

## GUIDELINES ON HOW TO DISCLOSE ERRORS

### BEFORE DISCLOSING

- ◆ Acknowledge any self-deprecating emotions that may be surfacing. These may be feelings of personal failure - a sense of incompetence and betrayal of the patient, regret for inflicting further pain on the patient, and fear of legal fallout.
- ◆ Approach this process with the attitude that it's the right thing to do and the patient's right to know. Ask yourself: *"Is this something that I would want to know if it happened to me or to someone in my family?"* Honesty is the best policy.
- ◆ Presume good will on behalf of all parties.
- ◆ Notify your Risk Management personnel of the occurrence. This should be done immediately if it is clear that an injury to a patient is the result of a medical error.
- ◆ Approach this disclosure process, mindful of the need to preserve the confidentiality of patient information.
- ◆ Make certain that the leaders of the clinical team are fully informed, including the Attending Physician, Nurse Manager, and when appropriate, the Director of Patient Care Services / Nursing Director.
- ◆ Gather all the facts. Review the medical record. Any "systems" issues should be recorded and reported through the Incident Reporting System.
- ◆ Assemble documentation and be prepared to review the chart with the patient/family member. In some cases, a detailed outline should be prepared to ensure that all information of the event is delivered in a concise manner. Gather pertinent studies, if they will help you explain what has occurred.
- ◆ Determine who from the medical team should have the conversation with the patient/family. If it is a nursing error, then the Nurse Manager should probably be the one to talk with the patient. The bedside nurse may or may not be present. This varies with the circumstances and is something you will want to discuss with Risk Management.
- ◆ Try to anticipate questions and/or concerns that may be raised and be prepared with answers.
- ◆ Determine who should be present with the patient. This will vary with the seriousness of what has occurred and can be discussed with Risk Management. If the patient is a minor or is incompetent, parents and/or guardians should be present for the conversation.
- ◆ Make a thoughtful analysis of the potential harm of disclosure to the patient/family. Give careful thought to the words that you will use in the disclosure conversation. Keep in mind

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that the patient's reaction may depend more on how the news is delivered than by what is actually said.

- ◆ Be sensitive to the patient's ethnic culture. Consult resources to enhance your awareness of ethnic customs around communication, family involvement, and other pertinent issues such as how their culture handles bad news, in particular death.
- ◆ Prepare a script and role-play - choose the best approach to take with this particular patient/family, select the right words to be spoken, and rehearse the encounter with someone beforehand.
- ◆ According to Buckman & Banja, keep in mind that *"When the news is painful, you must be prepared to have a conversation."*

### WHILE DISCLOSING

- ◆ Ensure that the conversation takes place in a private setting, where there is room for persons to walk around, if need be. However, you should remain seated during the conversation.
- ◆ Everyone should know who is in the room. Introduce yourself and any support staff accompanying you and find out the relationship to the patient of all persons who are accompanying the patient.
- ◆ Ascertain what information the patient may already have, based on his/her own suspicion or on actual knowledge. This is important to dispel inaccuracies and to determine the level at which the discussion should take place.
- ◆ Ascertain how much detail the patient wants to receive or if he/she would rather someone else be the recipient of the information.
- ◆ Convey the information slowly in simple terms that are understandable to the patient, avoiding any medical jargon, and in a manner that minimizes distress to the patient. Explain what happened, when and where it occurred, any decisions that were made including those in which the patient participated, any repercussions and recommended corrective action. At this point, you might have some clues as to how it happened, but it may not be feasible to speculate as to why it happened.
- ◆ Identify and offer any support that is available to the patient and his/her family, including the venue for future conversations. Work collaboratively with the patient devise a follow-up treatment plan for him/her to mitigate the effects of any injury. Pay attention to patient preferences and cultural considerations.
- ◆ Let the patient/family know what will be done to follow-up, both with regards to preventing this from happening again and how the patient's care will be managed from this point on. This includes an explanation that a full analysis of the events leading to this bad outcome of care will be conducted.

