

Patient Safety Tip of the Week

March 9, 2021

Update: Disclosure and Apology: How to Do It

We’ve come a long way in our responses to medical errors. It’s now widely accepted that disclosure and sincere apology to patients and their families or significant others are the right thing to do following errors that lead to adverse patient outcomes (and even those that do not lead to patient harm).

Ever since we set up our first guidelines on responding to serious incidents in the early 1990’s (see our July 24, 2007 Patient Safety Tip of the Week “[Serious Incident Response Checklist](#)”) we have always included a section in our “[Serious Event Response Checklist](#)” for notifying the patient and/or family that errors had occurred in their care. Yet we continue to see hospitals and physicians struggle with “how do we do it?” even once they have bought into the basic concept.

Physicians have historically been poorly prepared to undertake disclosure and apology. In the past, legal concerns have made physicians reluctant to discuss such errors with patients and families. But even as disclosure and apology and communication and resolution programs have become accepted, many physicians feel awkward in communications with the involved parties.

We did discuss how to undertake such communication back in our June 22, 2010 Patient Safety Tip of the Week “[Disclosure and Apology: How to Do It](#)” and multiple other columns listed at the end of today’s column.

An excellent recent review ([Kaldjian 2020](#)) discusses all the elements necessary to make such conversations productive. These involve respect, compassion, and commitment by providing information, acknowledging harm, and maintaining trust through a process of dialogue that involves multiple conversations.

Kaldjian begins with a succinct summary: “Communication about medical errors with patients and families demonstrates respect, compassion, and commitment to patients and families after an error has occurred by providing information, acknowledging harm, and maintaining trust through a process of dialogue that involves multiple conversations.”

It is especially important that any apology is sincere and honest. It must be delivered with empathy and respect.

Patients and families also want to hear that you will be using lessons learned from the event to **ensure similar errors do not occur in the future** and impact other patients. One of the most important points, from our perspective, is letting them know that you will be having multiple conversations with them, **periodically keeping them up to date** with regards to the status of your investigation and RCA (root cause analysis) and the steps you take to prevent recurrence of such errors.

You also want to let them know about continued care for the patient (assuming it was not a fatal error), what harm the error may have caused, and how what will be done about that harm.

Kaldjian outlines the key elements of a medical error discussion:

1. Prepare for the discussion
2. Provide information
3. Encourage dialogue
4. Appreciate suffering
5. Express regret
6. Accept responsibility
7. Explain the care plan
8. Outline the next steps
9. Promise to improve

We note one important consideration missing from the otherwise excellent Kaldjian review: **the venue for the discussion**. You need to make the patient/family comfortable and encourage them to engage in dialogue. The worst mistake we see is holding the discussion in the board room of a hospital with multiple hospital figures dressed in white coats or suits and ties sitting across from them. That is an intimidating environment and almost immediately puts the family in a defensive posture. We recommend the discussion take place in a small room with comfortable seating and no table or other furniture in the way.

We recommend you keep the number of hospital personnel to a minimum. That should include the clinician providing the disclosure. That is usually the attending physician, though in some cases it may be someone else, such as a medical director or department head. It's good to have one other "hospital" person in the room. That might be a risk manager or the person who will lead the RCA sessions, though it could also be a patient advocate if your organization has such a position. Or it might be a nurse or other healthcare worker who has developed a good rapport with the family. Patients and families often look to that other person for support and clarification. That person also may be more experienced in these discussions and can keep the clinician focused on the key elements of the discussion. And the patient or family may come to that person with questions they are afraid to ask the physician.

One other issue not discussed in the Kaldjian review is the question “**When should you notify the patient and family?**”. In our June 22, 2010 Patient Safety Tip of the Week “[Disclosure and Apology: How to Do It](#)” we recommended that you let the patient/family know about the incident **as soon as possible**. Obviously, you need to know enough about the event or incident to be able to discuss it with them. But sometimes you may not have all the details early on (for example, you may not yet have done your root cause analysis). It is okay to tell them that a serious incident did take place and that your investigation will be taking place within a few days and that you will keep them posted regularly on the status of that investigation. Let them know that you are doing this to help ensure that similar events will be prevented in the future. You need to show honesty, contrition, and empathy in order to build a trusting relationship with that patient or family. If you wait to disclose that an incident occurred, the patient or family is likely to find out about it in other ways, your credibility will suffer, and you will lose the opportunity to develop a rapport with them.

Kaldjian notes that a variety of strategies may be used to help train clinicians for the process: didactic lectures, videos, training-level-appropriate clinical scenarios, discipline-specific considerations, role play (preferably with realistic simulated settings), standardized patients, patient perspectives, and assessment of error disclosure skills. We like using simulations. While some will use actors during the simulations, we prefer that the “actors” be experienced clinicians who have participated in real life disclosure and apology sessions.

