Examining Disclosure Options

PROCEDURES FOR DISCLOSING ADVERSE EVENTS: A LITERATURE REVIEW

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ON HORMONE RECEPTOR TESTING**

Overview

- Disclosure practices
- Components of the disclosure process
- Current practices and patient preferences
- Advantages and disadvantages of disclosure
- Patient safety culture

Background

Literature on disclosure consistently recommends:

- Culture change to promote patient safety
- Education on disclosure
- Embracing the disclosure process

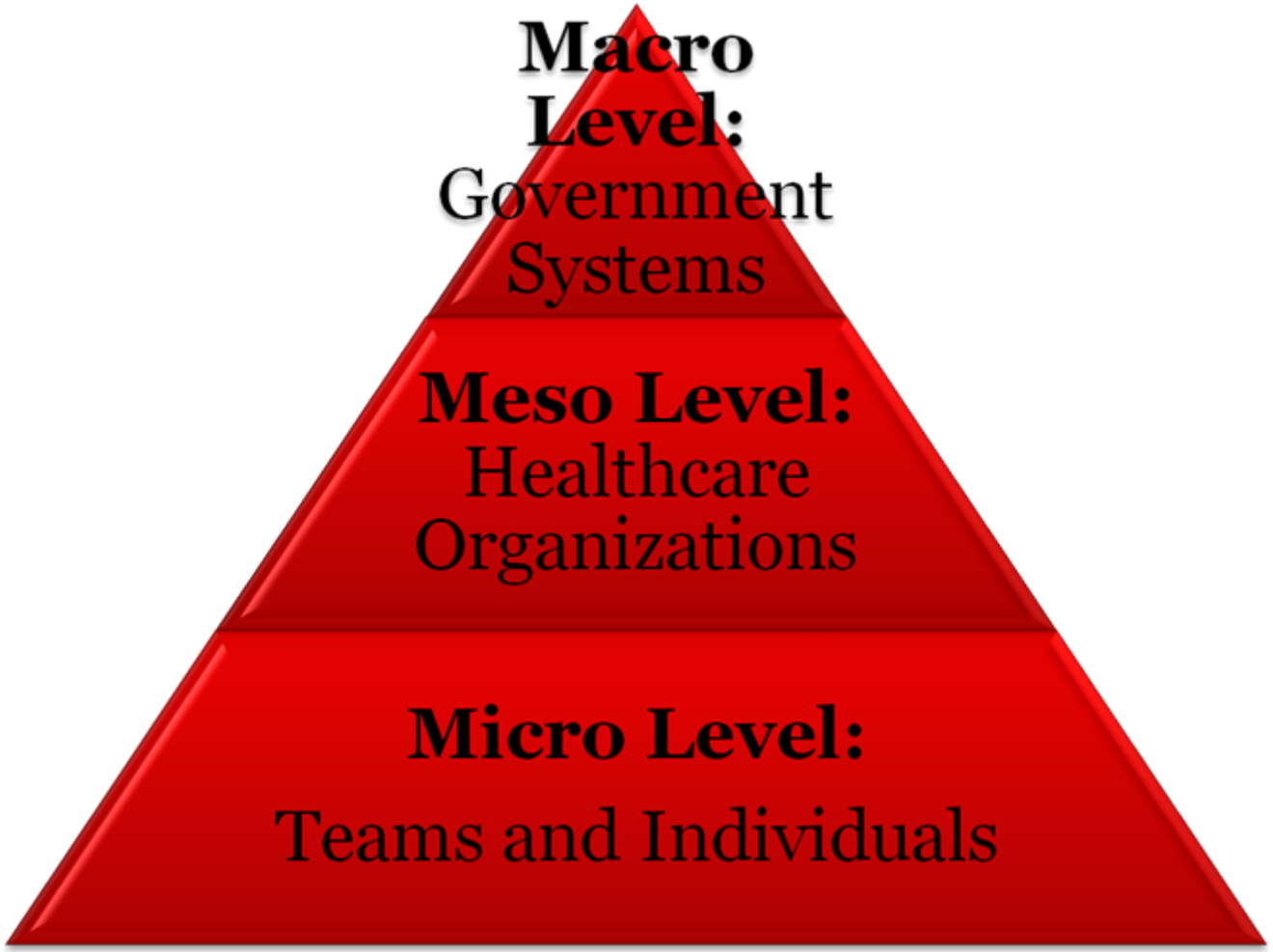
“The process by which an adverse event is communicated to the patient by health care providers.”

