

Disclosing harm from healthcare delivery

Open and honest communication with patients

TRUST • RESPECT • EMPATHY • CARE • LEARNING

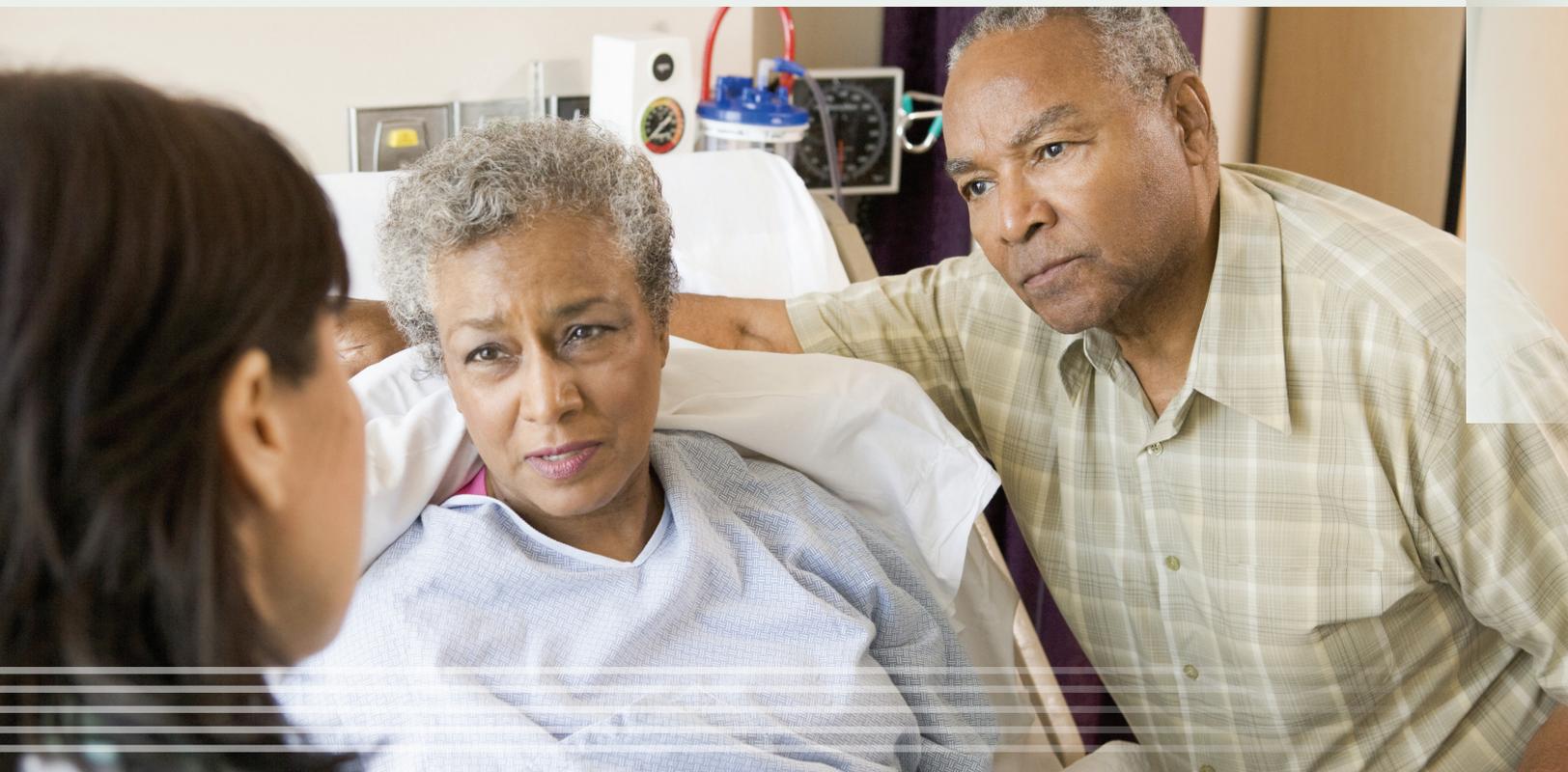


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Terminology

This publication provides guidance and good practices about physician communications with patients concerning the disclosure of harm stemming from healthcare delivery, and aligns with the Canadian Patient Safety Institute's (CPSI) *Canadian Disclosure Guidelines* (2011).¹

