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Cultivating Relational Competence in Healthcare

Coaching for Disclosure after an Adverse Event

At the time the coach is notified of an adverse event…

☐ **Assure that the clinicians stay fully attentive to the medical needs of the patient.**
Clinicians may withdraw from the patient's clinical needs, fearful of the patient's anger and/or preoccupied with the implications of the event for themselves.

☐ **Assure that key individuals are notified and involved as soon as possible, including the attending physician and the hospital risk manager.**
Contact information can be found in the PPD http://ppd.partners.org. Also consider whether hospital leadership, such as department chiefs or the CMO, should be notified.

☐ **If the adverse event involved medical equipment or devices, assure that these have been sequestered for later investigation.**
Additional information can be found at Current MGH Policy (2) 5_5_2008.doc (Section 5.1) Responding to Adverse Events 4 12 (Part 3).

☐ **Determine if the adverse event meets the threshold requiring disclosure.**
A useful rule-of-thumb is that an event should be disclosed if 1) You would want to know about the event, if it had happened to you or a relative, or 2) It may result in a change in treatment, now or in the future.

Initial Intake

☐ **Gather information about the event from all the clinicians involved.**
Sometimes this is most efficiently accomplished with a small team meeting or "huddle," while sometimes a phone call may be sufficient.

☐ **Assess the psychological and emotional needs of those involved.**
Emphasize that feelings of anxiety, anger, and shame are normal and to be expected. Reassure the clinicians that they will have access to support without implying that this is because they are not coping well or not able to "handle" the situation. Additional resources can be found at http://www.mitss.org/ LEND_Patient-Family Support.pdf

☐ **Determine which clinicians should be present for the initial conversation**
Consider their level of involvement in the event, their emotional state, and their capacity to make a positive contribution. Consider involving clinical leaders, like division chiefs or nurse managers. The hospital risk manager or others who are not clinically involved should usually not participate in this initial meeting.

Prepare the Team for the Conversation with the Family

☐ **Determine an optimal time and setting for the conversation.**
Initial conversations should occur as soon as possible after the event, usually within a few hours and almost always within a day. Find a quiet location where everyone can be seated, and remind clinicians to have their pagers turned off or covered by others during the conversation.

☐ **Decide who should lead the conversation.**
In most cases, this should be the attending physician, even when the situation is one in which he/she was not directly involved.

☐ **Decide who will take primary responsibility for following up, so that this can be communicated unambiguously to the family.**
Follow up is critical, as it is a chance for the clinicians to begin to restore trust and confidence in the hospital and the providers.

☐ **Assess who should be present for support of the patient and family.**
Determine whether it would be helpful to have chaplains, friends, or other family members present. If English is not the patient's primary language, an interpreter is essential.

☐ **Discuss with the team how the patient's culture, health literacy, disabilities, and level of sedation may impact the conversation.**
Remind the team to speak slowly and avoid jargon, while being careful not to "talk down" to the patient. Prepare the team for a wide range of reactions, such as anger, tears, sarcasm, and denial. If violence is a possibility, have security personnel nearby.

☐ **Remind the team that the purpose of this conversation is solely for the benefit of the patient and family.**
Discuss the need to present themselves as a unified team. Contract with the participants that they will not engage in blaming or debate about the event during this conversation. "I know how difficult this is for everyone, that there are lots of strong feelings, but the purpose of this meeting is to support the patient and family, not to iron out all of the facts or disagreements of this case."

Content of the Conversation

☐ **Above all, encourage the clinicians to express themselves as compassionate and caring human beings.**
Everyone has interpersonal strengths and weaknesses. Help the clinicians to recognize their strengths and to build on that foundation.

☐ **Apply the "Golden Rule": What would you want to be told if you were the patient?**

☐ **Acknowledge and convey empathy for the patient and family's suffering.**
"We are so sorry that this has happened," "This must be a nightmare for you," "I can't imagine how hard this must be for you."

☐ **Set the agenda for the meeting.**
The patient and family may not know why everyone is coming to talk with them, explain the purpose of the meeting.

☐ **Clearly state the facts as they are known at the present.**
There is no legal risk to disclosing the facts as they are known at the moment. Be careful, however, not to speculate beyond the facts, because initial impressions about how the facts "fit together" are usually incomplete and sometimes completely wrong.

☐ **In some cases, disclosure of the facts may not be of immediate benefit to the patient and may be psychologically harmful.**
Non-disclosure requires a high level of justification, and should not be used simply to avoid difficult conversations. In almost all cases, the clinicians should be committed to disclosure as soon as the patient and family are capable of having the conversation.