When to begin training for disclosure and apology is not clear. We think it should begin in **medical school**, where we need to make it clear that errors will occur and prepare medical students to recognize errors and understand what to do when errors occur. But, we think the most important training should take place **during residency**. The ACGME (Accreditation Council for Graduate Medical Education) has a core requirement for residency programs to incorporate training in error disclosure. It states “Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.” It requires that all residents must receive training in how to disclose adverse events to patients and families. Furthermore, residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated.

We cannot overemphasize the **importance of role models** in this regard. The response to errors is molded by how residents perceive their attendings and mentors respond to errors. Unfortunately, that has not always been productive. When attendings are hesitant to reveal errors to patients and families, residents pick up on that and may adopt similar attitudes toward disclosure. On the other hand, seeing an attending physician be forthright in disclosure and meet with patients or families in a respectful, compassionate manner can positively impact a resident’s attitude toward disclosure and apology.

Borz-Baba et al. ([Borz-Baba 2020](#)) conducted a cross-sectional survey of medical residents in the Yale Primary Care Residency Program, who were working in a

community hospital in an underserved area. They observed that 62.5% of the residents were not familiar with the error-reporting process at their institution. General concerns about disclosing errors were related primarily to negative patient reactions (66.7%). The majority (58.3%) of the trainees' negative psychological experience after an unanticipated outcome resulting in harm has caused increased anxiety about future errors. Residents also expressed concerns about malpractice litigation, professional discipline, and harm to professional reputation.

While a majority of the residents were hypothetically familiar with the steps necessary to disclose medical errors, none had undergone training in disclosure. There is a gap between the hypothetical attitude and real practice. Their hospital did have in place a policy for disclosure of the outcome of care but there was no formal process that clarifies what information the patient communication should contain. The authors state this reveals the “need for a more comprehensive program that addresses the pre-disclosure action plan, the content of the error disclosure, and the techniques to be adopted for delivering a well-formulated message”.

Borz-Baba et al. recommend the implementation of both lecture-based educational strategies and simulated patient-training sessions. The lecture-based educational sessions would include an e-learning session that will review the definition and types of errors, the disclosure conversation process, and disclosure content. This would be mandatory for all medical residents in the first year of training. Yearly conferences would revisit the reporting system used at their institution and a practice session with core teaching to promote a positive role-modeling approach. They would also present and discuss the pre-disclosure and post-disclosure support system developed with the participation of risk management. The standardized patient-simulation session would briefly review the content of the disclosure discussion and the message errors to avoid. This would be followed by actual practice, reflection on the discussion, and feedback sessions on the performance. Simulation of real-life experience would allow trainees to become more confident with the conversation flow and prepare them to embrace an attitude or style that emphasizes preserving a trustworthy patient-doctor rapport.

Our June 22, 2010 Patient Safety Tip of the Week “[Disclosure and Apology: How to Do It](#)” included examples from the Harvard and Canadian guidelines (listed below) of the types of words and phrases that should and shouldn't be used in communicating with patients and families after a medical error has occurred.

We always remind all of the old adage “90% of communication is non-verbal”. That point should be included in all your simulations and other training activities on disclosure and apology. The critical importance of “**body language**” in fostering trust during these discussion with patients and families cannot be overstated. So, it is important in critiquing simulation exercises that attention to body language is as important as attending to the words actually spoken.

Having real patients or families who have experienced a medical error discuss their experience is very useful. We can usually find families who have had a positive

experience willing to speak to students or residents. But we can probably learn even more from those families whose experience with the process was unsatisfactory.

The **organizational culture** is equally important. We've seen too many organizations dominated by attorneys whose attitude has been "say as little as possible". Fortunately, the literature over the past 2 decades has shown that disclosure and apology has resulted in less litigation expenses and settlements, while maintaining the trust of patients and families.

In fact, that **trust** is far more important than the direct financial issues resulting from adverse medical incidents. Prentice and colleagues studied the long-term impact after a medical error and its relationship to how openly healthcare providers communicate ([Prentice 2020](#)). They did a survey in Massachusetts assessing experience with medical error and re-contacted respondents several years later and assessed "open communication" with six questions assessing different communication elements. Of respondents self-reporting a medical error 3–6 years previously, 51% reported at least one current emotional impact; 57% reported avoiding doctor/facilities involved in error; 67% reported loss of trust. Open communication varied: 34% reported no communication and 24% reported ≥ 5 elements. Respondents reporting the most open communication had significantly lower odds of persisting sadness (OR=0.17), depression (OR=0.16) or feeling abandoned or betrayed (OR=0.10) compared with respondents reporting no communication. **Open communication** significantly predicted less doctor/facility avoidance, but was not associated with medical care avoidance or healthcare trust.