The term "patient" is used throughout this material to refer to the individual who is the subject of the patient safety incident. The term may also refer to the patient's:

- family when the patient has consented to them being involved in the disclosure process
- substitute decision-maker when the patient lacks the capacity to consent
- legal representative when the patient is deceased

The term "patient safety incident" is also used in this guide. The World Health Organization (WHO) provides terminology to facilitate the sharing and learning of patient safety information globally.² The CPSI has adopted some of these terms.³ To support clarity and consistency in patient safety discussions, the Canadian Medical Protective Association (CMPA) now uses these terms:

Patient safety incident: An event or circumstance which could have resulted, or did result, in unnecessary harm to the patient.

Harmful incident: A patient safety incident that resulted in harm to the patient. Replaces the terms "adverse event" and "sentinel event."

No harm incident: A patient safety incident which reached the patient but no discernible harm resulted.

Near miss: A patient safety incident that did not reach the patient. Replaces "close call."

In Québec, the terms "accident" and "incident" are defined in the applicable legislation. Neither term corresponds exactly to the WHO terminology. An "accident" in Québec means "an action or situation where a risk event occurs which has or could have consequences for the state of health or welfare of the user, a personnel member, an involved professional, or a third person."⁴ The term "incident," on the other hand, is defined as "an action or situation that does not have consequences for the state of health or welfare of a user, a personnel member, an involved professional or a third person, but the outcome of which is unusual and could have had consequences under different circumstances."⁵

As the CMPA interprets the Québec legislation, the term "accident" would align with the WHO term "harmful incident" whereas the term "incident" would include the WHO terms "no harm incident" and "near miss."

CMPA members may call the Association at 1-800-267-6522 for individual advice on disclosure. Training on disclosure is also available. Visit the CMPA website at www.cmpa-acpm.ca for details.

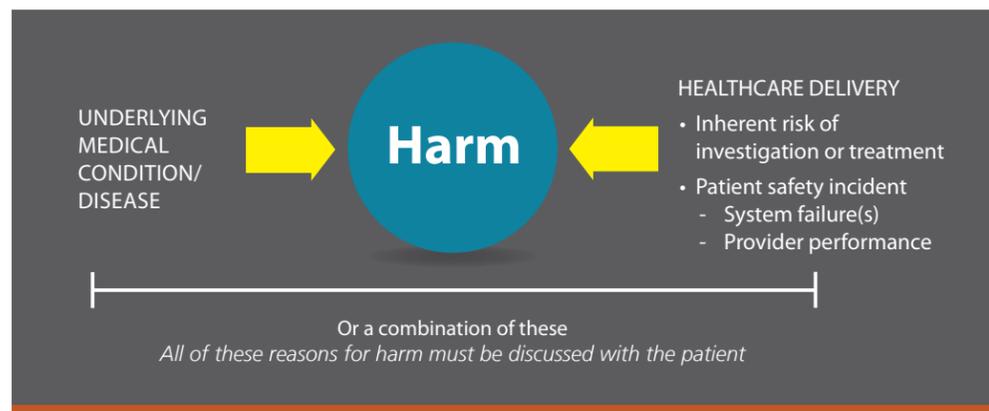
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Introduction

A just culture of safety in the modern healthcare workplace encourages and develops the knowledge, skills, and commitment of healthcare providers to deliver safe patient care. Physicians and patients work in partnership with other providers and administrators to optimize care and achieve the best possible clinical outcomes.



How harm comes to patients

Despite the commitment to provide the best care possible, clinical outcomes may not be as originally desired or anticipated. Harm — a negative effect on the patient’s health or quality of life — most often results from the progression of a disease. Harm can also result from complications related to healthcare delivery itself, usually stemming from the risks inherent in clinical investigations and treatments. Biologic and physiologic variability may play a role.

Unfortunately, harm from healthcare delivery may also result from patient safety incidents. The reasons for patient safety incidents are failures in the processes of care or in the performance of providers, including provider error. Patient safety efforts focus on improving care by reducing the number of patient safety incidents. Disclosure discussions serve to communicate to the patient the reasons why a patient safety incident occurred.