- ☐ **Discuss the appropriate form and content of expressions of apology and regret.**
  Expressions of regret and empathy for what the patient is experiencing are always appropriate. Expressions of personal or institutional responsibility for the adverse event should only be made when the facts clearly indicate that the adverse event was an avoidable consequence of a medical error.
- ☐ **Explain what has been done to care for the patient and the current plans for care going forward.**
- ☐ **Assure the patient and family that the event will be thoroughly investigated, and that all facts will be communicated as they become known.**
  If the investigation reveals that mistakes were made, assure the patient that steps will be taken to prevent similar adverse events in the future. If the patient asks about financial compensation, explain that someone who is qualified and authorized to address this issue will follow up with them.
- ☐ **Offer support services – chaplains, social workers, patient advocates**
- ☐ **Clearly identify who will be following up with them, and when.**
- ☐ **Close with sincere expressions of support, sympathy, and concern.**

Documentation and Follow-up

- ☐ **Whenever possible, have a post-conversation huddle to debrief the event.**
  Again, the coach should assess the emotional and psychological needs of the clinicians, reassure them that these responses are normal and expected, and arrange for temporary relief from clinical duties or follow-up, as appropriate.
- ☐ **Assure follow-up for clinicians impacted by the event**
  The variants of human response to stressful events (and the choice of helpful responses to them) are vast. Events such as these will have an significant impact. In the great majority of cases these reactions should be managed individually, quietly and in a healthy and safe way. Nevertheless, vigilance for (other) possible reactions represents a universal and mandatory "first response". Should behavioral manifestations (or in some cases, the inappropriate absence of manifestation) cause concern, experienced staff should be quickly consulted for advice.
- ☐ **Assess whether the existing clinical relationships can be maintained, or whether care needs to be transitioned to alternative providers.**
  Consider whether trust with the existing care team can be supported and maintained by involvement of additional subspecialists or by requests for second opinions.
- ☐ **Assure that the clinicians document in the medical record.**
  This should include a summary of the facts surrounding the adverse event, a synopsis of the initial conversation (including a list of those present), and a description of the care provided and current plans for care going forward.
- ☐ **Advice from the coach should not be documented in the medical record.**
  The chart is for communication about the patient's treatment. The purpose of the coaching session is to provide support to the staff.
- ☐ **Enter the incident into the hospital Event Reporting System, if appropriate.**
  http://safetyreporting-mgh.partners.org/riskweb3.dll

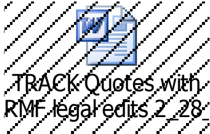
- ☐ **Activate mechanism to hold the medical bills.**

Additional Resources

- ☐ **CRICO/RMF Affirmation Statement, White Paper, and Powerpoint on Disclosure**

- ☐ **Partner's & MGH Policies on Disclosure**

- ☐ **The TRACK Model on Coaching for Disclosure**



- ☐ **Annotated Bibliography on Disclosure of Adverse Events & Medical Error, with selected articles**

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- ☐ **"When Things Go Wrong"**

Document: This document was developed by a group of risk managers and clinicians from several Harvard teaching hospitals, the School of Public Health, the Risk Management Foundation (Malpractice Captive for the Harvard Teaching Institutions), patients, and legal representatives. The concepts and principles are supported by all of the Harvard teaching hospitals and are to be used in the development of specific policies and practices to implement the recommendations.

WhenThingsGoWrong_Brochure_MACoalit

Video: This frank and moving film features eight patients and their families sharing the impacts of medical error on their lives. Their searing insights offer ideas for improving the healthcare system and patient/provider communication. The patient's perspective, in this unique format, is a rare and compelling gift. This educational DVD package includes the feature film (26 minutes) created by Tom Delbanco, MD and Tom Augello, CRICO/RMF; six theme-based vignettes; five patient narratives; A Guide for Learners and Facilitators; and an annotated bibliography. Dr. Delbanco is the Koplow–Tullis Professor of General Medicine and Primary Care at Harvard Medical School and a physician in the Division of General Medicine and Primary Care at Beth Israel Deaconess Medical Center. For more information regarding this DVD, please go to: http://www.rmf.harvard.edu/education-interventions/films/when-things-go-wrong/index.aspx

- ☐ **"Sued: The Physician's Journey"**

This film offers viewers a unique insight into the lawsuit experience. In addition to the main 19-minute feature, the DVD offers additional content that can serve as a resource by offering brief "impact statements" from three of the physician defendants, a legal timeline, ways in which defendants can help their own legal defense, and a description of one defendant's subsequent involvement with the patient safety effort. For more information regarding this DVD, please contact your Risk Manager:

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