BEST PRACTICES

RISK MANAGEMENT RESOURCE

DISCLOSURE OF UNANTICIPATED OUTCOMES

ABOUT NORCAL GROUP

The NORCAL Group of companies — including NORCAL Mutual Insurance Company, NORCAL Specialty Insurance Company, Medicus Insurance Company and FD Insurance Company — provide medical professional liability insurance to physicians, health care extenders, medical groups, hospitals, community clinics and allied health care facilities throughout the country. They share an A.M. Best "A" (Excellent) rating for their financial strength and stability.

An "unanticipated outcome" can be defined as a negative or unexpected result stemming from a diagnostic test, medical judgment or treatment, surgical intervention, or from the failure to perform a test, treatment or intervention. It is not always the result of medical error or professional negligence.

A patient has a need and a right to know about his or her condition and to make educated, meaningful healthcare decisions in the event of an unanticipated outcome. Disclosure is not only required by medical ethics, but it also can restore the patient's faith and trust, allowing the healthcare team to provide the best possible care going forward. Finally, disclosure can be a powerful liability risk management tool — many healthcare professionals have found that rather than prompting litigation, communication about problems or errors actually defuses anger and may prevent litigation.

Disclosure and the Informed Consent Process

Disclosure really starts when a patient and provider engage in the informed consent process. Ideally, during consent discussions, the patient is initially exposed to the possible adverse outcomes associated with the anticipated treatment or procedure. Frequently, patients have a difficult time understanding that adverse outcomes are the occasional outcome of treatment and not necessarily the result of medical error. During the consent process, therefore, it is the provider's job to help the patient understand how even the best medical care can have unintended results.

A significant number of medical negligence claims involve an unanticipated outcome that is a known risk. During the consent process these risks are sometimes not addressed, or they are discussed, but the patient does not understand them or forgets about discussing them. Ensuring that the patient understands what he or she is consenting to is the responsibility of the provider. Providers must, therefore, be able to determine whether the patient actually understands what he or she is agreeing to. A patient who does not understand the provider has not given a valid informed consent.

When complications lead to an unanticipated outcome, documentation of the informed consent process, including efforts to ensure patient comprehension can be used as a guide for providers in disclosure discussions with the patient. For example, the informed consent notes in the medical record can be used as a reference in a discussion with a patient that might begin as follows: "Do you remember when we discussed that one of the risks of taking warfarin was bleeding? Unfortunately, this is what has happened. This is what we need to do…" A truly informed patient, one who feels he or she has made decisions meaningfully about healthcare and fully realizes the risks, is less likely to file a medical liability claim. But if a claim is filed, documented evidence that the unanticipated outcome was discussed, and particularly any notes about extra efforts to confirm comprehension of that outcome, provides significant support to a provider's defense.

Nine Steps for Responding to Unanticipated Outcomes

When an unanticipated outcome occurs, the best response is one that is thoughtful and organized. NORCAL Mutual has developed *Nine Steps for Responding to Unanticipated Outcomes* to aid physicians or other providers faced with taking action after an unanticipated result of care. The order in which the

nine steps are completed may vary depending on the individual situation, whether the outcome is a known complication or the result of medical error, and whether additional institutional policies exist. In every instance, however, caring for the patient's immediate needs should always come first. The nine steps are designed for hospital, group and individual physician office settings. An involved provider should ensure that all steps are addressed, which may involve delegating an action to another individual(s).

1. CARE: Take Care of the Patient
2. PRESERVE: Preserve the Evidence
3. DOCUMENT: Document in the Medical Record
4. REPORT: Complete Mandatory Reports If Required
5. NOTIFY: Notify the Claims Department of Your Medical Professional Liability Carrier
6. DISCLOSE: Conduct the Initial Disclosure Discussion
7. ANALYZE: Analyze the Unanticipated Outcome to Prevent Recurrence and/or Improve Future Outcomes
8. FOLLOW THROUGH: Conduct Subsequent Disclosure Discussion(s)
9. HEAL: Heal the Healthcare Team

Responding promptly to unanticipated outcomes helps to preserve the physician-patient relationship; ensures that the patient's medical needs are met and possibly averts litigation. Moreover, the healthcare team's understanding of why and how the event occurred can lead to corrective action and prevent the occurrence of similar events in the future. These processes can serve to improve overall patient care in a medical group, hospital or clinic.