Disclosure is supported by a just culture of safety

In a just workplace culture, the reasons for unexpected clinical outcomes and patient safety incidents are not prejudged. The rights of all individuals, including patients, are protected. There is also an attempt to understand the circumstances and context for the decisions and actions of providers at the time the care was provided.

In a just culture of safety, all individuals are able to trust that the initial responses to a patient safety incident, as well as any subsequent analyses and proceedings, will be conducted with fairness, and in accordance with the applicable legal frameworks and hospital policies and bylaws. In such a culture, healthcare providers are aware of what is professionally expected, and when analyzing patient safety incidents, the accountability of the provider and the organization are determined fairly.⁶

Obligations to communicate

When the clinical outcome is not as anticipated and whatever the reasons for harm, physicians will want to and are obligated to communicate directly with their patients. Communicating and disclosing what has occurred is necessary — and is the right thing to do. The discussion provides information, promotes safe and quality medical care, and can maintain trust and strengthen the physician-patient relationship.

Healthcare providers have an ethical, professional, and legal obligation to disclose harm from healthcare delivery to patients. The Canadian Medical Association’s *Code of Ethics* states physicians must “take all reasonable steps to prevent harm to patients; should harm occur, disclose it to the patient.”⁷ In Québec, the *Code of Ethics of Physicians* states the doctor must “inform his patient or the latter’s representative of any incident, accident, or complication which is likely to have or has had a significant impact on his state of health or personal integrity.”⁸

Some jurisdictions have also enacted legislation regulating the disclosure of patient safety incidents. Although different terms may be used, the intent of the legislation is to promote disclosure. Physicians should also be familiar with and follow any relevant guidelines

Physicians will want to and are obligated to communicate directly with patients whatever the reasons for clinical outcomes. Disclosure of patient safety incidents supports patients, families, organizations, and healthcare providers.

Patients want an open and honest discussion. Physicians should meet patients’ clinical, emotional, and information needs.

Disclosure is the right thing to do.



or standards regarding disclosure set out by their medical regulatory authority (College) and any policies in place at the institution in which they practise.⁹

If the patient lacks mental capacity (competency), communication with a substitute decision-maker is appropriate.

Disclosure in pediatrics

Disclosure conversations in pediatrics are usually with the parents or legal guardians. Children and adolescents who have sufficient emotional maturity and ability to comprehend, and are capable of making decisions about their treatment, should similarly be capable of receiving appropriate information about a patient safety incident. This may also depend on the nature and complexity of the incident. In Québec, a child who is 14 years of age or older and permitted by law to provide consent to treatment should receive the disclosure information after a patient safety incident. It is often prudent to seek permission to involve the parents in these discussions, even if a child is sufficiently mature, or in Québec has attained the legal age to consent.

Substitute decision-maker: A person who is legally authorized to make decisions on behalf of the patient. This authority may be granted by the patient himself or herself with a legal document such as an advance medical directive, by legislation in each province or territory, or by the courts.

Disclosure concerning patients with mental illness

The presence of a serious mental illness is not a reason to withhold disclosure, however it may impact the timing of the discussion. There should be a careful balance between the patient’s right to know and the risk of clinical decompensation, including the risk of harm to self or others. A respectful assessment of risk, along with an environment of respect, empathy, and collaboration will be vital to helping people with mental illness in the disclosure process.¹⁰ If the patient lacks capacity, the discussions should occur with a substitute decision-maker. It may be necessary to repeat the initial disclosure discussion when the patient’s mental state has improved.

Reporting is different than disclosure

Reporting involves notification of the occurrence of a patient safety incident through appropriate channels inside or outside a healthcare organization.

In a just culture of safety, the primary purpose of reporting is to drive improvement. Quality improvement reviews should focus on strengthening processes and prompting education to reduce the risk of similar patient safety incidents.

Comprehensive reporting helps local institutions and provincial and territorial healthcare departments identify trends related to patient safety incidents that might otherwise seem unique or infrequent. Reporting facilitates the sharing of information about patient safety issues and strategies to improve the system of care.

Physicians will want to be aware of their reporting obligations, which are generally outlined in institutional policies or in legislation. Reports should always be factual and not contain speculation or lay blame as to the reasons for what happened.

