Aftermath of an adverse event: supporting health care professionals to meet patient expectations through open disclosure

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An important element of how adverse events are handled is effective communication between health care providers and patients and their families. This review addresses the main questions: What do patients expect in the aftermath of an adverse event? What is known about the practice of open disclosure? How can organizations support health care providers in the aftermath of an adverse event, both professionally and personally?

Patients clearly expect open disclosure to include an explanation of what happened, an apology for harm done, that appropriate remedial action will be taken and an explanation of what will be done to learn from the event and to prevent recurrence.

Research has found that open disclosure is not very common although the ethical duty to disclose is widely acknowledged. Barriers to open disclosure include discomfort and a lack of training how to disclose, a fear of litigation, a culture of infallibility among health professionals, and inadequate systems for analysis, discussion and learning from mistakes.

Significant commitment is required from health care organizations and managers to develop frameworks for open disclosure to occur, to assure its quality and to support health care providers in this process. Organizations also need to address the emotional needs of health care professionals in the aftermath of an adverse event. Last but not least, adequate systems for debriefing and incident analysis need to be in place to learn from adverse events and to avoid recurrence.

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Sooner or later most health care providers will be confronted with an adverse event, that is, a deviation from the expected course with the potential for an adverse outcome (1). The event itself and the consequences are stressful for patients and family members as well as for the health care team. The existing literature suggests that open disclosure plays an important role in how well patients and their families as well as health care providers can cope with adverse events in the course of patient care (2, 3). Open disclosure can be defined as the open and timely communication about adverse events to keep patients and family members informed and to avoid recurrence. Open disclosure does not equate with an admission of liability and does not attach blame. It ideally includes: (a) an explanation of the adverse event, potential consequences and appropriate remedial action, (b) an apology, and (c) information as to what will be done to avoid recurrences.

Despite the growing acceptance of the ethical obligation to disclose adverse events, evidence suggests that open disclosure may be uncommon. Many health care providers wonder if they should tell patients about a minor adverse event if there is no lasting harm, if the problem can easily be resolved, and if they feel that disclosure might damage their relationship with the patient. However, research from various areas within health care shows that patients do not want to be ‘protected’ in this way.

What do patients expect in the aftermath of an adverse event?

The expectations of patients and family members after an adverse event have been investigated across health care domains focusing on patients’ attitudes towards disclosure of adverse events and their reasons for taking legal actions (3–6). Research clearly shows that open disclosure after an adverse event is
crucial from the perspective of patients and their families.

Results of a scenario-based survey of 149 internal medicine patients (6) show that almost all respondents (98%) expect an active acknowledgement of an adverse event, regardless of its severity. Moreover, the likelihood of litigation increased with a lack of information and acknowledgement by clinicians as well as with the severity of the adverse event.

A recent study surveying 958 adults showed that non-disclosure was associated with lower patient satisfaction, less trust in the physician, and a stronger negative emotional response. Whether a patient seeks legal advice depends on the type of error, the severity of outcome, and the level of disclosure (5).

In a survey of patients and relatives taking legal action (3), 70% of the 227 respondents were seriously affected by the adverse event (physically, financially, and/or socially). Four main reasons for litigation were identified: accountability, explanation, standards of care, and compensation. The authors conclude that although in some cases the need for compensation may be the main reason for litigation, the desire for a full explanation was a major motivation.

In sum, research provides empiric evidence for the following:

- Patients expect open disclosure: Patients and their families need an explanation of what happened and what to expect—besides expression of regret and an apology when appropriate. Uncertainty itself is disturbing and painful, and silence has been interpreted by some patients and families as hiding information, attempting a cover-up (4) or as a lack of respect and compassion. Anything less than open disclosure is likely to undermine the patient–physician relationship (7).
- Patients expect learning from adverse events and prevention: Patients want to make sure that similar events will be less likely in the future (3). People who have lost loved ones in an accident ruminate about its causes and possible prevention (8). They have a need for information about changes and efforts to prevent recurrence such as incident analysis, and for ongoing support concerning the physical, psychological, social, and financial consequences of an adverse event.
- Open disclosure is associated with fewer lawsuits: Research shows that disclosure might help to prevent legal consequences under some circumstances (3, 4, 9, 10). Once an adverse event has occurred, all the factors influencing the likelihood for legal consequences only the level of disclosure can directly be influenced by health care providers.

