Disclosure: Understanding the Barriers to Communicating Unanticipated Outcomes

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The communication of an unanticipated outcome can be difficult and painful. Such occurrences can create emotional and psychological stress for everyone involved, and it is important to understand the underlying causes of these feelings in order to effectively disclose an adverse event or unanticipated outcome to a patient or his or her family.

The disclosure of unanticipated outcomes or events requires appropriate planning by healthcare professionals and organizations. In order to maintain the trust of the patient, it is critical that the healthcare practitioner communicate openly and honestly when an unanticipated outcome occurs. A specialized team with training and experience in disclosure can serve as an invaluable asset in this important communication process.[1]

In my role as Patient Safety Liaison for the Northwest Region of Pennsylvania, I have had the opportunity to discuss the disclosure process at several of the facilities in my region. This experience has demonstrated that the most effective disclosure programs involve a specialized team approach.

One of the successful programs I have observed is the Family Assistance and Communication Team (FACT) of the West Penn Allegheny Health System. FACT comprises several individuals who have experience with patient disclosures and family meetings regarding serious events and unexpected outcomes, including patient safety department staff, physicians, nurses, social workers, and patient representatives. The team is trained to offer guidance in planning and conducting a disclosure or family meeting. The level of involvement of the team can vary, from acting in an advisory capacity for the practitioner who requested the team's services to coordinating and participating in the entire disclosure process.

Regardless of its level of involvement in the disclosure process, the team has developed guidelines for disclosing unanticipated outcomes to patients that address the following information.[2]

Why Disclose Unanticipated Medical Outcomes

It is important to disclose unanticipated medical outcomes for several reasons. First, it is the right thing to do. Patients are entitled to know the details of their care, good or bad. Communication of unanticipated events helps to maintain the patient/physician relationship by creating a culture of openness and trust. Second, Vincent et al. discussed that many patients sue because they feel that their physician or hospital has not communicated openly with them and view a lawsuit as the only way to obtain answers to their questions; disclosure, if done well, can be a valuable communication tool.[3] Finally, Pennsylvania law requires that a healthcare provider disclose to the patient that an unanticipated outcome has occurred.[4]

When Disclosure Is Appropriate

Disclosure is appropriate when outcomes differ from the results expected, even if the outcome is a known risk of the procedure.[5] Furthermore, the Pennsylvania Medical Care and Reduction of Error Act (MCARE Act 13 of 2002) requires "medical facilities in the state to provide written notification to a patient affected by a serious event."[4]

Key Elements of Disclosure Discussion[5]

The facts of any event that may have occurred and any immediate treatment rendered should be discussed. This discussion is to be done as soon as possible, so the family does not speculate about what may have occurred and so that clear conveyance of regret is provided by the facility. Avoid any speculation or opinions regarding the care rendered by another healthcare provider. It is important to establish reasonable expectations for the family. Clarify any limitations of the conversation, such as the need for additional testing. Also, establish a reasonable time frame to obtain and communicate information, and strive to stay within those time frames. Finally, discuss steps already taken to prevent reoccurrence of similar events.

Important Steps in West Penn Allegheny Health System's Disclosure Process[2]

1. Any unexpected outcomes should be reported to the Patient Safety Officer.
2. The discussion should involve an initial disclosure of the event, as well as follow-up disclosure. For the initial disclosure, a private setting should be selected and sufficient time for emotions, venting, and questions should be allowed. Typically, it is the attending physician or healthcare provider most directly involved in the event who makes the disclosure; however, that may vary.
3. The initial disclosure should occur as close to the time of the event as possible. The patient or the family of the patient should be provided with the facts known at the time of the discussion. The patient should be advised of any additional information that will be gathered, and your discussion should be limited to your area of expertise. Unless

you have been able to immediately obtain all relevant facts, the patient or his or her family should be advised that you will follow up once you have obtained additional relevant information.

4. Gather all the available facts surrounding the event.
5. As a follow-up disclosure, consider a family meeting that would involve additional healthcare providers. Include a detailed review of the medical records, and offer to follow up with any additional facts that are not available initially.
6. If you have limited time, the patient or his or her family should be informed of that constraint at the beginning of the discussion, and another time for a follow-up conversation should be provided in the very near future.
7. If involved in a family meeting, some simple considerations may be helpful toward achieving a successful meeting, such as offering parking validation or beverages.

It is often the way the situation is handled and not the incident itself that leads to litigation.[3] The key is to step back and consider how you would want to be treated and to do whatever you can to assist the family through the process. Even if litigation is not avoided, establishing open and honest lines of communication can prevent a breakdown in the patient/physician relationship and minimize hostility and the sense of betrayal that families often feel. Direct, honest, nondefensive communication can go a long way toward achieving an amicable resolution.

Notes

1. American Society for Healthcare Risk Management of the American Hospital Association. Disclosure of unanticipated events: the next step in better communication [monograph online]. 2003 [cited 2009 Oct 27]. Available from Internet: http://www.ashrm.org/ashrm/education/development/monographs/monograph.disclosure1.pdf.
2. West Penn Allegheny Health System. Guidelines for disclosing unanticipated outcomes to patients and family [brochure].
3. Vincent C, Young M, Phillips A. Why do people sue doctors? A study of patients and relatives taking legal action. *Lancet* 1994 Jun 25;343(8913):1609-13.
4. Medical Care Availability and Reduction of Error (MCARE) Act. 40 P.S. § 1301.101, et. seq. (2007).
5. American Society for Healthcare Risk Management (ASHRM) of the American Hospital Association. Perspective on disclosure of unanticipated outcome information. Chicago (IL): ASHRM; 2001.

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