Why shared decision-making and informed consent are important

Most investigations and treatments have inherent risks — certain complications or side effects may occur and are independent of who is providing care. However, patients are often surprised at poor outcomes and some may suspect that mistakes have been made. A frank discussion of the benefits and risks of a proposed investigation or treatment can go a long way in preventing future misunderstandings.

1. Discuss the common and serious risks in clear and understandable language. Discuss appropriate alternatives and the likely outcome of not doing anything.
2. Provide the opportunity for the patient to voice concerns. Encourage questions.
3. Even when patients waive aside all explanations or seem prepared to submit to the procedure or treatment without discussion, explain that the risks should still be discussed.
4. Print material, videos, and other handouts all support the consent discussion, but do not replace it.
5. Document the consent discussion in the medical record in a timely manner.

Roadmap to disclosure

Disclosure is a process typically requiring several discussions at each of two general stages:

Initial disclosure should be made with the patient as soon as reasonably possible, focusing first on the known facts and the provision of further clinical care.

Post-analysis disclosure focuses on the reasons for harm as determined by appropriate analysis.

Patients should be provided information on the likely timing of follow-up discussions. Patients need to know if a review will occur, its timing and focus, and the nature of their participation. Patients should also be told that at the end of a quality improvement

Stages of Disclosure

INITIAL DISCLOSURE

Who – by the provider(s)

Leadership/management may provide advice or participate

Communication support may be requested/provided

Analysis

Reasons for harm

POST ANALYSIS DISCLOSURE

Leadership/management may lead
Provider(s) may be still involved

review, recommendations may provide guidance to reduce the future occurrence of the patient safety incident.

At both stages, patients benefit from knowing who to contact if they have further concerns and questions. A designated staff person, such as a healthcare provider or administrator, can ensure the disclosure process advances properly and the needs of the patient and providers are addressed.

Attend first to the patient's safety and clinical care needs

Physicians must attend to the patient's clinical needs and seek to improve the patient's existing clinical condition. This includes making the environment safe for the patient (and others); and once urgent matters are addressed, obtaining informed consent for any clinical investigations, treatments, or consultations the patient may need; seeking help, as appropriate; and if time allows, considering whether it would be best for another physician to assume care.

In some circumstances, it may be best to transfer responsibility for care. Such a transfer may be needed due to the clinical skills required to treat the condition as it exists, or when the treating physician is experiencing undue stress. Patients should understand the reasons for the transfer as being in their best interests and that they are not being abandoned. The physician may offer to continue to follow the patient.

Patients may also request a transfer of care and this is their right. Maintaining an open, honest dialogue with the patient will often help to preserve a trusting physician-patient relationship.

To further patient care, colleagues should support each other to facilitate any necessary investigations, treatments, consultations, and transfers.

Plan the initial disclosure

Before speaking to the patient, the physician should gather facts to gain a preliminary understanding of what happened. This will likely include speaking to other healthcare providers who were involved in the patient safety incident, and reviewing the medical record. If possible, the physician should also confirm whether there will be a quality improvement review concerning the patient safety incident.

All of the reasons contributing to what happened will usually not be known and this will need to be explained to the patient. Rushing to provide an explanation based on an incorrect initial understanding of the situation or the clinical information, or an incomplete grasp of the reasons for what happened, will complicate further discussions and potentially result in a lack of trust in the physician-patient relationship.

While disclosure cannot be scripted, physicians should organize their thoughts, main discussion points, and reasoning prior to meeting with the patient. Even when a physician thinks an error occurred, an admission of fault is generally not wise in the

immediate aftermath of a patient safety incident. It is normally not until a full analysis of the patient safety incident has been completed that all of the reasons for harm are established.

Physicians should anticipate and prepare for emotional reactions, questions, and responses from patients and families. They should also be prepared to provide further information in the future.

Who should be present at initial disclosure meetings?

Those individuals who have a direct role in providing clinical care and emotional support to the patient should attend the initial disclosure meeting. The patient's wishes regarding the participants should be considered.