Canadian Patient Safety Institute, 2008

Adverse Event

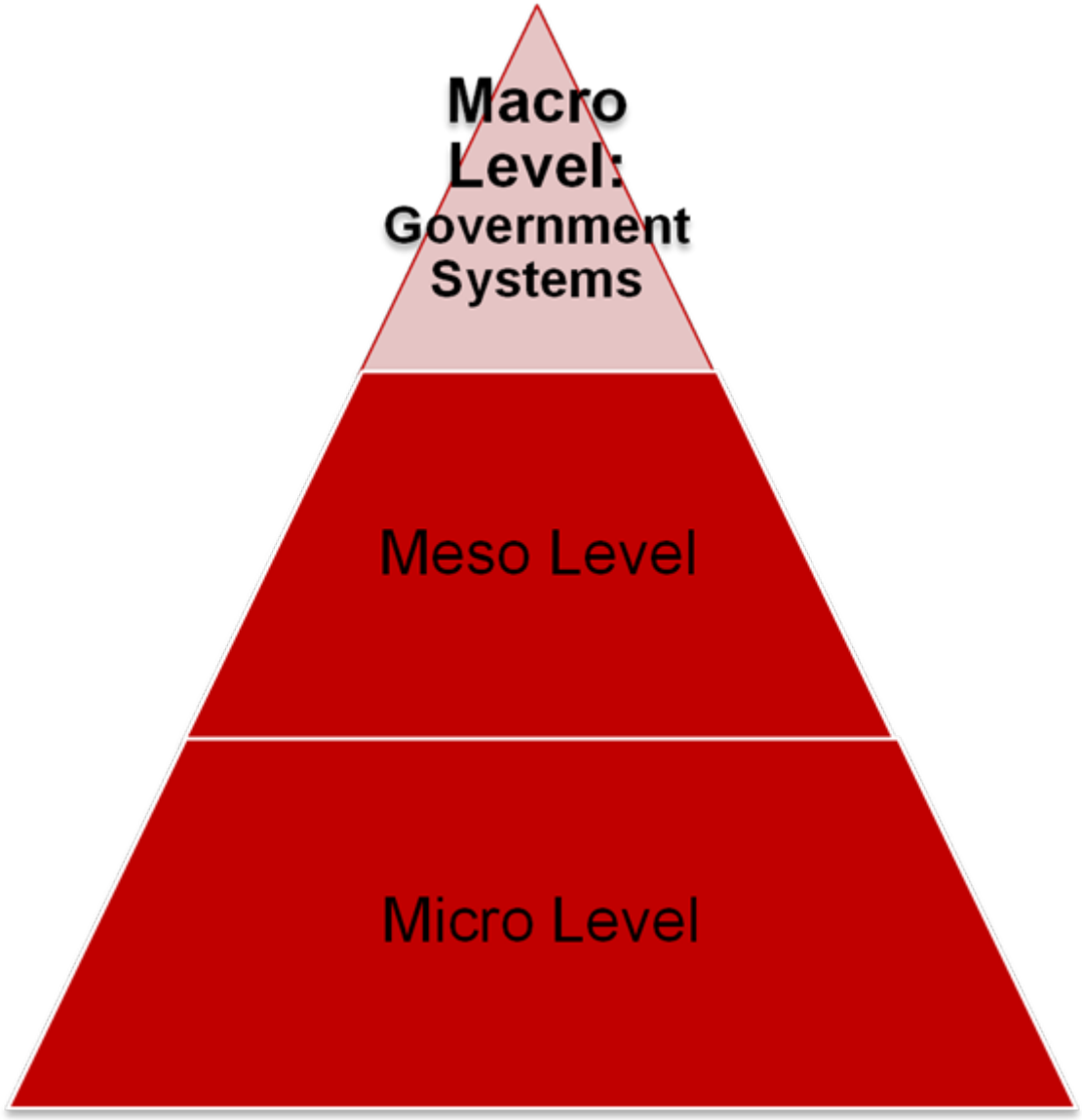
An event which results in unintended harm to the patient, and is related to the care and/or services provided to the patient rather than to the patient's underlying condition