Essential Elements of Disclosure

Who discloses?

Who informs the patient will vary depending on the circumstances. The provider(s) involved in the unanticipated outcome will have the most knowledge of the circumstances surrounding the event and should therefore have a central role in the discussion(s). If another provider will be responsible for the ongoing care of the patient, he or she may also be involved. Facilitating communication may warrant the involvement of additional individuals, such as an interpreter and/or another member of the healthcare team with whom the patient has developed a rapport, or in an instance of medical error, a representative of the healthcare organization or a risk manager.

Those involved in the disclosure discussions may need assistance when preparing for the disclosure task, depending on their communication skills and the circumstances surrounding the care. Members of a hospital's risk management department or patient safety function can usually help healthcare providers who want or need assistance with facets of the disclosure task. It is also appropriate for a healthcare provider to discuss a disclosure situation with a risk management or claims representative from his or her liability insurance company to get advice or answers to questions about going through a disclosure process.

When should disclosure take place?

After an unanticipated outcome, disclosure should happen as soon as feasible after immediate healthcare needs are addressed. The disclosing physician or team should consider the patient's physical and emotional readiness to listen to and process the information. The patient's permission is needed to discuss care issues with family members.

What information should be disclosed?

The nature of the problem and the plan for corrective action to be taken should be stated as clearly and simply as possible. Disclose "known facts" — these are objective facts "known to date that are either documented in the medical record or learned through the event analysis." Physicians are ethically required to tell patients what they need to know in order to understand what has happened, and full disclosure in nontechnical language is important and is advised. If an outcome requires a new treatment plan, even if it only means an extended length of stay, it is an unanticipated outcome and should be disclosed.

If a physician is involved in writing an incident report or is participating in "event analysis" or peer review meetings, he or she may be viewing and producing documents and taking part in discussions that are legally confidential. The physician must refrain from referring to confidential information (that is, information generated in these internal analyses) in his or her discussions with the patient and family. This does not mean participating in a cover-up of facts. It means not referring to specific events, documents, and conversations that are part of peer reviews, event analyses, or other legally confidential activities.

Physicians who are unsure about what information is confidential and what may be shared can seek assistance from their facility's risk managers, quality improvement staff, legal counsel from their medical professional liability carrier, or from their practice attorneys.

Providers should avoid speculating and offering opinions on causes or outcomes, and should resist the impulse to blame the patient or other providers involved in the patient's care. Many providers have rushed to confess their shortcomings or those of colleagues only to find out later that the outcome was unrelated to the care given. If the cause of the unexpected outcome is not known, in response to a specific question from the patient, an honest answer may be "I don't know" or "I don't know yet." However, the patient needs reassurance that the provider will share information when he or she ultimately learns it. Patients should be given an estimate of how long the analysis process may take so that they have realistic expectations and don't begin to wonder if something is being hidden. When additional analysis is necessary, the patient should be given the name of a contact person in the practice and/or at the hospital who will be coordinating future communication.

If it is established that an error occurred, an apology may be part of the disclosure conversation. The majority of states have implemented "I'm sorry" laws that are designed to promote disclosure and apology in healthcare by making apologies by healthcare providers inadmissible in malpractice cases. A careful understanding of the applicable state law is in order, however, because the laws can vary greatly and some of the laws are restrictive in what they protect. For example, many laws will protect

expressions of condolences or apologies to patients or their families but statements admitting culpability (e.g. "I'm sorry I did this to you") may not be protected.

How should the information be disclosed?

