Considerations When Disclosing Adverse Events

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Healthcare professionals pride themselves on achieving high levels of excellence, if not routine near-perfection, in the care they provide. When an adverse event occurs, facing a patient and his or her family members can be challenging, especially when the adverse event resulted from an error. Approaching disclosures of adverse medical events with deliberation can reduce risk for providers and anxiety for patients.

Adverse events are typically described as an unintended injury caused by medical care that necessitates additional treatment or causing a disability at the time of discharge. The disclosure of adverse events has been the subject of ongoing debate within the medical community for decades. To some extent, the debate is influenced by societal and cultural considerations. As our society increasingly expects transparency in various aspects of life, a healthcare provider's failure to disclose an adverse event is likely to be viewed by a jury as, at best, secretive, and, at worst, deceptive. In some cases, a patient may claim that a physician's failure to disclose an adverse event was an attempt to conceal what happened. An allegation of fraudulent concealment - if proven - could result in the imposition of punitive damages and eviscerate noneconomic damage caps.

Some adverse events are preventable; others are not, even when the treatment provided was within or exceeded the standard care. While other considerations surround discussions with patients about unexpected outcomes that do not result in an injury, physicians should be prepared to discuss an adverse event—particularly one that could have been prevented—with a patient and his or her family. In these situations, physicians should be mindful of AMA Code of Medical Ethics Opinions on Patient Safety 8.12, which states in part:

It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients. Patients have a right to know their past and present medical status and to be free of any mistaken beliefs concerning their conditions. Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician's mistake or judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred. Only through full disclosure is a patient able to make informed decisions regarding future medical care.

When confronted with an adverse event, physicians should be aware of the benefits and

risks of discussions about these occurrences and be thoughtful in how these discussions should occur with patients and their families.

Perhaps chief among the benefits of open dialogue with patients and their families about an adverse event is fostering trust. While conversations regarding an adverse event can be challenging, patients may feel shut out or discouraged by a lack of communication. A frustrated patient may believe that the only avenue to obtain the information sought is through the discovery process in litigation. In some cases, post-event discussions will satisfy a patient's desire for information. Even in instances where a patient proceeds with a lawsuit after an adverse event disclosure, these conversations allow providers to disclose, on their terms, before suit is filed and while memories are still relatively fresh, the same information which is likely to be uncovered in subsequent litigation. Additionally, a patient or family member that is inclined to pursue a lawsuit as a result of an adverse event is likely to do so regardless of whether information about the adverse event is disclosed. A physician who is forthcoming with facts at the time of an adverse event may be viewed more favorably by a jury in contrast to a physician perceived as having information he or she conceals from a patient.

When discussing adverse events with patients, it is important that the provider is clear about the facts surrounding what happened. This is particularly a concern when an investigation is ongoing at the time of the discussion, and all of the facts have not been ascertained. There is also the risk of disclosing information that may be protected by attorney-client privilege or quality improvement committee privilege. Appropriate training may help mitigate this risk. The reality is that the majority of patients experiencing an unexpected result do not file a lawsuit, even when negligent care is suspected to be the cause of the adverse outcome. However, there is an inherent risk that discussing an adverse event may be perceived by a potential plaintiff as a concession of guilt to professional negligence. While some strategies can be employed to reduce this risk, patients' perceptions of an admission of liability by the disclosing provider may be difficult to avoid, particularly when the adverse event could have been prevented.

Providers and healthcare organizations must engage in discussions with patients regarding adverse events in a thoughtful manner. Organizations should determine who will communicate with the patient and his or her family and establish a procedure for initiating these discussions. While there may be apparent benefits of the treating physician communicating with the family, the familiarity of the physician may be outweighed by the physician's inability to communicate effectively following an adverse event. If a patient has been unsatisfied with the care he or she received even before the adverse event, the physician may not be the best communicator in that situation. The physician should be present for the discussion, but it may be advisable for someone else, such as a risk manager or practice administrator, to do most of the talking. In contrast, if the patient has had a long and satisfactory relationship with a physician, the one-on-one interaction directly with the physician may be beneficial.

Facts concerning the event must be accurately and concisely stated in terms the patient

can understand and, to the extent possible, the patient's understanding of the facts should be confirmed. If facts are unestablished or under investigation, any discussions regarding such circumstances should be clearly qualified that the information is unconfirmed and subject to further investigation. If remedial measures are discussed with the patient, care should be given not to exaggerate or overpromise what has been done or will be done to prevent similar incidents from occurring in the future.

Anyone communicating with the patient should have a clear understanding that liability should not be conceded during a discussion about an adverse event. It can be difficult however for both providers and patients to distinguish between statements communicating empathy, support and interest in the patient's well-being and statements expressing regret for why something has happened. Clear and thoughtful words conveying these often delicate messages must be used. For example, contrast "We are all hoping for a better outcome here and I am going to do what I can to the patient back on the track to a full recovery" with "This result should not have happened. It was a mistake because of my oversight." It is advisable to consult with your professional liability insurance company and perhaps legal counsel before having a discussion with a patient or his or her family about an adverse event. If compensation to a patient is an appropriate consideration following an adverse event, such an offer should only be made following such consultation.

Those involved with the discussion should remember that the conversation may not remain private between the parties present. Statements made during the conversation may be shared with other friends and family members or even on social media posts. The conversation should be documented by the physician, risk manager, or administrator in objective terms. Any care-related aspects of the discussion should be documented in the medical record. If any memorandum memorializing the discussion is made separately outside of the medical record, maintaining objectivity and reciting the discussion accurately, without including implications or unstated impressions, is important, as the document may be discoverable in litigation. Consultation with legal counsel may be helpful in properly documenting the discussion regarding the adverse event.

While beyond the scope of this article, yet intrinsically related to the topic of adverse event disclosures, healthcare providers must be familiar with their administrative and, in some cases, legal duties to report sentinel events and other adverse occurrences within their organization. Providers should be aware of what constitutes a reportable incident for the organization and the provider's obligation to promptly report such an occurrence. Healthcare organizations should provide recurring training and periodic reminders on procedures and expectations for reporting events, including identifying whom within the organization should be the first point of contact for such reports.

Whether reasonably preventable or not, adverse events are unavoidable in medicine. When handled correctly, disclosures of adverse events provide physicians an opportunity to foster trust with patients through transparency and a chance to explain, largely on the physician's own terms, these inevitably difficult situations.

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attorney for legal advice, as specific legal requirements may vary from state to state and/or change over time.