Disclosure Practices: Canadian Healthcare System



Macro Level

Provincial Disclosure Policies & Guidelines



Similarities: The Facts

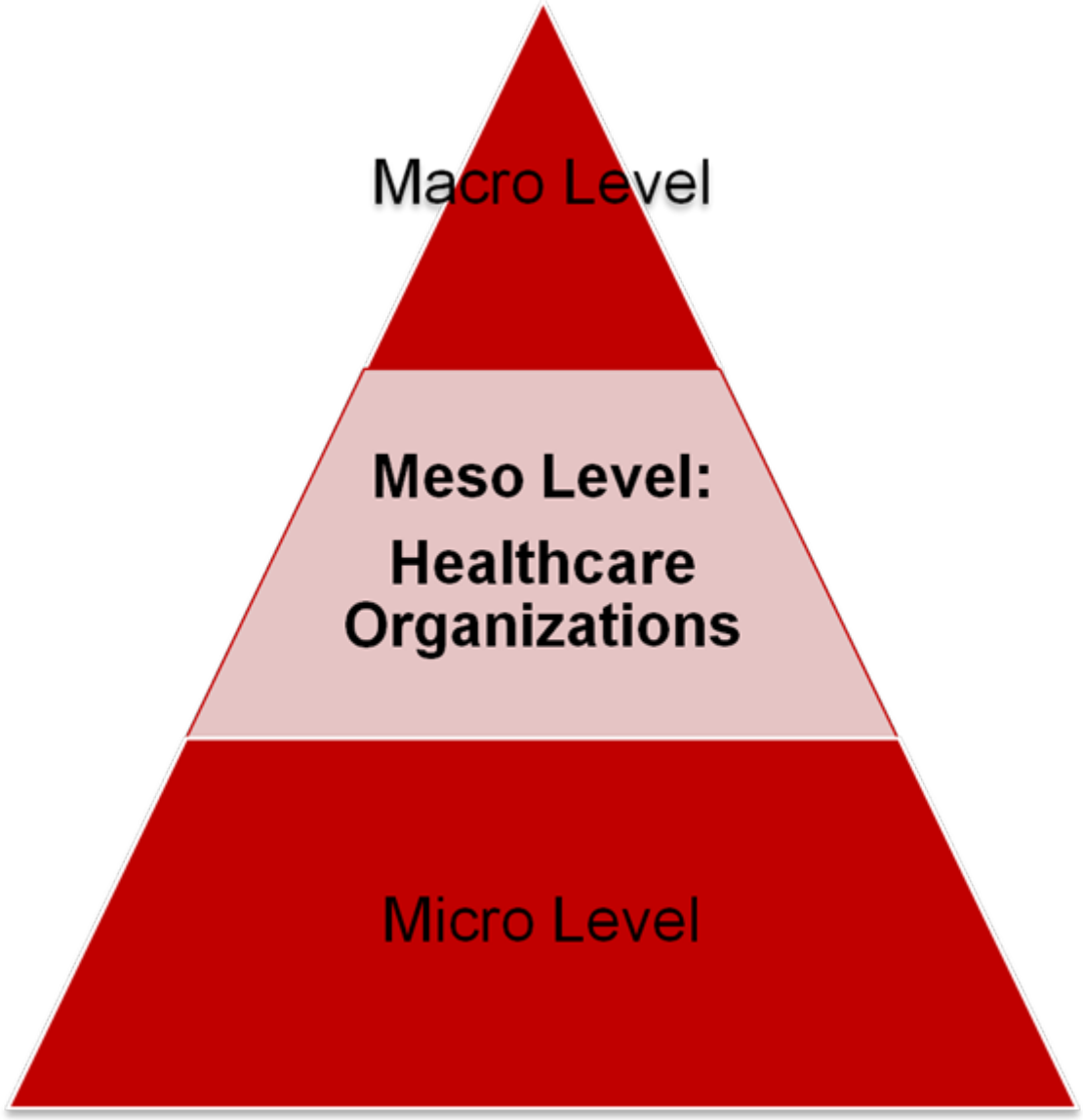
Province	What must be disclosed
Alberta	"Only **facts** related to the patient's treatment and care should be shared."
British Columbia	"Stick to the **facts** during an explanation of the events."
Nova Scotia	"The initial disclosure should include the **facts** of the event and its outcome,"
Saskatchewan	"Discussions should focus on currently known information about the **facts** surrounding the event."
Newfoundland & Labrador	" Focus should be placed on what is **known at the time**."