When a patient is injured or is not as well as expected, the patient's needs should be the center of the physician's attention. The physician should try to address the patient's and family's concerns without minimizing them.

One way to organize and keep in mind some of the main ideas about disclosure is to think of an acronym: SEED. Ultimately, a good disclosure process plants the seed for a continuing relationship that may grow stronger as time goes on. SEED stands for:

- **S**etting
- **E**mpathy
- **E**ducation
- **D**ocumentation

Setting

The setting should be conducive to a private discussion. Keeping the patient's needs at forefront, a physician should find a quiet and comfortable place to have the disclosure discussion, which should occur in person, face-to-face with the patient and any family members or others that the patient wants to include. This setting could be at bedside or in a consultation room or private lounge. The physical area between the physician and the patient should be as open as possible so that eye contact can be easily made.

Empathy

The physician should express understanding of the patient's and family's pain and suffering. A sincere attitude of empathy from a provider shows that the provider cares about the patient's and the patient's family's pain and suffering and is not insensitive to the outcome. Providers are encouraged to convey a receptive attitude by:

- Maintaining an open posture (e.g., arms uncrossed, concerned expression, eye contact, empathetic listening).
- Naming and validating patient concerns and feelings ("I can understand your anger…")
- Avoiding a defensive or accusatory reaction if care is questioned or criticized. Admissions of liability should be avoided, for example, "I'm sorry that I caused your…" or "I'm sorry Dr. Smith caused your…" Instead, the focus should be on the patient or family's situation, for example, "I am sorry that you…" or "I am sorry for your…"

If an unanticipated outcome was simply a random result, not the consequence of any error, compassion can be expressed without apologizing or taking on blame. If the patient is deceased, and a physician is interacting with the family, he or she can extend sympathy to the family through verbal expression, by

sending a note, card, flowers, memorial gift, or by attending the funeral. In cases in which a physician knows that he or she has made an error, an apology should be given.

Taking an empathetic stance also means a physician elicits patient and family responses to the outcome, listens to the responses and acknowledges them. The patient or family may react to an adverse event with silence, hostility, an angry outburst, by complaining to the institution, by making threats, by contacting the media, or in other ways. In most cases, it is best to try to remain calm and listen to the patient and the family express their concerns. In cases in which the patient or family is threatening or abusive, steps may need to be taken for protection, including notifying the facility's risk management or security department, consulting an attorney, or if warranted notifying local law enforcement authorities.

Communicating with the patient or patient's family about the unanticipated outcome empathetically and non-defensively within the shortest appropriate time period may help dispel much of the patient's anger, confusion and distrust. A patient's belief that he or she is not being told the whole story, or is not being given the opportunity to ask the provider questions and vent feelings, often provokes a decision to seek the advice of an attorney and pursue a professional liability claim against the provider.

Education

The physician should honestly educate the patient and family about the adverse event by telling them all the facts known about what happened. He or she can talk about future steps that will be taken to minimize or eliminate problems related to this particular unanticipated outcome. When educating the patient about the adverse event, the physician should stick to objective facts so that the patient doesn't confuse what might have happened with what is known to have happened.

The "teach back" method can be used to verify that the patient/family understands the outcome and prognosis. For example: "This is upsetting news. I want to make sure that I have clearly communicated what we know so far. What is your understanding of what happened?" Based on the responses received, misunderstandings, confusion and information gaps can be addressed as needed.

When explaining matters to the patient, the physician may be asked to comment on the treatment or role of other healthcare providers. He or she should only comment on his or her own care and interaction with the patient. When conveying to the patient and family what is known about the unanticipated outcome, a physician should avoid blaming anyone. Ideally if an error is known, and multiple providers are involved, all providers involved in the care should participate in the disclosure discussion. Each provider can describe the course of events and the nature of the mistake.

