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Saying Sorry: The physician's role in patient and public disclosure of adverse events

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Introduction

Recent events in Newfoundland and Labrador, such as inaccurate hormone receptor testing and the resultant Cameron Inquiry, have shone a spotlight on the abilities of physicians, healthcare corporations, and even governments, to deal with adverse events.

An event may be considered adverse if it relates to the care and/or services provided, rather than the patient's underlying medical condition, and results in unintended harm to the patient.[1] It is estimated that adverse events affect up to 7.5% of patients admitted to acute care hospitals. Of that 7.5%, an estimated 37% may have been preventable.[2]

When adversity strikes, patients and the public often look to physicians for explanations and solutions. As medical experts, physicians should, ideally, be effective communicators, collaborators, managers, health advocates, professionals, and scholars.[3] It is within these roles that physicians are trained and, therefore, it is within these roles that physicians should disclose information to their patients and, if necessary, to the public.

The Physician as Communicator

Dealing with patients, families, the public, and the media, can be challenging for physicians in the best of times. When things go wrong, challenging turns into grueling. Many physicians have little to no training in how to disclose adverse events.[4] More often that not, physicians are left to rely on the skills they have acquired in daily communication with patients.

One such acquired skill is the ability to be mindful of the patient's desires. This skill is one of the most useful in the disclosure of adverse events. Patients want their treating physicians to explicitly inform them that an error has occurred. They also want to hear plausible explanations for the error as well as details and descriptions of future prevention plans. Finally, and perhaps most importantly, patients want to hear their physician apologize.[5,6]

Disclosure of an adverse event should consist of two stages, consisting of multiple conversations between physician and patient.[1] It is during the first, or "initial disclosure", stage that the physician should speak with the patient about the event, the patient's current condition, and possible treatment plans. This conversation should take place as soon as is reasonably possible after the event has occurred. There should be no speculation, by physician or patient, at this time.

During the second, or "detailed disclosure", stage, the physician should provide the patient with a particularized analysis of the adverse event. The physician and patient should discuss the possible and probable causes of the event, the event's effect on the patient's past and future treatment, and the prevention of future similar events.

Before embarking on this two-stage disclosure process, the physician may wish to consult other healthcare team members, such as nurses and social workers. Physician and patient alike may find it beneficial for the team to discuss the information that may be disclosed to the patient in light of his/her needs, as well as any restrictions that may result from federal and provincial legislation or local institutional/hospital bylaws and policies. Although the lot often falls on the physician to disclose adverse events, he/she cannot be expected to approach such an important task alone.

The Physician as Collaborator

Collaborating with other health care professionals following an adverse event is frequently a necessary and critical step in addressing the situation placed before the physician. One important topic of conversation among professionals concerns who, exactly, should inform the affected patient of the adverse event. While individual Provinces have differing views on which party should be the bearer of bad news, many health authorities agree that the responsibility belongs to the health care team as a whole, with the treating physician taking the leading role.[7] It is important, then, for physicians to work with the team to ensure that all necessary information is conveyed to

the patient, and the patient's family. Collaboration also provides the physician with the opportunity to ensure that he/she is fully informed of all the details surrounding the adverse event *before* speaking with the patient.

Only after effective collaboration can the physician sincerely express his/her own regret as well as that of the health care institution, both of which are desirable to patients and the public.[8] Collaboration with institutional managers and health care boards also facilitates the initiation of future disclosure policies, as well as procedures by which future medical errors and adverse events will be reviewed.[4] In creating such policies and procedures, institutions and boards support their frontline health care workers, particularly physicians, by providing tools to better manage patient care.

Where collegiality exists, adverse events are likely to be replaced by "near misses", or errors that could cause harm but actually do not, either by chance or timely intervention.[9] "Near misses" result in less harm to patients and facilitate higher levels of trust between patients and health care providers. It may be said, therefore, that by preventing future adverse events, collaboration is an effective tool in securing the health of the patient.

The Physician as Manager

It is no surprise that chosen methods of disclosing harmful errors vary amongst physicians.[5] Such variations are undoubtedly related to the personal perspectives of individual physicians. For example, a physician focused on ethics and/or patient advocacy may be more comfortable promoting full disclosure than a physician focused on malpractice insurance and risk management.[10,11] The former physician may view an open apology as ethical and necessary for full disclosure. The latter may consider apologizing an open invitation to litigation.