What is known about the practice of open disclosure?

The ethical duty to respect a patient’s autonomy and to disclose unintended outcomes is widely acknowledged (11–13). Societal expectations towards disclosure have recently changed dramatically due to an increased public awareness of adverse events and medical error. Research shows that although some clinicians have been disclosing adverse events this has not necessarily happened as consistently or completely as patients expect (14). In a survey comparing the views of physicians (n = 831) and the public (n = 1207), for example, only a third of the respondents in both groups who had experienced an adverse event in their own care or that of a family member reported that the physician involved told them about it or apologized to them (14). A survey of patients and relatives showed that no explanation was given to patients or relatives in 37% of the adverse events (3), and in another study the 114 responding house officers reported a discussion with the patient or family in only 24% of adverse events (15). The willingness of physicians to disclose adverse events decreases as the severity of the outcome increases (16).

Barriers to open disclosure

Discomfort and lack of training

Giving patients and their family bad news, to explain what contributed to the situation and to communicate the uncertainty that accompanies many adverse events is difficult. Most practitioners experience discomfort and want to avoid this stressful experience. Two thirds of ER trainees prolonged CPR efforts to delay telling parents that their child had died (17). When talking to patients and family members after an adverse event, health care professionals sometimes experience fear of unleashing an emotional reaction (e.g. anger, grief, being blamed) (18). The communication of bad news is particularly difficult for medical professions where contact with the patient is brief and lacks the benefits of an ongoing professional relationship (e.g. anesthesia or emergency medicine).

The difficulties can in part be attributed to a lack of knowledge and training how to approach this situation. Integration of disclosure training into
medical curricula is by no means universal in training programs (19, 20). Less than 15% of the surveyed emergency medicine providers had received disclosure education (21) and the communication of bad news appears to be rarely modelled by attending physicians (22).

**Lack of knowledge about patient expectations**

In a recent survey of 182 patients, 291 physicians, and 346 nurses in Denmark, significant differences existed between patients’ expectations and physicians’ perspectives of their patients’ expectations in most aspects (23). Nurses matched the expectations of patients more closely but both professional groups assigned less weight to the importance of accountability and lessons learned for the benefit of future patients than did the patients. Another survey, comparing the views of 302 patients and 48 ophthalmologists of informing patients after unintended injury during treatment showed that the patients expected more detailed information after an adverse event than the doctors believed should be given (24). Using focus groups to investigate the attitudes of patients and physicians regarding the disclosure of medical errors, Gallagher et al. showed that patients expected disclosure and an apology (25). The participating physicians, however, stated that words should be chosen carefully when disclosing adverse events and were concerned that an apology might create legal liability.

**Fear of litigation**

Existing literature points out a huge disconnection between the humane perspective on the situation of patients and families and the legalistic perspective of risk managers (26). A survey of risk managers in a randomized sample of 245 US hospitals showed that disclosure is less likely in hospitals concerned about malpractice and in case of preventable harm (10). Risk managers sometimes advise health care professionals not to talk to patients and families after an adverse event (27). Ironically, people sometimes take legal action because they could not get answers to their questions any other way (3, 9, 28)! Not disclosing adverse events may be an important contributor to patient dissatisfaction and resulting litigation, and in case of a lawsuit, failure to disclose may place the physician in greater jeopardy.

**Organizational culture**

Failure to disclose is a systemic problem, as some barriers to disclosure indicate. The culture of infallibility in health care does not encourage the honesty needed for open communication about adverse events (29). Health care professionals often experience little support from colleagues and supervisors. On the contrary they often face sanctions or disapproval from senior management. Many hospitals still react to adverse events such as anomalies and attach blame to the health care professionals involved (30). This approach has diverted attention from the system-wide improvements that have the potential to decrease error.

