

Viewing Time

The program will take up to one hour to complete.

Target Audience

This program is designed for primary care physicians.

Other health care professionals working with patients and their families may also find this program of interest.

Faculty Disclosure

It is the policy of Children's Hospitals and Clinics of Minnesota to ensure balance, independence, objectivity, and scientific rigor in all its educational programs. Our faculty have been asked to disclose to our program audience any real or apparent conflicts of interest related to the content of their presentation. They have also been requested to let you know when any product mentioned in their presentation is not labeled for the use under discussion or is still under investigation.

Faculty Disclosure

Phillip M. Kibort, MD, MBA has disclosed no actual or potential conflict of interest in relation to this educational activity.

During this educational activity **Dr. Kibort** will not be discussing the use of any commercial or investigational product not approved for any purpose by the FDA.

Disclosure in Health Care

Phillip M. Kibort, MD, MBA
Vice President of Medical Affairs & Chief Medical Officer, Children's Hospitals and Clinics of Minnesota

Disclosure in Health Care

A lecture about when, why, and how to disclose a medical mistake to a patient and/or a patient's family.

Program Objectives

Upon completion of this program, participants should be able to:

- Know when to disclose
- Know why to disclose
- Know how to disclose
- Know why there is hesitancy to disclose

Disclaimer

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Accreditation

Children's Hospitals and Clinics of Minnesota is accredited by the Minnesota Medical Association to provide continuing medical education for physicians. Children's Hospitals and Clinics of Minnesota designates this educational activity for a maximum of 1 AMA PRA Category 1 Credits™ toward the AMA Physician's Recognition Award. Each physician should only claim those credits that he/she actually spent in the activity.

Receiving CME Credit

To receive CME credit you must view the entire program and complete the evaluation form at the end.

Disclosure

Children's of Minnesota's Experience

Phillip M. Kibort, MD, MBA
VPMA/CMO
2009




Remember

Your mother always told you

“Tell the Truth”



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**Do No Harm
Before or After**

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A Patient's View

"It is so hard to articulate the profound sense of betrayal and abandonment that my family felt. I can only describe it as a hit and run healthcare accident. My family was abandoned at the side of the road, injured and traumatized by a well-meaning motorist who fled because of legal and personal fears."

Shaidan

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A Patient's View

A hit and run in our world is considered criminal. Why is it okay in medicine? The non-disclosure of medical error is the most destructive phenomena in healthcare. Trust and confidence disappear in a heartbeat.

Shaidan

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Non-Disclosure

Nondisclosure of a medical error undermines the public's trust in the profession and undermines efforts to improve patient safety.

C.J. Vercler

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When patients suffer an injury

- ★ confusion
- ★ uncertainty
- ★ fear
- ★ loss of trust

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If injuries or error are not acknowledged patients feel

- 1) Devalued
- 2) Humiliated
- 3) Disrespected
- 4) Anxiety → Anger

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When Doctors Say, "We're Sorry"
Aggrieved patients often just want an apology, but will accepting a mistake increase the risk of a lawsuit?

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We Know


As families have told us, the worst thing is not knowing if you cared about what happens to us.



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Disclosure Goals

- **What** is disclosure?
- **What** type of events require disclosure?
- **Why** do I need to provide disclosure?
- **Who** should provide disclosure?
- **When** do I need to provide disclosure?
- **What** is the process of disclosure?



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Truth

Falsehood is easy, truth is difficult.



- George Eliot




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Admit Error?

Traditionally, error has been met with blame, shame, and punishment.


When the unintended happens, individual scapegoats are found, error is suppressed, and learning and improvement stops.



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Children's Key Principles



"Nothing about me, without me," is our pledge to families that they will be involved in decision-making and will participate in every aspect of their child's care.



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Children's Key Principles



"If it looks wrong, it is wrong" provides legitimate authority and responsibility for anyone to "stop the line" when they think danger is imminent.



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What is Disclosure?