Differences in Apology

Provinces	What must be disclosed?
Alberta	“An expression of remorse and empathy to the patient and family; an appropriate apology.”
British Columbia	“Empathize with the patient/family, ‘we are so sorry this has happened to you’.”
Nova Scotia	No policy regarding apology.
Saskatchewan	No policy regarding apology but “blame should not be assigned.”
Newfoundland & Labrador	“An expression of sympathy is often appropriate and not an admission of guilt.”

Meso Level

Disclosure Policies of Healthcare Organizations



Similarities: The Facts

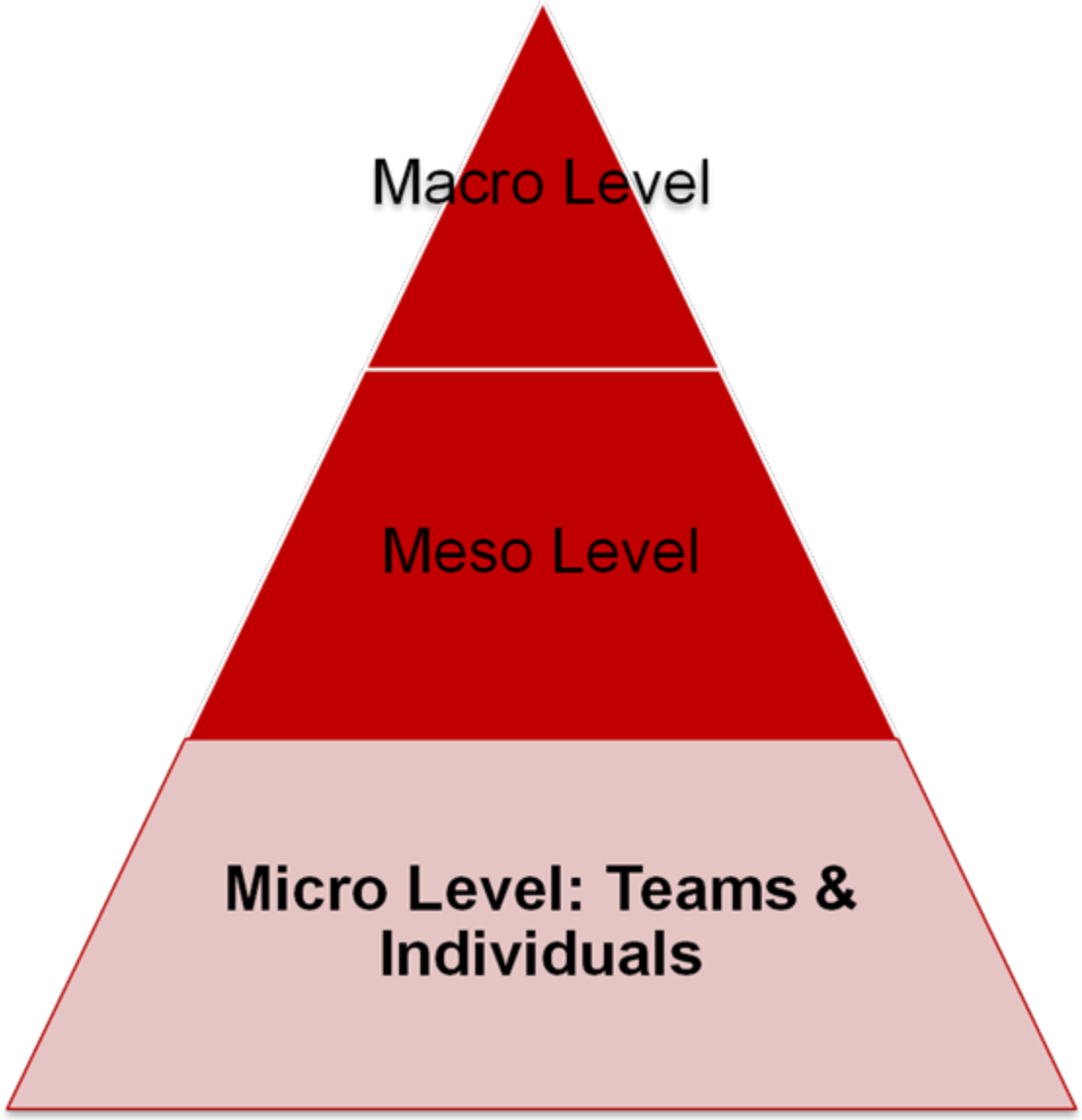
Healthcare Organization	Content of Disclosure
McGill University Health Centre	"Disclosure should be made at the earliest possible moment. It should include the **facts** of the accident."
The Ottawa Hospital	"**Facts** of an incident."
Vancouver Coastal Health and Richmond Health Services	"The **facts** of the adverse event or adverse outcome, no speculation and blame."