**How can organizations support health care professionals in the aftermath of an adverse event?**

On an organizational level, the main hindrances to open disclosure are a lack of commitment and support from health care institutions as well as inadequate systems for analysis, discussion and learning from adverse events. Hospital leaders and board members play a central role by helping to develop a culture where there is open communication about adverse events and respect for the patient. Health care organizations should address the professional and emotional needs of health care professionals involved in adverse events by establishing guidelines for the management of the immediate aftermath of an adverse event, implementing open disclosure policies, training health care professionals how to disclose, and providing adequate systems for debriefing and incident analysis.

**Managing the aftermath of an adverse event**

The first and foremost goal is the continuation of patient care. For anesthesia, it is recommended that initially the same team provides patient care. If there is a supervising anesthetist or an event manager, this person should be informed as soon as possible (31). The complex decisions in the immediate aftermath of an adverse event may require an experienced clinician and will be affected by the emotional impact that an adverse event has on the practitioners. If feasible, an experienced anesthetist should take on the responsibility to develop and oversee a care strategy. A transfer of management responsibility to a more experienced person is very well accepted among anesthetists (32). In other high-risk industries such as fire fighting or aviation guidelines for the transfer of management responsibility to a senior person in an emergency
have been developed based on incident and accident analyses (33).

Health care organizations should share the responsibility for managing an adverse event by establishing guidelines for clinicians and other hospital staff that define responsibilities, communication ways, and decision processes. One example for guidelines that specify immediate actions, follow-up investigations, and responsibilities in the management of an adverse event are the Administrative Guidelines for Response to an Adverse Anesthesia Event that have been approved by Harvard Medical School (31). Recommendations include that each involved team member writes a detailed narrative as soon as possible after the adverse event, and that all drugs, equipment, and supplies should be sequestered for further investigation (31).

Disclosure policies and guidelines

Decisions about disclosure are a crucial component of the response to an adverse event. Some national standards now require that patients be informed about adverse events in their care (13, 34). The individual health care provider should not be solely responsible for disclosure but should be supported by an experienced institutional body. There is a need for adequate systems to support the process of disclosure, to monitor its occurrence, and to assure its quality. Disclosure policies and guidelines can support health care providers and increase public confidence (35). Results of a survey showed that most surveyed hospitals had a disclosure policy in place (36%) or under development (44%) (10). These policies have to be adapted to the national legal framework and the local practice. Each department has its own needs and requirements which have to be coordinated with the disclosure guidelines of different disciplines to make this a truly interdisciplinary process. Ideally a consultant of each specialty involved in an adverse event should attend the meeting with patients and family members to provide optimal information and make unjustified accusations less likely (20). If appropriate a chaplain or social worker should join the team to provide adequate support to the patient or their family (36).

Education and training

Even under ideal circumstances, disclosure is difficult and stressful. Health care professionals need training in what to say and do when disclosing an adverse event and how to deal with reactions of patients and family members. Learning what patients expect and find most important in the aftermath of an adverse event (18, 37, 38), communication skills in breaking bad news, attitudes towards adverse events and disclosure, self-awareness, and cultural variations are all important teaching points (19). In most training programs, role-playing or simulation is a key part. The Program to Enhance Relational and Communication Skills (PERCS) at the Children’s Hospital Boston offers training courses on communication in critical care situations using teaching methods such as lectures, short films, and role-play experience during which professional actors portray patients and family members. Each role play is followed by a debriefing in a multidisciplinary team (39). Within anesthesia the breaking of bad news was integrated into a mandatory simulator curriculum (40). During the ‘death scenario’ participants experience the death of an otherwise healthy (simulated) patient during general anesthesia. Participants do not know in advance that the patient will die despite their best efforts, nor that the scenario will continue with a role-playing experience with a family member after the patient is pronounced dead. The fact that participants have just undergone a very intense clinical simulation intensifies the learning experience. However, the general principles taught are also applicable to less severe events. Questionnaire data evaluating this component of the simulator curriculum have been very positive (40).