- Disclosure is the act or instance of uncovering or revealing information.
- Disclosure is a commitment to providing information to a patient/family regarding Medical Accidents or significant Patient Safety Events.



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How Does Children's Respond to Accidents and Significant Patient Safety Events ?



- Children's intends to identify and analyze all events related to patient safety and will partner with parents, patients, and physicians/providers to improve patient safety.



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How Does Children's Respond to Accidents and Significant Patient Safety Events ?

- An analysis of each accident or significant patient safety event is conducted to understand the multi-causal components producing the conditions that allowed the event to occur.
- Focused Event Review [FER]





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Why Disclose?

Full disclosure is the right thing to do. It is not an option; it is an ethical imperative.

L. Leape



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Why Do I Need to Provide Disclosure?

Because Children's of Minnesota values:


- ✓ Safety
- ✓ New Knowledge and Skill Development
- ✓ Information Dissemination and Ethical Responsibility
- ✓ A Transparent Learning Environment and Blameless Reporting
- ✓ Accountability




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Truth

The truth of the matter is that you always know the right thing to do, the hard part is doing it.



- General Norman Schwarzkopf



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Patients want us to

- 1) Take responsibility, admit, apologize
- 2) Care givers to acknowledge what and why
- 3) Serious efforts to find out why
- 4) Make sure it doesn't happen again*




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Understand

When weighing the potential consequences of full disclosure

The potential benefits and harms to the patient must be given more significance than the potential benefits and harms to the physician.

The nature of the patient-physician relationship mandates this.




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Disclosure

Information "should be disclosed whenever it is considered material to the patient's understanding of his or her situation, possible treatments, and probable outcomes... However uncomfortable for the clinician, information that is essential to and desired by the patient must be disclosed."

American College of Physicians Ethics Manual




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Key Principles

We are obligated to care for both victims.


- * Patient/Family
- * Clinicians



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Why Disclose?

- To preserve patient autonomy and patient-physician trust
- Because ethically it is the right thing to do





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“The only question we need to answer is whether what is proposed is right or wrong; not what will happen to us, what people will think of us, or how we feel about what has happened”

He insists that principles are the basic aspect of morality and the other considerations such a ‘what will happen to me’ are to be secondary.



Scheirton



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Apology


An effective apology can reassure people that the transgression is understood and are not likely to be repeated.



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Apology



Apologies matter for two reasons, they mend relationships and they mend the transgressors reputation.



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Who should disclose?



- Health care worker with whom the patient has a trusting relationship, usually the responsible physician
- Others involved in the incident (eg, nurse, pharmacist may be included)
- Hospital Administrative Leadership



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Who else should be at disclose?



- The patient’s primary nurse should be included in the discussions to be able to support the patient after the disclosure has occurred.



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To whom should the communication be made?



- To the patient
- If this is not possible, to family members or substitute decision-makers



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What types of events should be communicated?



- Any incident that has resulted in harm to the patient
- Other incidents at the discretion of the responsible physician/provider
- Near misses?



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When should communication take place?

- As soon as the event is recognized and the patient is physically and emotionally capable
- Ideally within 24 hours after the event is recognized
- Ongoing communication will be required as more information becomes available and should be led by the responsible physician or delegate



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We Know

“Done wrong an apology can compound the original mistake, sometimes to disastrous consequences.”

Holly Weeks

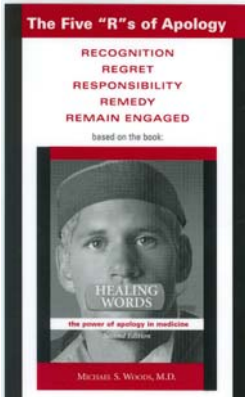


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The Five “R”s of Apology

RECOGNITION
REGRET
RESPONSIBILITY
REMEDY
REMAIN ENGAGED

based on the book:





HEALING WORDS
the power of apology in medicine
Michael S. Woods, M.D.