The most responsible physician (MRP) generally has the obligation to lead the meeting, perhaps supported by another colleague with strong communication skills, or by the person with the most information, or by another trusted provider known to the patient such as a family physician or nurse. If the MRP cannot be present, an appropriate delegate should sensitively explain why the MRP is not available to speak with the patient directly. An appropriate delegate can explain the clinical condition as it now exists, in addition to options and recommendations for future care. Residents should report a patient safety incident to their supervising physician(s) and should be encouraged to participate in the disclosure discussion, when appropriate.

If language translation is required, a healthcare translator, not a family member, is preferred to ensure the best possible communication. A counsellor, social worker, spiritual advisor, or those familiar with the disclosure process can help support the patient.

The initial disclosure

Address the patient's information needs

If possible, everyone should sit at eye level in a private area with the patient, free from interruptions.

The discussion should begin with an expression of sympathy and compassion for the circumstances. The physician should offer to explain what happened, keeping the explanation factual and avoiding the use of medical jargon. If the facts are not yet known, the physician should demonstrate a desire to find the answers. It is unfair and unprofessional to speculate or blame others.

The physician should provide a brief overview of the investigative process that will be followed and what the patient and family can expect to learn. If known, specific timelines should be shared to reduce uncertainty.

Physicians must first address the patient's immediate clinical needs. Doctors should consider whether they are the best individuals to provide further care.

Facilitate further care.

In planning initial disclosure, physicians should gather the facts, consider who should be present, establish the meeting time and place, and organize what to say and how to say it.

Do not prejudge what happened or leap to conclusions.

Physicians should communicate with the patient as soon as reasonably possible after the patient safety incident, focusing on the known facts. Physicians must be sensitive to how much information is being provided, and what the patient can absorb. Do not speculate or blame.

Demonstrate compassion and empathy.



Good communication means more listening than talking: patients need to feel they have been heard. The physician should invite the patient to provide his or her perspective on what has happened. Seeking the patient's ideas on how to proceed also shows respect. Physicians must be sensitive, and allow time for the patient to absorb and understand what is being said. Information may need to be repeated. The physician should be aware of his or her own body language and non-verbal communication, as well as that of the patient.

It is important to assess the patient's level of satisfaction, and ask if there is anything further that can be done to assist the patient at this time.

Physicians should ensure the patient does not feel abandoned. The name of a contact person (e.g. a physician, nurse, or administrator) should be provided to the patient. The contact person may periodically touch base with the patient, even if there is nothing new to report.

All members of the care team should be made aware of the patient's care needs and the facts that have been communicated.

Address the patient's emotional needs

While patients may have different reactions to the information, all need to hear expressions of caring and support.

The physician should always discuss patient safety incidents with compassion and empathy, and his or her tone of voice and demeanor should reflect such sentiments. The physician should welcome questions, and repeat information as needed.

Strong emotions such as anger need to be dealt with empathically. Doctors should remain professional and avoid becoming defensive, argumentative, or appearing resentful. The perception that a physician has been dismissive of a patient's concerns is a common reason for dissatisfaction and further complaint.

All patients need to hear expressions of caring and support at every meeting.

The post-analysis disclosure

Following a patient safety incident, the focus is on learning so processes of care can be improved. Healthcare providers should be supported to do the best possible work and avoid similar patient safety incidents in the future. And patients and families want assurance that appropriate steps are being taken to prevent similar occurrences in the future.

Quality improvement (QI) reviews conducted by hospitals and institutions examine the system and processes of care to identify areas for improvement. The CMPA generally advises members to participate fully in properly constituted QI reviews to help identify and correct any system failures. The patient's and family's perspectives on what happened are important to the success of a review and can be obtained by interviewing patients or asking for a written statement. Patients or family members might attend part of the review to propose system-level improvements that could benefit other patients. However, they should not sit in on all discussions given the confidential nature of QI reviews and the need to foster a learning environment where healthcare providers feel they can provide their opinions and speculations without fear of the information being used in subsequent fault-finding forums such as legal or disciplinary proceedings.

Post-analysis disclosure in hospitals and institutions must consider any restrictions or requirements on the exchange of information stipulated in provincial or territorial legislation, regulations, hospital/institutional bylaws and policies, and legal privilege. To encourage full participation by providers and obtain a more complete and frank discussion and understanding of problems, legislation in each province or territory generally protects the information generated by a QI committee in a hospital or institution from being disclosed in any subsequent proceedings, such as civil actions or College investigations.