Support for health care professionals

Health care providers are often unsure where to seek support after an adverse event (25). They need 24-h access to resources that facilitate the process of disclosure. Equally important is providing emotional and psychological support for the practitioners involved. The better the support for the caregivers the better they can meet the needs of the patient and family members. Therefore, health care organizations should support the emotional needs of practitioners as an integral component of debriefing and incident analysis.

The few studies focusing on the emotional impact of adverse events on health care providers show that physicians and nurses clearly experience negative emotional responses and psychological distress (41–44). Factors such as prior beliefs about adverse event causation or attitudes such as infallibility might increase these effects. Common coping strategies involve denial of responsibility, discounting
of importance, and emotional distancing (42). It appears that few health care professionals discuss adverse events with colleagues despite an expressed need for professional reaffirmation, validation, and support (15, 45). Open discussion is likely to mitigate psychological distress and can be a relief for health-care professionals. A system that values stories and story-telling is potentially more reliable because people know more about their system, know more of the potential errors that might occur, and they are more confident that they can handle these errors because they know others have handled similar errors’ (46). Without open communication and adequate debriefing after an adverse event, feelings of incompetence and isolation and psychological distress such as depression or even symptoms of post-traumatic-stress-disorder, such as sleep disturbance, nightmares, irritability and problems concentrating, which may even lead to inability to work are far more likely. Not everyone will have the same needs after an adverse event and given the growing body of research that challenges the efficacy of single-session psychological interventions such as critical incident stress debriefing (47–49), such psychological debriefing should by no means be compulsory. However, as part of the organizational response to an adverse event a team debriefing should be offered to all health care personnel involved in an adverse event. The team debriefing led by an experienced consultant should be initiated as soon as possible after an adverse event and should take place in a calm atmosphere with no time pressure. The main function of such a team debriefing is to further open communication about adverse events and to provide information about organizational support and resources among which individuals can choose. The team debriefing must be confidential and must focus on ‘what’ happened instead of ‘who’ did what, maintaining open communication and avoiding blame. Every team member should have the possibility to speak up, raise questions and show emotions. At the end of the team debriefing, further steps should be discussed and team members should be assured that they can bring up questions or problems at any time (20).

Learning from adverse events

Without a culture that supports open communication and systems that facilitate debriefing and provide a systematic approach to incident recording and analysis (50, 51) there will be little or no learning from adverse events. Therefore, the process of analyzing the event systematically from a systems perspective is crucial to the effective management of an adverse event (52–55). As far as possible considering the legal framework of where the incident took place, this analysis has to be confidential and there has to be feedback to the patient, the health care providers involved in the adverse event, the hospital, and other institutions if appropriate. Although determining the cause of an adverse event is important in its analysis, the final goal is prevention of future adverse events from a systems perspective.

Conclusion

The medical literature is unambiguous with regard to the ethical duty to disclose. As stated by the American College of Physicians ‘Errors do not necessarily constitute improper, negligent, or unethical behavior, but failure to disclose them may’ (11). The management of the aftermath of an adverse event should be central to any patient safety strategy and medical organizations should promote such activities. A safer health care system needs to include systems that support the patient, family members, and involved health care professionals and allow for active interventions after an adverse event. Medical societies and hospital management play a central role in this process. It is clear from research conducted with patients and family members that there is more at stake than the addition of behavioral skills to the practitioner’s repertoire. There is empiric evidence that a proactive approach to disclosure might decrease the number of lawsuits and mitigate the financial repercussions of adverse events (56, 57). However, it is too soon to determine how well this experience might translate to different health care settings. What we do know is that disclosure keeps the patient informed and can reduce feelings of abandonment and acknowledge suffering. In this area much could be done relatively quickly to reduce suffering and to maintain the trust of patients and families.

References


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