There can be a clinical situation where a clear-cut error is determined but the responsible party chooses not to disclose to the patient. The question then turns on the merit of mandatory disclosure of another healthcare worker's error. One thought is to engage a neutral third party (e.g. an ethics committee) to review the case and help resolve disagreements between providers about whether and how disclosure should take place. If the event takes place in a hospital setting, an institutional approach could be taken when communicating with patients about another healthcare provider's error.

Documentation

After an unanticipated outcome, documentation in the patient's medical record should include the known facts associated with how the event happened and the care given in response. There should also be a succinct but thorough note about the disclosure discussion, including who was present, the key issues of the conversation and the questions the patient/family asked along with the answers provided.

In addition, all the plans for future care as well as the plans for further discussion about the situation should be noted in the patient's medical record. Notes in the medical record should always focus on the care of the patient. There should be no notes that blame or speculate or disparage other providers or the patient. Statements that blame or contain speculation should not be made in the medical record. These types of statements do not reflect well on the physician and can affect the physician's credibility.

If the unanticipated outcome occurred in a hospital or a surgicenter, the facility may require the physician to complete an incident report or to follow some other reporting process. There should never be statements made in a medical record regarding the completion of an incident report, contacts with risk management or consultations with legal counsel. Incident reports should never be photocopied, included in or referred to in the medical record. Incident reports are internal documents used to communicate adverse outcomes to facility administrators for the purpose of investigation and prevention of similar adverse events. The facility's risk manager or patient safety officer should be contacted regarding questions related to internal reporting processes and investigation.

Medical Professional Liability Risks

Physicians have an ethical obligation to honestly explain the various aspects of a patient's condition and treatment, which includes giving accurate, non-evasive information when there has been an unanticipated outcome in a patient's care. Studies reported in the medical literature undertaken over the years have convincingly substantiated that patients want to know the full details associated with any unanticipated outcomes and that they want to be clearly informed about any errors that occurred in their care. Findings suggest that not informing a patient of a medical error — even a seemingly minor mistake — increases the physician's risk of being sued and jeopardizes good physician-patient rapport. In addition, recent analysis of jury opinions has indicated that jurors may consider disclosure a sign of integrity while viewing nondisclosure as a type of cover-up indicating untrustworthiness.

A patient has a need and a right to know about his or her condition and to make educated, meaningful healthcare decisions in the event of an unanticipated outcome. Disclosure is not only required by medical ethics, it can restore the patient's faith and trust, allowing the healthcare team to provide the best possible care going forward. Unanticipated outcome disclosure is advocated by organizations such as the American Medical Association (AMA) (see AMA Code of Medical Ethics, Opinion 8.6 – Promoting Patient Safety, available at www.ama-assn.org/about-us/code-medical-ethics), the National Patient Safety Foundation (NPSF) and the American Society for Healthcare Risk Management, and mandated by The Joint Commission (Ethics, Rights and Responsibilities Standards (RI.2.90). Additionally, state laws, medical staff bylaws, medical group policies and procedures, health plans and healthcare organizations may require disclosure of unanticipated outcomes.

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Risk Management Recommendations

- Follow the Nine Steps to Respond to an Unanticipated Outcome.
- Identify, involve and coordinate the appropriate participants in the disclosure process.
- Establish the facts.
- Assess patient readiness, health literacy and cultural issues.
- Consider and address patient privacy needs and concerns.
- Determine where the disclosure discussion will take place.
- Consider the communication skills and the emotional well-being of the healthcare team participants and provide assistance when necessary.
- Document known facts associated with how the event happened, the care given in response and the treatment plan. Include a succinct note about the disclosure discussion noting who was there and the key issues discussed.
- Do NOT blame, speculate or disparage other providers or the patient.
- Do NOT include facility incident reports in the patient's medical record.
- In a medical group, be aware of disclosure policies in facilities where group members provide health care treatment and consider developing a group policy for disclosing unanticipated outcomes, which may mirror a facility's disclosure policy. Ensure group members support disclosure and that they know who to go to first if disclosure is indicated. Educate group members about the steps to be taken before, during, and after disclosure. If disclosure occurs in a facility not operated by the group, cooperate with the facility's risk manager.
- Be careful in how an apology is expressed to patients and families. It should be communicated in a way that does not imply culpability when no error has been committed. Know if your state has an "I'm sorry" law, and if it does, know the extent of its protections.
- If another healthcare provider is thought to have committed an error, consider use of an ethics committee to mediate disagreements. Collaborate in the error investigation and jointly disclose when an error occurs.
- Encourage full disclosure of unanticipated outcomes in the healthcare organization by developing a nonpunitive approach to handling errors in care, i.e. a "just culture" philosophy.