The review and analysis may determine that the patient's unexpected clinical outcome resulted from the disease process itself, from a recognized and unavoidable risk inherent to an investigation or treatment, from healthcare system failures or provider performance, or from a combination of these. Where the performance of an individual provider is suspected to be a significant reason for the harm to the patient, a separate accountability review should be conducted to focus on the specific provider's role in the patient safety incident. An accountability review looks at the conduct or performance of an individual healthcare provider, rather than at the system-level concerns that are the subject of a QI review.

Doctors working in a hospital or institution could have a more limited role in the post-analysis disclosure, as hospital leaders and administration may lead the discussion. In all cases and with the consent of the patient, physicians and medical trainees involved in the patient safety incident should still have an opportunity to participate. A physician working in an office, clinic, or in the community will likely lead the post-analysis disclosure discussion.

Physicians should contribute to properly structured and conducted quality improvement reviews.

New clinical facts discovered during a review must be conveyed to the patient. Conclusive reasons for harm should be communicated.

Focus on what has been learned and communicate any improvements to prevent similar patient safety incidents in the future.



It is appropriate for physicians to state they are sorry for the circumstances or the condition of the patient at every disclosure meeting.

How you apologize for a poor clinical outcome depends on the reason for the outcome.

The conclusive, factual reasons for harm should be communicated to the patient at the post-analysis disclosure meeting. What is already known may be confirmed, previous information may need to be corrected, and new clinical facts discovered during a review should be conveyed. The focus should be on key learnings and improvements being made to prevent similar patient safety incidents. When appropriate, an apology should be provided to the patient. However, the work-product, speculations, hypotheses, and best-guesses that contributed to the review should not be shared.

Patients may want to take notes at the meeting and this is encouraged. If patients insist on recording the discussion or bringing a lawyer to the meeting, physicians are encouraged to contact the CMPA for advice. The final report of the QI committee should be empathetic, factual, contain no personal identifiers, and focus on what has been learned and the efforts to improve quality and safety.

Patients may request a copy of the written report. It is important for leadership/management, in consultation with legal counsel, to determine what information should be disclosed to the patient and included in the report. The legislation in some jurisdictions prohibits the sharing of findings, conclusions, or recommendations of QI committees to anyone other than leadership/management. Further, the obligation to make system-level recommendations more widely available resides with the institution, regional health authority, or in certain circumstances the provincial or territorial ministry, and not the QI committee.

Apology

At every disclosure meeting, a statement of being sorry for the circumstances or the condition of the patient is important and appropriate.¹¹ Physicians should not hesitate to express their regret or sympathy to the patient. This is not an admission of error or liability. Genuine concern by a caring physician will be appreciated by most patients and families.

The failure to be empathetic and apologize is a leading driver of complaints and legal actions.

After the review and analysis:

- If the harm was a result of the progression of the underlying medical condition, *an expression of concern and sympathy is sufficient and will be appreciated by the patient and family.*

- If the harm was related to an inherent risk of an investigation or treatment, *an expression of regret should be provided, such as, "I feel badly that this happened to you."* An apology (with acceptance of responsibility) should not be provided.
- If a careful analysis determines the harm was related to system failures or provider performance, *an apology should be considered by the responsible provider or responsible organization.* In these circumstances, it is appropriate to acknowledge responsibility for the harm and to apologize. Relevant examples might include mistakenly administering a different than prescribed medication, operating on the wrong patient, or not acting on an important finding because of a lost laboratory report.

Physicians are not responsible for apologizing on behalf of another healthcare provider or an organization. Where a hospital or institution is partly or fully responsible for what has happened, the organization's leadership should decide on the appropriate course of action.

Physicians should avoid words that express or imply legal responsibility, such as negligence, liable, fault, or "failing to meet the standard of care." Legal responsibility is not usually clear, and courts and Colleges are mandated to make these complex determinations. This protects patients, providers, and organizations.

Documentation

Disclosure meetings

The physician should document all relevant details in the patient's medical record, including meeting dates and times, who participated, matters discussed, the patient's reaction and responses, the questions asked and answers provided, agreed upon next steps, and expressions of empathy.