Differences in Apology

Healthcare Organization	Content of Disclosure
McGill University Health Centre	No policy regarding apology, but "personal opinions as to fault or responsibility are to be avoided."
The Ottawa Hospital	No policy regarding apology.
Vancouver Coastal Health and Richmond Health Services	"Regret that the adverse event or adverse outcome occurred."

Micro Level

Disclosure by Teams and Individuals across Healthcare Facilities



Micro Level: Disclosure by Teams and Individuals

- Adapted to specific situation
- Support from individuals & teams
- Research is relatively new in this field

Physician Attitudes

"Physicians' willingness to disclose errors to patients increased with the error's harm."

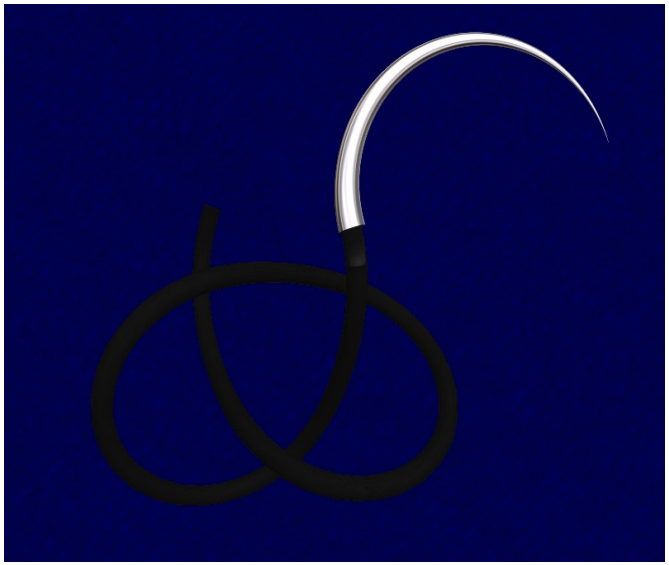
"Physicians acknowledged that certain factors might make them less likely to actually disclose."

Of the physicians, 60% reported being less likely to disclose if they "thought the patient would not understand what I was telling him or her."

Gallagher, et al. 2006

"Full disclosure would be necessary to guard against the patient thinking 'that the large removal of breast tissue was because of the cancer alone."

Team Perceptions



Dropped Specimen

Espin et al. 2006

Partial Disclosure:

- Partial disclosure entailed strategies such as describing *what* happened but not *how.*

"I wouldn't get into the subtle nuances" (S)

Rationales for Partial Disclosure:

Participants' rationales for partial disclosure included:

- "self-protection"
- nature of "physician-patient relationship"
- a desire not to "create a mess"
- a sense that it is "not helpful for patients to know who is at fault"

Espin et al. 2006

Patients Want Full Disclosure

- Patients advocated more often for full disclosure than team members.

- Patients demonstrated a different reasoning process than team members, asserting full disclosure as a right.

"Well it's [my body], it's not the surgeon's body, so I would want to know all the details." (P)

Espin et al. 2006

Summary: Disclosure at the Macro, Meso & Micro Levels

MACRO: PROVINCES SHARE POLICIES AND PRACTICES — DISCLOSING "JUST THE FACTS" OF ADVERSE EVENTS

MESO: HEALTHCARE ORGANIZATIONS DIFFER IN THE ART OF APOLOGY

MICRO: INDIVIDUAL AND TEAM ATTITUDES – CURRENT CULTURE

Components of the Disclosure Process

Who
What
When
Where
How

Who Should Disclose

"The medical practitioner who was the most responsible physician for the health care treatment during the course of which the adverse outcome occurred."
(College of Physicians and Surgeons of Newfoundland & Labrador, 2006)

