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Serious Event Disclosure Policy

*Wentworth-Douglass Hospital
Dover, New Hampshire, USA*

This policy developed by Wentworth-Douglass Hospital assists staff in disclosing serious events to patients and families, and provides a standardized mechanism to identify, report, and resolve such events to improve patient safety.

Directions

Use this policy as a reference when developing or modifying policies about disclosure of serious events in your own organization.

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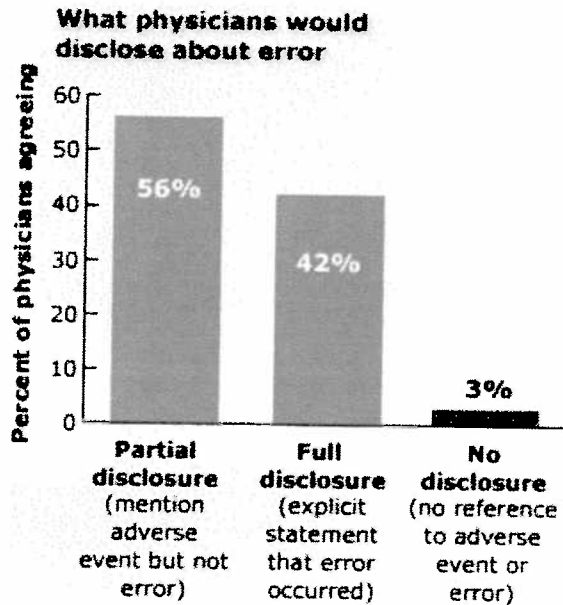
Patient Disclosure[Jump down page to What's New & Editor's Picks in Patient Disclosure](#)**Background**

Many patients harmed by a medical error never learn of the error. Physicians have traditionally shied away from discussing errors in part due to fear of precipitating a malpractice lawsuit, but also due to embarrassment and discomfort with the disclosure process. Attitudes have changed in recent years—most physicians in a [2006 survey](#) had disclosed a serious error to a patient and agreed that disclosure was warranted.

Surveys have helped to define the components of disclosure that matter most to [patients](#). These include:

- Disclosure of all harmful errors
- An explanation as to why the error occurred
- How the error's effects will be minimized
- Steps the physician (and organization) will take to prevent recurrences

"Full disclosure" of an error incorporates these components as well as acknowledgement of responsibility and an apology by the physician. However, there may be a disconnect between physicians' views of ideal practice and what actually happens. For example, many physicians believe that errors should be fully disclosed to patients, but in practice many "choose their words carefully" by failing to clearly explain the effects on the patient's health.



Source: Gallagher TH, Garbutt JM, Waterman AD, et al. Choosing your words carefully: how physicians disclose harmful medical errors to patients. *Arch Intern Med.* 2006;166:1585-1593. [[go to PubMed](#)]

Accomplishing Full Disclosure

Increasing the amount and quality of error disclosure will require addressing physician discomfort with disclosure and fear of being sued. It was long assumed that disclosure of errors increased the chances of being sued, an oft-cited study showed that patients are more likely to file a lawsuit if physicians apologize and fully disclose errors. The impact of this finding, or disclosure policies in general, on malpractice is unclear.

Few physicians have received formal training in how to discuss errors with patients, and given that the circumstances surrounding errors are invariably complex, physicians may be unclear as to how much information should be disclosed and how to explain the error. Guidelines have been formulated in an effort to assist physicians with this process.

Current Context

Disclosure of errors and adverse events is now endorsed by a broad array of organizations. Since 2001, the Joint Commission has endorsed disclosure of unanticipated outcomes of care. In 2006, the National Quality Forum endorsed full disclosure of "serious unanticipated outcomes" as one of its 30 "safe practices" for health care. The disclosure safe practice includes standards for practitioners regarding the key elements of disclosure. It also calls for health care organizations to create an environment conducive to disclosure by integrating risk management activities and providing training and support for physicians.

As of July 2007, seven states (Nevada, Florida, New Jersey, Pennsylvania, Oregon, Vermont, and California) mandate disclosure of errors and adverse events, and 34 states have enacted laws that preclude some or all information contained in a practitioner's apology from being used in a malpractice lawsuit. Major professional societies, including the American College of Physicians and the American Medical Association, encourage physicians to disclose all errors.

What's New in Patient Disclosure

Study: [Disclosing errors to patients: perspectives of registered nurses.](#) Shannon SE, Foglia MB, Hardy M, Gallagher TH. *Jt Comm Patient Saf.* 2009;35:5-12.

Study: [Health care professionals' views of implementing a policy of open disclosure of errors.](#) Sorensen R, Iedema R, Piper Williams A, Tuckett A. *J Health Serv Res Policy.* 2008;13:227-232.