Clinical care

Complete documentation of the clinical condition is important. If further investigations and treatments, consultations, and transfers of care are required, the physician should include the details of any informed consent discussions.

Corrections

If information in the existing medical record is incorrect or incomplete, then this information needs to be carefully rectified. Physicians should correct or modify only their own entries. When missing information or mistakes are discovered, it may be appropriate to make an additional entry in the record, provided it is clearly marked as an addendum or correction. Physicians should be aware of the relevant legal and College requirements for making late entries. Corrections to an electronic record should follow the same principles as with a paper record.

Physicians must capture the details of all disclosure meetings in the medical record.

Sign and date any amendments to the medical record.

Frequently asked questions

Do I need to disclose near misses and no harm patient safety incidents to the patient?

Sometimes patient safety incidents result in no evident harm. This can occur in the following situations:

No harm incidents: The event reached the patient, but no harm occurred at the time and no potential for harm realistically exists in the future. However, sometimes an incident has the *potential for harm*, that is, harm might manifest in the future. For example, a patient exposed to poorly sterilized equipment might subsequently acquire a viral infection. The infection would take time to declare itself and serial monitoring would be required. No harm incidents require disclosure.

Near misses: The event did not reach the patient because of timely intervention or good fortune. In general, a near miss need not be disclosed, although there are exceptions. The patient should be informed about a near miss if there is a similar, ongoing safety risk for that patient, or if the patient is aware of the near miss and an explanation will allay concern and promote trust.

What should physicians do when they have concerns about the clinical care delivered by another provider?

Physicians need to first consider whether they know enough about the facts and circumstances. Often, the care in question was actually reasonable at the time and in the context of the progression of the medical condition and available information. For example, many delays in diagnosis result from the variable progression of pathophysiology and symptoms and signs, and the atypical presentations of diseases.

It is important not to speculate or lay blame. An uninformed or thoughtless comment is unprofessional and often forms the basis for dissatisfaction and complaint by a patient or family member. Physicians should focus on the needs of the patient as they now exist.

In the spirit of learning, physicians are encouraged to contact the other provider and constructively discuss what happened and how the case evolved. A department chief or clinical supervisor may be helpful in giving a valuable perspective or in resolving a dispute. If there is concern about the care or outcome, the original healthcare provider may be best suited to discuss the care with the patient.

What about communications with patients concerning legal actions and compensation?

The CMPA encourages physicians to disclose poor clinical outcomes to patients as soon as reasonably possible. This can help maintain trust and prevent complaints. Nevertheless, a legal action may sometimes be initiated. At times, the CMPA's advice on early communication with patients has been confused with its guidance to limit direct communication with patients after a legal action has started. If a patient has initiated a legal action or if a physician believes a patient has made a substantive threat to do so, the care should be transferred to another physician. The member should also contact the CMPA and all communication with the patient should be through the legal counsel assigned by the Association. Even when there is no legal action, it may be best to transfer care if the trust in the physician-patient relationship has been damaged.

How can physicians involved in patient safety incidents manage their stress?

Patient safety incidents can be stressful events for patients and families. Physicians and other providers may also feel stress and should consider their own emotional and physical health.

Doctors should seek out the necessary resources, such as talking to a colleague or a personal physician. In the course of these discussions, clinical details should not be discussed and patient health information should be safeguarded. In some circumstances, however, it may be prudent to transfer the patient's care to another physician.

Physicians may also seek support and resources from the Canadian Physician Health Institute or the Canadian Medical Association's Centre for Physician Health and Well-being. In addition, a number of provincial physician health programs provide personal assistance.

The CMPA website includes a "Physician wellness" section with links to more resources and information on coping with stress arising from patient safety incidents and medico-legal issues.

For more information

The CMPA Good Practices Guide, available at www.cmpa-acpm.ca/gpg, is an interactive online learning resource for practising physicians, students, and teaching faculty, and includes further guidance on disclosure.

Glossary

Apology: A genuine expression of sympathy or regret, a statement that one is sorry for what has happened. An apology includes an acknowledgement of responsibility if such responsibility has been determined after analysis of a patient safety incident.

Disclosure: The process by which a harmful patient safety incident is communicated to the patient. (Canadian Patient Safety Institute)

Harm: An outcome that negatively affects the patient's health and/or quality of life.