"Assistance by those trained in the disclosure process, with strong interpersonal skills may be helpful. The participation of others over time may be appropriate to help the patient."
(Canadian Patient Safety Institute, 2007)

What Should Be Disclosed

- The facts
- Steps taken in the care of the patient
- An expression of sympathy or regret
- An overview of the process that will follow
- An offer of future meetings
- Time for questions
- Offers of support

What Should Be Disclosed

The disclosure should:

- Provide a factual description of the adverse event
- Explain medical terminology
- Avoid speculation or conjecture

When Should Disclosure Take Place

"The earliest practical opportunity and preferably within one to two days."
(Canadian Patient Safety Institute, 2007)

"The medical practitioner should disclose the adverse outcome with the according urgency."
(College of Physicians and Surgeons of Newfoundland & Labrador, 2006)

Where Should Disclosure Take Place

In person; at a location and time of the patient's preference; in a private area.
(Canadian Patient Safety Institute, 2007)

To the patient directly; ensuring patient privacy; with support person, patient and practitioner
(College of Physicians and Surgeons of Newfoundland & Labrador, 2006)

How Should Disclosure Take Place

- Active Listening Skills
- Open and forthright
- Clarify information
- Sensitive to cultural and language needs.
  (Canadian Patient Safety Institute, 2007)

- Consider patient choice for disclosure to a substitute decision maker or in writing
  (College of Physicians and Surgeons of Newfoundland & Labrador, 2006)

Current Disclosure Practices

A status report in 2007 revealed that within the last ten years, disclosing errors has gradually become more acceptable and frequent between doctors and their patients

Levinson & Gallagher, 2007

Patient Preferences

- Patients want **full disclosure**
- **Fear** they are not being told the truth

Levinson & Gallagher, 2007; Espin et al., 2006

Advantages of Disclosure

Patient	Physician
• Proper & timely treatment. • Reduced anxiety. • Improved quality of treatment. • Improved patient-physician relationship. • Improved autonomy.	• Relief. • Learn from colleagues' mistakes. • Continue an "honest patient-doctor relationship". • Increase patient confidence in the medical field/practice.

Wu, 1997; Straumanis, 2007; & Stewart, 2002

Disadvantages of Disclosure

- Lack of time for disclosure
- Lack of professional confidentiality
- Legal liability
- Negative publicity
- Loss of stature
- Sense of failure
- Patient & family's anger

Straumanis, 2007

Public Disclosure

Advantages	Disadvantages
• Safety of the public is the most important factor. • Improvements would be made to the system and are actively sought out by the public.	• Risk for litigation. • Changes may occur slowly, potentially compromising patient safety. • Negative press.

Stewart, 2002; Weissman et al. 2005

Example of Public Disclosure

A public apology was issued by the Alberta Health Officials when a 44-year-old Edmonton woman died from an accidental overdose of a chemotherapy drug

- Leads to improvements in patient safety practices
- Serious action taken at Princess Margaret Hospital in Toronto
- Reviewed their procedures on dispensing chemo to prevent the same mistake from happening

Talaga & Cribb, 2007

Public Disclosure vs. Patient Privacy

"Can healthcare professionals honour their duty to patients and the organization when public disclosure of medical errors is involved?"

(Stewart, 2002)

Patient Safety Culture

"The collective values, knowledge, skill and commitment to safer patient care that is demonstrated by every member of the organization"

Canadian Patient Safety Institute, 2007

Ten Dimensions of Patient Safety

1. Manager expectations and actions promoting patient safety
2. Organizational learning—continuous improvement
3. Teamwork within units
4. Communication openness
5. Feedback and communication about error
6. Non-punitive response to error
7. Staffing
8. Hospital management support for patient safety
9. Teamwork across hospital units.
10. Hospital handoffs and transitions

AHRQ, 2004

Creating a Patient Safety Culture

"Systems theory emphasizes that focusing on the system rather than on the individual will prevent more adverse events"

Canadian Patient Safety Institute, 2007

Summary

- Strong national agreement on disclosure
- Patient and family expectation of disclosure
- Consider the advantages and disadvantages
- Explore the complexities
- Culture of individual blame needs to shift

Conclusion

"Disclosure is always the right thing to do"