



Protecting providers.
Promoting safety.



Institute for Professionalism
& Ethical Practice

Cultivating Relational Competence in Healthcare

Guidelines for Disclosure after an Adverse Event

First Priorities

- Assure that the clinical team stays fully attentive to the medical needs of the patient.**
Clinicians may withdraw from the patient's clinical needs, fearful of the patient's anger and/or preoccupied with the implications of the event for themselves.
- Assure that key individuals are notified and involved as soon as possible, including the attending physician and the hospital risk manager.**
Also consider whether hospital leadership, such as department chiefs or the CMO, should be notified.
- Contact an institutional "coach" and make arrangements for a meeting to plan disclosure.**
Unless the event is of only minor significance, disclosure should occur only after thoughtful deliberation and planning with a knowledgeable and experienced colleague, such as a coach, and should include all members of the clinical team.

Preparation for the Disclosure Conversation

- The institutional coach should be regarded as a knowledgeable consultant**
Serious disagreements about whether disclosure should occur, or about the information that should be communicated, are rare, but may require discussions up the institutional chain-of-command.
- The coach should gather information about the event from all the clinicians involved.**
Generally this is most efficiently accomplished with a small team meeting or huddle.
- Determine if the adverse event meets the threshold requiring disclosure.**
A useful rule-of-thumb is that an event should be disclosed if (1) you would want to know about the event if it had happened to you or a relative, or (2) it may result in a change in the patient's treatment.
- Remind the team that this conversation is solely for the benefit of the patient and family.**
Discuss the need for the team to present themselves in a unified manner. Enlist agreement from all participants that they will not engage in blaming or debate about the event during this conversation.
- Determine which clinicians should be present for the initial conversation.**
Consider their level of involvement in the event, their emotional state, and their capacity to present themselves as an engaged member of the clinical team. If they are not capable of making a positive contribution, their involvement should be deferred until later. The hospital risk manager or others who are not clinically involved should usually not participate in the initial meeting.
- Assess who should be present for support of the patient and family.**
Determine whether it would be helpful to have chaplains, friends, or other family members present. If English is not the patient's primary language, arrange for the services of an interpreter.
- Decide who should lead the conversation.**
In most cases, this should be the attending physician, even when he/she was not directly involved. In some cases, however, others, such as a nurse, may be the appropriate one to have the conversation.
- Agree on the core information that will be communicated**
Anticipate questions that may be asked, and formulate responses. Practicing key aspects of the conversation ahead of time (as a "role play") may be very helpful.
- Determine an optimal time and setting for the conversation.**
Initial conversations should occur as soon as possible after the event, usually within a few hours and nearly always within a day. If clinicians have concerns for potential violence, a safe location should be chosen with the involvement of hospital security.
- Decide who will take primary responsibility for following up, so that this can be communicated unambiguously to the family.**
Follow up is critical, and essential to beginning to restore trust and confidence in the hospital and the providers.

The Conversation with the Patient and Family

- ❑ **Above all, clinicians should be encouraged to express themselves as compassionate and caring human beings.**
Apply the “Golden Rule”: What would you want to be told—and how would you want to be treated—if you were the patient or family? When in doubt – ask the patient and family if they are receiving the information they want and if their needs are being met.
- ❑ **Acknowledge the patient’s suffering and convey empathy:**
“We are so sorry that this has happened,” “This must be a nightmare for you,” “I can’t imagine how hard this must be for you.”
- ❑ **Set the agenda for the meeting.**
The patient/family may not know why you are coming to talk with them. Explain the meeting’s purpose.
- ❑ **Clearly state the facts as they are known at the present.**
There is no legal risk to disclosing the facts as they are known at the moment. Patients deserve accurate information about what took place. Be careful, however, not to speculate beyond the facts, because initial impressions about how the facts “fit together” can be incomplete and at times completely erroneous.
- ❑ **In rare circumstances, disclosure of the facts may not be of immediate benefit to the patient/family.**
Non-disclosure requires a high level of justification, and should not be used simply to avoid difficult conversations. In nearly all cases, the clinicians should be committed to disclosure as soon as the patient and family are capable of having the conversation.
- ❑ **Express the appropriate form of apology and/or regret.**
Expressions of regret and empathy for what the patient is experiencing are always appropriate. Expressions of personal or institutional responsibility for the adverse event should only be made when the facts clearly indicate that the adverse event was an avoidable consequence of a medical error.
- ❑ **Explain what is being done to care for the patient and the plan for care going forward.**
Offer support services—chaplains, social workers, patient advocates, etc.
- ❑ **Assess whether the existing clinical relationships can be maintained or whether care needs to be transitioned to alternative providers.**
Consider whether trust with the existing care team can be supported and maintained by involvement of additional subspecialists or by requests for second opinions, and respect the patient’s choice to have alternative careproviders, if necessary.
- ❑ **Assure the patient/family that the event will be thoroughly investigated and that all relevant facts will be communicated as they become known.**
If the investigation reveals that mistakes were made, assure the patient that steps will be taken, to the extent possible, to prevent similar occurrences in the future. If the patient asks about financial compensation, explain that someone qualified and authorized to address this issue will follow up with them.
- ❑ **Remember that disclosure may not be greeted with thanks or “forgiveness”**
Although disclosure is the right thing to do, clinicians may find it difficult to accept that families may not respond to their efforts to be honest, straightforward, and compassionate with expressions of thanks, relief, or forgiveness. Rebuilding the relationship with the patient and family takes time.

Follow-up and Documentation

- ❑ **Whenever possible, have a post-conversation huddle to debrief the event.**
The coach should describe the normal range of responses, assess the ongoing emotional and psychological needs of the clinicians, and, if indicated, arrange for temporary relief from clinical duties and additional support as is necessary.
- ❑ **Clinicians should document the conversation in the medical record.**
This should include a summary of the facts surrounding the adverse event, a synopsis of the initial conversation (including a list of those present), and a description of the care provided and current plans for care going forward.
- ❑ **Advice from the coach should not be documented in the medical record.**
The chart is for communication about the patient’s treatment. The purpose of the coaching session is to provide support to the staff.