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**Recognition:
Know when an apology is in order**



- Read the feelings of your patient and family – is there fear, disappointment, or anger regarding an outcome?
- Be aware of your own feelings about the situation
- Analyze exactly what happened to cause these feelings



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**Regret:
Respond empathetically**



- Tell your patient you’re sorry for what they are going through
- Acknowledge their feelings of disappointment, fear, and anger
- Remember that an apology does not imply guilt or fault on your part



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**Responsibility:
Own up to what's happened**



- Be accountable for the problem – even if it was unforeseeable
- Disclose all details that led to the outcome or complication and explain why it happened
- Use “I” statements instead of “we” statements



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**Remedy:
Make it right**


- Explain to your patient what's being done to correct the problem
- Evaluate how it will affect your patient's health and then begin appropriate therapy
- Consider who will bear the cost of the error or complication – are there any costs you can absorb?



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**Remain Engaged:
Be there for your patient**



- Reassure the patient that you will not abandon them
- Focus on and provide for your patient's continuing care needs after the outcome or complications



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What is the Process for Disclosure?



- Take immediate action to ensure the safety of the patient, staff and others in the environment.
- The Attending should be immediately told of the event, and will determine whether any immediate change in delivery of care is necessary.



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What is the Process for Disclosure?

- Once the safety of the patient has been ensured, the attending physician has been informed of the event and all equipment has been preserved from the event, a Patient Safety Report must be filed via:
 - ✓ Written Safety Learning Report form
 - ✓ The call-in line (612-813-TIPS)
 - ✓ An Intranet Safety Learning Report



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The process should



- Investigation and corrective action
- Be safe
- Have procedures to ensure required reporting to regulators
- Inform communications department



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At Children's



Honoring the patient's perspective also means accepting the difficult reality that some patients will not want any contact with those responsible for their injuries.



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At Children's



Physicians should not expect to hear any patient say, "I forgive you" as a quid pro quo for disclosure and apology and repentance.



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At Children's



The goal is to make it possible for patients to forgive, not to obligate them to do so.



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What is the Process for Disclosure?



The event must be documented in the Medical Record as a complete, accurate record of clinical information pertaining to the event



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Doctors talk a good game – fully 98 percent endorsed the need to disclose serious errors to patients, according to survey results published in the Archives of Internal Medicine. But most had something less than full disclosure in mind. Only 42 percent would actually use the word "error", while 56 percent would mention the adverse event but not the error, relegating the harm to the "stuff happens" category. Only 33 percent would explicitly apologize for their mistake.

NY Times – Sept. 9, 2006





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Why Doesn't This Occur?

We have a vague but disturbing recollection of the phrase:

"anything you say can and will be used against you".



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Why Physicians Resist Disclosure

- 1) Risk of malpractice
- 2) Tradition of self-regulation
- 3) The mask of infallibility
- 4) Potential loss of trust
- 5) Guilt & shame
- 6) Physician as healer
- 7) Asymmetry in the physician-patient relationship





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Lost Opportunities: How Physicians Communicate About Medical Errors

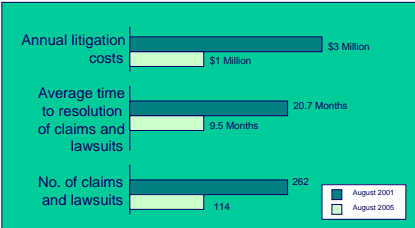
Physicians' dissatisfaction with existing error-reporting systems could lead them to share such information with their colleagues but not with their hospital.

By Jane Garbutt, et al



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Does Disclosure = \$\$



Metric	August 2001	August 2005
Annual litigation costs	\$3 Million	\$1 Million
Average time to resolution of claims and lawsuits	20.7 Months	9.5 Months
No. of claims and lawsuits	262	114

Results of Medical Error Disclosure Program at the University of Michigan Health System.