Commentary: [Practising open disclosure: clinical incident communication and systems improvement.](#) Iedema R, Jorm C, V Dunn S. *Social Health Illn.* 2008 Oct 2; [Epub ahead of print].

Review: [Narrative review: do state laws make it easier to say "I'm sorry?"](#) McDonnell WM, Guenther E. *Ann Intern Med.* 2008;148:100-105.

Newspaper/Magazine Article: [Learning from never events: one hospital's reaction to a wrong-site surgery.](#) *Jt Comm Patient Saf.* 2008;8:8-10.

Commentary: [Apologies and medical error.](#) Robbenolt JK. *Clin Orthop Relat Res.* 2009;467:376-382.

[View all AHRQ PSNet resources on Patient Disclosure](#)

Editor's Picks for Patient Disclosure

From AHRQ *web* **M&M**

Removing Insult from Injury—Disclosing Adverse Events. Albert W. Wu, MD, MPH. AHRQ WebM&M [serial online]. February
The Wrong Shot: Error Disclosure. Thomas H. Gallagher, MD
 Wendy Levinson, MD. AHRQ WebM&M [serial online]. June 2004

Journal Article

CLASSIC The many faces of error disclosure: a common set of elements and a definition. Fein SP, Hilborne LH, Spiritus I
 Intern Med. 2007;22:755-761.

CLASSIC Patients' and physicians' attitudes regarding the disclosure of medical errors. Gallagher TH, Waterman AD, Ebe
 Levinson W. JAMA. 2003;289:1001-1007.

CLASSIC Choosing your words carefully: how physicians would disclose harmful medical errors to patients. Gallagher TH
 JM, Waterman AD, et al. Arch Intern Med. 2006;166:1585-1593.

CLASSIC To tell the truth: ethical and practical issues in disclosing medical mistakes to patients. Wu AW, Cavanaugh TA
 Micco GP. J Gen Intern Med. 1997;12:770-775.

CLASSIC Does full disclosure of medical errors affect malpractice liability? The jury is still out. Kachalia A, Shojania KG,
 M, Saint S. Jt Comm J Qual Safety. 2003;29:503-511.

Special or Theme Issue

Disclosure of Unanticipated Outcomes. ECRI Institute. Healthcare Risk Control. 2008;(suppl A):1-21.

Book/Report

CLASSIC Serious Reportable Events in Healthcare 2006 Update: A Consensus Report. Washington, DC: National Quality
 1933875089.

Risk Management Pearls on Disclosure of Adverse Events. Amori G. Chicago, IL: American Society for Healthcare Risk Man

Audiovisual

When Things Go Wrong: Voices of Patients and Families. Cambridge, MA: CRICO/RMF; 2006.

Web Resource

Sorry Works! The Sorry Works! Coalition, PO Box 531, Glen Carbon, IL 62034. Phone: 618-559-8168.

Being open: patient safety incidents with patients and their carers. National Patient Safety Agency.

Tools/Toolkit

Apologies for Medical Errors. American College of Physician Executives.

Newspaper/Magazine Article

Coming clean on medical mistakes. Talaga T, Cribb R. Toronto Star. March 19, 2007.

Doctors learn to say 'I'm Sorry.' Landro L. Wall Street Journal (Eastern edition). January 24, 2007:D5.

Full disclosure and apology—an idea whose time has come. Leape LL. Physician Exec. 2006 Mar-Apr;32:16-18.

Related Patient Safety Primers:

Never Events

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University of Michigan Hospitals and Health Centers

Policy 03-07-011 Disclosure of Unanticipated Patient Outcomes

Issued: 09/01 Last Reviewed: 9/04 Last Revised: 9/04

I. POLICY STATEMENT

It is the policy of the University of Michigan Hospitals and Health Centers that patients be treated with openness and honesty at all times, and that their right to know their medical status is respected. Full disclosure of results, including results that differ significantly from what was anticipated (Unanticipated Outcomes) enables patients to make informed decisions regarding future medical care.

II. POLICY/PROCEDURE PURPOSE

In general patients should be informed about all aspects of their care and treatments, including unanticipated outcomes. The purpose of this policy is to establish guidelines for providing information about unanticipated outcomes of treatment to patients, and when appropriate as authorized by the patient under HIPAA to their families/significant others. Please note: this policy refers to a patient's right to know their medical condition and unanticipated outcomes. The reasons or causes for unanticipated outcomes are not always readily apparent and may not be understood as quickly. This policy should not compel attending physicians to speculate as to causes or reasons for unanticipated outcomes before those causes are fully understood. Under those circumstances, it is best to defer explanations until comfortably understood.

