DISCLOSING ADVERSE EVENTS TO PATIENTS: STRENGTHENING THE DOCTOR-PATIENT RELATIONSHIP

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ADVERSE EVENTS AND LITIGATION

Patients and families litigate for a variety of reasons. Financial need is certainly a factor. Disappointment and anger over poor clinical outcomes or unfulfilled expectations also play significant roles. Surprises at unanticipated outcomes or the incidental discovery of important undisclosed details in and around an adverse event are also strong motivators. Surprise may quickly turn to mistrust and anger. Patients and families sometimes state that litigation is an attempt to find out what happened after other attempts at communication and enquiry have not successfully answered their questions. Litigation may also be an attempt to change the system for the better so that similar events do not reoccur.

Some patients and families have said they may even be forgiving of preventable adverse events but are less inclined to be so if they perceive that the physician or hospital is evasive or dishonest. There is some evidence to suggest that physicians who have a good bedside manner and a caring attitude, and who support their patients through an adverse event may be less likely to be sued.

Physicians react to unexpected complications and poor clinical outcomes for their patients in a variety of ways. Most want to understand what went wrong. Moreover, the majority of physicians are instilled with a profound sense of personal responsibility and are immediately self-critical when an adverse event affects their patient. There is also sometimes a tendency to attribute the cause of the harm to others even before all of the contributing circumstances and facts are known. All physicians are motivated to prevent, to the extent possible, the adverse event from happening again.

WHAT IS AN ADVERSE EVENT?

Adverse clinical outcomes usually are not caused by negligence. In fact, most adverse events—unanticipated injuries or outcomes that occur during the course of medical care—are an inevitable part of clinical practice even with the best of care. In the courts, the medical standard of care to determine negligence is not one of perfection, but rather the standard of care that might reasonably have been applied by a colleague in similar circumstances. The courts rely heavily upon the testimony of other physicians working in a similar specialty in the same kind of practice to help establish the applicable standard of care.

The term medical error is often used instead of the term "adverse event"; however, many of those charged with improving patient safety dislike the term because it carries with it a sense of blame or fault that may be inappropriate, especially when it is used before all the circumstances and facts about a case are known.
Disclosure of adverse events is often used to refer to two sorts of communication that are quite different: disclosure of adverse events to patients and families; and reporting of the event to quality of care committees or other authorities (this topic was partly covered in the June 2004 Information Sheet, Disclosure to quality assurance committees in hospitals, and the CMPA will revisit this topic in a future Information Sheet.)

DISCLOSURE OF ADVERSE EVENTS TO PATIENTS
The CMPA has for many years encouraged member physicians to disclose to patients the occurrence and nature of adverse outcomes as soon as is reasonable to do so after their occurrence. This is an ethical, professional and legal obligation. This recommendation sometimes is unfortunately confused with specific CMPA advice given to a specific physician related to limiting communications with a patient after a legal action has commenced. Prior to communicating directly with a patient who has commenced a legal action against them, members should consult the CMPA or their legal counsel.

DISCLOSURE TO PATIENTS SOON AFTER THE ADVERSE EVENT IS RECOGNIZED
Ideally, the communication of adverse events should be done in a gentle, non-rushed manner in a private setting. Formulate a plan of communication prior to approaching the patient and/or family.

The CMPA suggests the following:

• Deal with any emergencies and immediate health concerns.
• If time allows, you may wish to seek telephone advice from the CMPA prior to communicating with your patient, family or hospital.
• Give your patient the clinical information about what has happened and the clinical nature of their condition as it now exists in a factual way. Avoid speculation about what may have happened if a different course of action had been followed initially. Avoid attribution of fault, particularly concerning the care provided by others.
• Give your recommendations as to what might be best done to deal with the medical condition as it now exists, including alternate treatments and the risks and benefits of any other investigations and treatments. This is an informed consent discussion on how to move forward. Answer any of your patient’s questions about the proposed treatments.
• Maintain close communications with your patient and the family (with the patient’s consent, of course) about the ongoing clinical condition and any ongoing plans for treatment.
• Facilitate any necessary treatments and consultations.
• Transfer the care to another physician if your patient requests or prefers it or if the condition requires care that you cannot provide.
• Express your feelings of empathy, sorrow and concern as appropriate. Expressing your sincere regret about what has happened or wishes that the event had not occurred are entirely acceptable and desirable statements. Sometimes, if the outcome is indisputably due to your improper care, you may acknowledge your responsibility.
• Inform your patient about any process through which the incident may be investigated and how your patient can obtain the results.
• Document in a factual way your care and the discussions that have occurred after the adverse event on your patient’s chart. Never make alterations to the patient record or change what has been previously written in any way.

The time a physician takes to disclose an adverse event to a patient may actually help restore or strengthen the doctor-patient relationship.
• Call the CMPA if you are concerned about potential medico-legal problems as a result of the incident.

In summary, patients and their families want to understand what went wrong, as do their physicians. Patients do not want to feel abandoned by their physician after an adverse event has happened. The patient’s most immediate concern is usually to know what needs to be done to improve the clinical situation. It is at this time that good communication may actually help restore or strengthen the doctor-patient relationship.

The bottom line

• Adverse events—unanticipated injuries or outcomes that occur during the course of medical care—are an inevitable part of clinical practice even with the best of care.

• The CMPA has for many years encouraged member physicians to disclose to patients the occurrence and nature of adverse outcomes as soon as is reasonable to do so after their occurrence. This is an ethical, professional and legal obligation.

• Ideally, the communication of adverse events should be done in a gentle, non-rushed manner in a private setting. Formulate a plan of communication prior to approaching the patient and/or family.

• The time a physician takes to disclose an adverse event to a patient may actually help restore or strengthen the doctor-patient relationship.

Previous related articles

• Information Sheet, October 2001, Disclosing Adverse Clinical Outcomes. This article describes what the CMPA recommends its members consider when they are faced with an adverse clinical outcome.

• Information Sheet, June 2004, Disclosure to quality assurance committees in hospitals. This article discusses the disclosure of adverse outcomes to quality assurance committees and makes suggestions on how physicians can participate in quality assurance activities without exposing themselves to undue risk.

All previous Information Letters and Information Sheets can be found on the Member Portal of CMPA's Web site at www.cmpa-acpm.ca.