Clinton, Obama NEJM 2006



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Apologies Heal




- Restores patients' dignity and self-respect
- Provides assurance of shared values mutual commitment to the relationship
- Assures patient that they are not at fault
- They are now safe (or safer)
- Levels playing field
- Provides extra attention



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Truth does not change according to our ability to stomach it.



- Flannery O'Connor



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How Do I Provide Disclosure?: Who Should Be Present?



➤ For discussion anticipated to be complex or difficult, parents should be given the option of having another person with them as support during the discussion.



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How Do I Provide Disclosure?
Beginning the Discussion:



- Introduce everyone and acknowledge that this will be a difficult conversation.
- Assess the family's current knowledge, desired level of detail, and ability to take in information.
- Begin to disclose information, stopping to solicit questions and reactions.



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Remember to Give the Discussion Enough Time

- Although everyone in health care is under constant time pressure, it is **critical not to shortchange this type of conversation** and unintentionally create the impression that the family and their concerns are not important.





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Remember to Give the Discussion Enough Time

- Also, people's sense of time is affected by the quality of the interaction.



By turning attention solely to this discussion, and listening well and reflectively, people's needs are often met in less time than we expect.



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Follow-up Communication


- Conduct follow-up sessions promptly
- Primary physician or team members should lead session
- Involve CMO or CEO in serious or difficult cases.




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Truth

The pure and simple truth is rarely pure and never simple.





- Oscar Wilde



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Follow-up Care of the Patient and Family

- Provide patients with contact information
- Plan a series of follow-up meetings with the patient and family.
- Provide psychological and social support.
- Provide continuing financial support for injury-related expenses, if needed.



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Support of Caregivers



- Establish a program to provide support to caregivers involved in the event.
- Adjust responsibilities and time off for caregivers as needed.
- Provide for structured debriefing and documentation of the event.
- Instruct caregivers in peer review, QA/QI, and root cause processes.



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Training and Education


- Develop a broad array of interactive training methods.
- Provide “just-in-time” training for caregivers.
- Provide expert assistance for caregivers to call after a serious incident.
- Establish a cadre of crisis communication.
- Coach caregivers in communicating with the patient and family.



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In Summary:


➤ Children's Hospitals and Clinics of Minnesota and its professional staff intend to achieve complete, prompt, and truthful disclosure of information and counseling to patients and their parents or legal guardians.





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Truth

Always tell the truth. That way, you don't have to remember what you said.





- Mark Twain



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THANK YOU

Phil.kibort@childrensmn.org



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Comments and Questions

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this presentation!*



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the CME Eval button below
and complete the form.*

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2009 June

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Box 1. The seven Ws of disclosure

Why disclose?

- To preserve patient autonomy and patient-physician trust
- Because ethically it is the right thing to do

Who should disclose?

- Health care worker with whom the patient has a trusting relationship, usually the responsible physician
- Others involved in the incident (eg, nurse, pharmacist may be included)
- If the physician cannot disclose, another health care worker with an established relationship with the patient or a member of the hospital leadership or quality and safety program should do the disclosure.
- A senior hospital administrator may need to be involved in serious cases.
- The patient's primary nurse should be included in the discussions to be able to support the patient after the disclosure has occurred.

To whom should the communication be made?

- To the patient
- If this is not possible, to family members or substitute decision makers

What types of events should be communicated?

- Any incident that has resulted in harm to the patient
- Other incidents at the discretion of the responsible physician

What information should be communicated?

- Acknowledge that the event occurred and give the facts.
- Take responsibility and apologize.
- Commit to finding out why.
- Explain what impact the event will have on the patient now and in the future.
- Describe steps being taken to mitigate the effects of the injury.
- Describe steps being taken to prevent a recurrence.

When should communication take place?

- As soon as the event is recognized and the patient is physically and emotionally capable
- Ideally within 24 hours after the event is recognized
- Ongoing communication will be required as more information becomes available and should be led by the responsible physician or delegate.

Where should the communication take place?

- In a private and quiet area

HATLOW et al
Peds (N.A.) 53(2006) 1091-1104