III. DEFINITIONS

Disclosure: Communication of information regarding the results of a diagnostic test, medical, surgical or other interventional treatment.

Unanticipated Outcome: A result that differs significantly from what was anticipated to be the result of a treatment or procedures.

IV. POLICY STANDARDS

A. Clinicians will provide timely and concise information to patients, and when appropriate as authorized by the patient under HIPAA to their families/significant others about all aspects of their medical care, including results and response to treatment.

B. Attending physicians have the primary responsibility for ensuring that the patient is informed about outcomes of care/treatment. The Chief of Staff/designee may become the physician who delivers the notification in those instances where the patient's attending physician is unavailable or circumstances dictate that communication by another is advisable.

C. Information gathered as parts of quality assurance processes must be kept separately within the quality assurance process by law and cannot be disclosed.

V. PROCEDURE ACTIONS

Who	<p>Attending physicians have the primary responsibility for ensuring that the patient is informed about outcomes of care/treatment. If more than one service is involved, they should collaborate in discussing outcomes of care when appropriate.</p> <p>The Risk Management Office is available to assist.</p>
What	<p>Entry of the discussion will be made into the patient's medical record by the provider who notified the patient of the unanticipated outcome in treatment. At a minimum, the patient will be informed about:</p> <ul style="list-style-type: none">• The factual information of the outcome that occurred.• Any known repercussions of the outcome may have on the patient's care and on short-and-long-term health.• The proposed plan to respond to these repercussions.• Point of contact for further questions and/or follow-up. <p>Patients should be given time and opportunity to ask questions.</p> <p>Any information based on peer review for the purpose of monitoring, assessing, or documenting the quality of the diagnostic or treatment services is confidential medical quality assurance information and cannot be disclosed to patients or documented in the medical record.</p>
When	<p>There are occasions when the sharing of outcome information can put a patient at risk of harm either due to the potential for psychological trauma or exposure to physical harm. Professional judgment will determine when and how the information will be shared. Reasons for withholding the information should be documented in the medical record. Disclosure may be deferred to a more appropriate time, but should be completed no later than the time of discharge/completion of care at the facility.</p>
How	<p>Attending physicians may review disclosure steps with their Department Chairs or the Office of Clinical Affairs. In the cases of serious unanticipated outcomes, the Chief of Staff will be consulted to assess if the event warrants a multidisciplinary meeting to review the facts surrounding the event before the patient disclosure meeting. Delivery of the unanticipated outcome disclosure will be with empathy and compassion, detailing full disclosure of known relevant facts and actions by all involved parties. <u>See Attachment A</u></p> <p>Often, use of a detailed outline can ensure that all information of the event is delivered in a concise and understandable manner.</p> <p>The attending physician should be prepared with answers to questions and/or concerns that may be raised and a plan to investigate those questions for which answers may not be available at the time of disclosure.</p> <p>Recommendations for further treatment should be identified and discussed at the disclosure meeting.</p> <p>In some cases follow-up meetings should be held after the initial meeting to provide updates about the event to the patient/significant other(s). All subsequent meetings will occur promptly as additional information relevant to the disclosure becomes available.</p>

VI. EXHIBITS

Attachment A: GUIDELINES FOR DISCLOSURE

Authors: Office of Clinical Affairs, Quality Improvement and Medical Center Risk Management

Approved by: ECCA, September 25, 2001; September 28, 2004

Approved by: Director and CEO, UMHC, October 5, 2001; October 11, 2004

UMHC Policy 03-07-011, Exhibit A Disclosure of Unanticipated Patient Outcomes GUIDELINES FOR DISCLOSURE

- Gather all facts needed for presentation of information.
- Presume good will on behalf of all parties.
- Approach the disclosure with honesty.
- Confidentiality of patient information is primary.
- Decisions are patient-centered.
- Input from family is invited, welcomed and valued.
- Patient's primary caregivers are valued and welcomed.
- Recommendations, not decisions are the goals.
- Pay attention to patient preferences and cultural considerations.
- Do not speculate on causes or reasons for unanticipated outcomes – communicate what is known and plan to follow up as more information becomes available.

IMPORTANT

In some cases, a *detailed outline* should be followed to ensure that all information of the event is delivered in a concise manner.

The attending physician should be *prepared with answers to foreseeable questions and/or concerns* that may be raised and a plan to further investigate should answers to questions not be readily available at the time of disclosure.

Recommendations for next steps for treatment should be identified and discussed at the disclosure meeting.

In some cases *follow-up meetings should be held* after the initial meeting to provide updates about the event to the patient as more information becomes available.

Support and advice from departmental chairs, OCA, Risk Management or the Health System Legal Office should be sought where helpful.

September, 2004

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