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- ◆ Express appropriate regret for the error and concern for the welfare of the patient/family.
- ◆ Try to avoid making a direct admission of fault at this point. Remember that hindsight bias plays heavily in these circumstances. Only a thorough objective review of facts can give an unbiased determination of fault.
- ◆ You may need to periodically give silent pause, allowing the patient/family time to process the information, rather than feeling the need to fill the void with words and gestures that, once conveyed, can't be taken back. Give opportunity for any questions.
- ◆ **Special note: If the event is serious, you should have a meeting as soon as possible**, even if you can explain only part of what happened. The conversation will most likely focus on what is being done for the patient, not what led to the present circumstance. If the family has questions about what occurred which cannot be answered yet, promise to return when additional facts are known. Explain treatment that may have been necessitated by the error. If tests are necessary, promise to share the results as soon as they are known. Give a general idea of how soon that might be, and be sure to follow up.

### AFTER DISCLOSING

- ◆ How you respond after the bad news is given is paramount.
- ◆ Acknowledge the patient's/family's emotions upon hearing the bad news. Validate their reaction appropriately so as not to aggravate the situation for the patient/family or for the institution. *"This must be difficult for you to hear"* might be one appropriate response.
- ◆ Do not give any appearance of insensitivity. An empathic and compassionate demeanor is essential. Sometimes the words *"I'm sorry"* are all that can be articulated.
- ◆ If you are met with anger, do not respond in kind. Work hard to avoid defensiveness, rationalizing, sermonizing, or lecturing. Listening to and absorbing feelings, disappointment, anger or frustration may go a long way toward resolving the matter.
- ◆ Input from the family is welcomed and valued.
- ◆ If the patient or family asks you for information that you don't have because you were not directly involved, be helpful and assist them in getting the information they seek.
- ◆ Let the patient/family know who to contact if they have any further questions or concerns and how they can be reached.
- ◆ If you are asked about what will happen to the responsible person, you can say that you don't know, but that it will be followed up by the manager/supervisor/supervising physician.
- ◆ Let the patient/family know that the institution will handle "systems" problems by referral to the Quality Program for review.

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- ◆ In some cases, follow-up meetings should be held within 48 hours after the initial meeting to provide updates about the event to the patient/family.
- ◆ If a lawsuit is threatened, do not panic. Most events can be resolved short of a formal litigation process. Inform Risk Management about any such declarations or demands for compensation.
- ◆ Once the disclosure conversation has concluded, now is the time to continue facilitating the healing process for the practitioner involved in the error. It is expected that practitioners will experience personal emotional fallout from the error and from the disclosure conversation - this will never be easy - yet, it is the right thing to do.

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### Based in part on the work of:

- (1) Banja J. "Implementing a Process for Disclosure." University HealthSystem Consortium Conference on Clinical and Economic Imperative for Patient Safety. (October 2001).
- (2) Buckman R. "How To Break Bad News." Baltimore,MD: The Johns Hopkins University Press. (1992).
- (3) Buckman R. "Breaking Bad News: Why is it still so difficult?" *British Medical Journal*. 276 (1984):496-502.
- (4) Wu A. et al. "To Tell the Truth: Ethical and Practical Issues in Disclosing Medical Mistakes to Patients." *Journal of General Internal Medicine*. 12.12(December 12, 1997):770-775.
- (5) Rabow M. and McPhee S. "Beyond breaking bad news: How to help patients who suffer." *Western Journal of Medicine*. 171 (1999):260-263.
- (6) Moore S. "The toughest task: How to break bad news." *Excellence in Clinical Practice*. 3.2 (2<sup>nd</sup> Quarter 2002):1-3.
- (7) Liang B. "A system of medical error disclosure." *Quality and Safety in Health Care*. 11 (2002):64-68.

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