Our many prior columns have also discussed the trend toward using "communication-and-resolution" programs (CRP's). After an initial flurry of positive reports on the success of communication-and-resolution programs, other reports did not paint as rosy a picture. Mello and colleagues ([Mello 2020](#)) did a comprehensive review of the factors contributing to success of these programs. They found facilitators of success:

- the support of top institutional leaders
- heavy investments in educating physicians about the program
- active cultivation of the relationship between hospital risk managers and representatives from the liability insurer
- the use of formal decision protocols
- effective oversight by full-time project managers
- collaborative group implementation
- small institutional size

Gallagher et al. ([Gallagher 2020](#)) make a point we thoroughly agree with: trying to "market" CRP programs by highlighting potential fiscal savings is not likely to be productive. They state "Honesty, transparency and an overriding urgency to improve the safety of clinical care represent goals with intrinsic value and resonate with patients, caregivers and healthcare organizations alike. When those goals and values, not dollars, sit at the center of an organization's efforts, it is far more likely that an authentic CRP will take hold." We couldn't agree more. We do disclosure and apology because "it's the

right thing to do”. If you are contemplating developing a CRP program, keep your core values as the main impetus.

Equally important is organizational training to recognize what clinicians involved in medical errors (the “**second victims**”) go through. All too often those clinicians, already riddled with guilt, become isolated or even ostracized because of lack of support from their colleagues, peers, and organization. Incorporating into the training on disclosure comments from such “second victims” can be very beneficial when it demonstrates how clinicians felt better about themselves after successful disclosure and apology.

We always seem to be talking about hospitals in our discussion on medical error disclosure and apology. Kaldjian is quick to point out that medical errors occur in all venues of care, not just inpatient care. So, it is equally important to take into consideration how to prepare for and handle such discussion when they occur in **outpatient settings and other venues**. And all specialties must adopt disclosure and apology approaches, even those in which the opportunity to develop a rapport with the patient is less likely, such as pathology and radiology. Brown et al. published an excellent review of the barriers involved in radiology error disclosure and steps that need to be taken to get the issue into the mainstream of radiology practice ([Brown 2019](#)).

How is your organization ensuring that your physicians are properly prepared for communicating with patients and families after a medical error?

Some of our prior columns on Disclosure & Apology:

July 24, 2007	“Serious Incident Response Checklist”
June 16, 2009	“Disclosing Errors That Affect Multiple Patients”
June 22, 2010	“Disclosure and Apology: How to Do It”
September 2010	“Followup to Our Disclosure and Apology Tip of the Week”
November 2010	“IHI: Respectful Management of Serious Clinical Adverse Events”
April 2012	“Error Disclosure by Surgeons”
June 2012	“Oregon Adverse Event Disclosure Guide”
December 17, 2013	“The Second Victim”
July 14, 2015	“NPSF’s RCA2 Guidelines”
June 2016	“Disclosure and Apology: The CANDOR Toolkit”
August 9, 2016	“More on the Second Victim”
January 3, 2017	“What’s Happening to “I’m Sorry”?”
October 2017	“More Support for Disclosure and Apology”
April 2018	“More Support for Communication and Resolution Programs”
August 13, 2019	“Betsy Lehman Center Report on Medical Error”
September 2019	“Leapfrog’s Never Events Policy”

Other very valuable resources on disclosure and apology:

- IHI’s “Respectful Management of Serious Clinical Adverse Events” ([Conway 2010](#))
- The Canadian Disclosure Guidelines ([Canadian Patient Safety Institute 2008](#))
- The Harvard Disclosure Guidelines ([Massachusetts Coalition for the Prevention of Medical Errors 2006](#))
- The ACPE Toolkit ([American College of Physician Executives](#))
- Oregon Patient Safety Commission [Oregon Adverse Event Disclosure Guide](#).

Some of our prior columns on “the second victim”:

- December 17, 2013 “[The Second Victim](#)”
- July 14, 2015 “[NPSF’s RCA2 Guidelines](#)”
- June 2016 “[Disclosure and Apology: The CANDOR Toolkit](#)”
- August 9, 2016 “[More on the Second Victim](#)”
- August 2017 “[ROI for a Second Victim Program](#)”
- April 2018 “[Joint Commission and the Second Victim](#)”

References:

Our “Serious Event Response Checklist”

https://patientsafetysolutions.com/docs/Serious_Event_Response_Checklist.htm

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