Patient: The individual who is the subject of the patient safety incident. The term may include the patient's family when the patient has consented to them being involved in the disclosure process; the patient's substitute decision-maker when the patient lacks capacity to consent; or the patient's legal representative when the patient is deceased.

Patient safety incident: See page 1.

Reporting: The notification of the occurrence of a patient safety incident through appropriate channels inside or outside the healthcare organization.

System failure: The lack, malfunction, or failure of policies, operational processes, or supporting infrastructure for the provision of healthcare.

Checklist

Disclosure is the right thing to do. Patients want an open and honest discussion. Physicians will want to, and are obligated to, communicate openly with patients — whatever the reasons for clinical outcomes.

Attend first to the patient's safety and clinical care needs

- Seek to improve the patient's existing clinical condition.
- Make the immediate clinical environment safe (e.g. remove malfunctioning equipment).
- Obtain informed consent for further clinical investigations, treatments, or consultations the patient needs.
- Consider whether it would be best for another physician to assume care of the patient.

Plan the initial disclosure

- Schedule the initial disclosure with the patient as soon as reasonably possible.
- Gather the facts to gain a preliminary understanding of what happened.
- Speak to other healthcare providers who were involved in the patient safety incident.
- Confirm whether there will be a quality improvement review of the patient safety incident.
- Organize the main discussion points.
- Anticipate and prepare for emotional reactions and questions from the patient and family.

Invite participants to attend the initial disclosure meeting

- Invite those individuals who have a direct role in providing clinical care and emotional support to the patient. Consider the patient's wishes.

Conduct the initial disclosure

The most responsible physician, or an appropriate delegate, usually leads the initial disclosure meeting.

- Sit at eye level in a private area with the patient, free from interruptions.
- Begin the discussion with an expression of sympathy and compassion for the circumstances. Address the patient's informational and emotional needs.

- Explain what happened, focusing on the facts. Avoid jargon.
- Invite the patient to provide his or her perspective on what has happened.
- Avoid speculating or laying blame.
- Remain professional and take care not to appear defensive.
- Briefly outline the investigative process that will be followed and what the patient and family can expect to learn. If known, share specific timelines.
- Assess the patient's level of understanding and satisfaction and ask if there is anything further that can be done to assist the patient at this time.
- Provide the patient with the name and telephone number of a person whom they can contact. This person may also periodically touch base with the patient, even when there is nothing new to report.

Quality improvement review

Physicians should contribute to properly structured and conducted quality improvement reviews.

Conduct the post-analysis disclosure

In hospital settings, hospital leaders usually lead the post-analysis disclosure meeting, while the responsible physicians may have a more limited role.

- Explain the conclusive, factual reasons for harm to the patient as determined by the quality improvement review. The focus should be on key learnings and improvements being made that could benefit other patients.
- Apologize to the patient, as appropriate. The nature of an apology for a poor clinical outcome will depend on the reason for the outcome. It is always appropriate to say you are sorry for the circumstances or condition of the patient.
- Avoid statements that express or imply legal responsibility, such as negligence or fault. Legal responsibility is not usually clear, and courts and medical regulatory authorities (Colleges) make these determinations.

Documentation

- Document all relevant details of disclosure meetings in the patient's medical record, including meeting dates, matters discussed, and expressions of empathy.
- Document the patient's clinical condition, including any informed consent discussions.

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11. Ibid, p.19

ABOUT THIS PUBLICATION:

Healthcare providers seek the best possible clinical outcomes for their patients. However, even with the best of medical care, a patient's outcome may not be what was originally desired or anticipated, and in some cases may be entirely unanticipated. Some unexpected outcomes are unfortunately related to healthcare delivery itself, despite the dedication, training, and professionalism of the healthcare providers.

Patients expect to be informed about harm they have experienced, whatever the reason for it, and this information needs to be delivered in a caring manner.

This resource provides advice on communicating with your patient if an unanticipated poor clinical outcome has occurred during care, particularly in the difficult circumstances in which healthcare delivery is suspected or known to have contributed to that poor outcome.

For information and advice: **1-800-267-6522 or 613-725-2000**

For educational sessions: **education@cmpa.org**

For web-based education, information and transactions: **www.cmpa-acpm.ca**