Whatever one's perspective, an apology can be a useful tool in resolving both patient and physician distress following an adverse event.[8] An apology may prevent litigation or, alternatively,

promote the expeditious and cost-effective settlement of a lawsuit. In considering how best to manage hospital resources, including finances, following adverse events, physicians must be aware of existing research and information suggesting that patients prefer explicit apologies.[12,13]

Physicians must also have a clear understanding of patients' attitudes toward medical errors and adverse events. Understanding the patient's perspective enables the physician, as medical manager, to become involved in shaping those policies that will better protect patients and health care in general.[5]

Managing adverse events involves not only addressing current events, but also constructing mechanisms by which to prevent the occurrence of future events. This allows the physician and the health care system to proactively deal with adverse events instead of combating the fallout after such events occur.

The Physician as Health Advocate

Physicians must always act as advocates of patient health. Research has shown, however, that physicians are less inclined to disclose errors that are not readily apparent as opposed to those that are blatant.[5] Patients, on the other hand, feel that full disclosure of *all* errors is in their best interests. Indeed, disclosure of unanticipated outcomes to affected patients is a core component of high-quality health care.[14] Disclosure enables patients to become part of the quality-improvement effort, thereby leading to enhanced patient care and improved safety.

Patients also believe that full disclosure of adverse events increases trust in their physicians and reassures patients that they are receiving complete and accurate information about their health.[5] As a result of this increased trust, physicians are better able to foster mutually beneficial relationships with patients.

However, the benefits of disclosing potentially harmful errors must be weighed and balanced against the risks of alarming patients by disclosing trivial errors (i.e., errors that do not impact the patients' health and overall care). If and when a physician determines that disclosure of certain information will likely lead to a patient's harm or suffering, the physician may choose to refrain from disclosure. Under such circumstances, the physician is free to withhold information on the basis of therapeutic privilege.[7]

Exercising therapeutic privilege, however, often limits the patient's autonomy[8] and requires the physician to balance the benefits and risks of disclosure against the patient's continued health and the public's wellbeing. It is therefore vital for the physician as health advocate to understand the needs of the patient as well as the needs of the community. The physician must determine whether he/she can disclose an adverse event to the public without jeopardizing the autonomy of his/her own patient.

The Physician as Professional

Ultimately, physicians have an ethical and professional obligation to disclose adverse events to patients and the public. Section 14 of the Canadian Medical Association's *Code of Ethics* states that the physician must "Take all reasonable steps to prevent harm to patients; should harm occur, disclose it to the patient."[15] While section 14 provides some guidance into the disclosure of adverse events, it does not provide guidance on *what* or *how* information should be disclosed.

Section 14 of the *Code of Ethics* reassures us that members of the medical profession agree, at least in principle, that it is ethically imperative that patients are told about adverse events. The focus now becomes putting principle into practice to best serve patients.

The Physician as Scholar

As society becomes more aware of medical errors, health care institutions are responding by creating disclosure-training programs for physicians.[5] While training is not mandatory, it is imperative that physicians strive to participate in such programs.[6] Ideally, training should focus on the basic content to be disclosed, including expressing regret for unanticipated outcomes and apologizing if and when those outcomes result in errors. As well, physicians should be encouraged to review and reflect upon each disclosure discussion and the resultant outcomes.[6]

It may also be prudent for developers of residency training programs to consider instituting mandatory disclosure training sessions for residents. Such sessions could involve the use of standardized patients, as well as patient safety groups, physicians, and institutional managers. Residents would also benefit from instruction regarding media relations and public forums. Resident training and information sessions will assist in equipping new physicians with the skills necessary to effectively work with patients in such trying circumstances.

Conclusion

As medical experts, physicians have an obligation to disclose adverse events to patients and the public. In considering strategies for best approaching adverse events, physicians must not underestimate the importance of their patients' desires. Patient-centered strategies require a better understanding of patients' needs following adverse events, as well as an understanding of existing barriers to meeting those needs.[8]

Physicians can, and indeed should, use their skills to work within the current health care system to enact change and protect health care within hospital and legislative policy. Experienced physicians can also play a vital role in establishing scholarly foundations on which younger physicians may develop the skills necessary to help patients following adverse events.

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