Quality and Patient Safety.”