Additional Resources

- NORCAL resource document Nine Steps to Respond to Unanticipated Outcomes

- Online toolkit from the Agency for Healthcare Research and Quality (AHRQ). The toolkit is based on a process called Communication and Optimal Resolution, or CANDOR, which gives hospitals and health systems the tools to respond immediately when a patient is harmed and to promote candid, empathetic communication and timely resolution for patients and caregivers. Available at www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/candor/index.html (accessed 6/10/2016).

- New England Journal of Medicine article *Talking with Patients About Other Clinicians' Errors*, available at www.nejm.org/doi/full/10.1056/NEJMsb1303119 (accessed 6/10/2016).

The order in which these steps are completed may vary depending on the individual situation and/or the relevant institutional policies in effect at the time. In every instance, however, caring for the patient's immediate needs should always come first.

By "unanticipated outcome," we mean a negative or unexpected result stemming from a diagnostic test, medical judgment or treatment, surgical intervention, or from the failure to perform a test, treatment or intervention. The unanticipated outcome may or may not be the result of error or negligence.

1. CARE: Take Care of the Patient

- Address current healthcare needs
- Obtain necessary consults
- Assign primary responsibility for care, and communicate the identity of the physician in charge and the physician's contact information to family[1] and healthcare team

2. PRESERVE: Preserve the Evidence

- Sequester machinery (pumps, anesthesia machines) and preserve settings
- Sequester equipment (syringes, IV tubing, medication vials)
- Inform hospital Risk Manager
- Inform Maintenance Department or supplier
- Acquire back-up equipment

3. DOCUMENT: Document in the Medical Record

- What to include:
  - "Known facts"[2] about the unanticipated outcome
  - Care given in response
  - Disclosure discussion and names of witnesses (see Step 6 below)
  - Treatment and follow-up plans
- What not to include:
  - Subjective feelings or beliefs
  - Speculation or blame
  - References to incident report forms or Event Analysis[3]
  - "Confidential"[4] information
- Begin the Event Analysis by completing an incident report
  - Record details about "known facts" in the report
  - Avoid speculation or blame
  - Treat as a confidential document
  - Do not place in medical record or discuss in medical record
  - Do not photocopy

4. REPORT: Complete Mandatory Reports if Required

- Inform hospital Risk Management, Department Chief, Peer Review as needed or if required
- Inform FDA if medical device or medication is involved

- Inform coroner
- Inform Public Health Department and/or other governmental agencies

5. NOTIFY: Notify Claims Department of Your Malpractice Carrier

- Report any incident that could lead to claim, settlement demand, or lawsuit
- Do NOT use incident report form to notify carrier

6. DISCLOSE: The Initial Disclosure Discussion

Why, Who, When, Where?

- Why disclose unanticipated outcomes?
  - Patient has right to know condition and make healthcare decisions
  - Improves doctor/patient relationship
  - Rebuilds trust
  - Improves quality of care
  - AMA Professional Code of Ethics calls for disclosure[5]
  - The Joint Commission Standards on Patient Safety and Error Reduction
  - May be required by hospital staff bylaws, medical group policies and procedures, health plans, and healthcare organizations
- Who will inform patient?
  - Healthcare provider(s) involved in the unanticipated outcome
  - Provider(s) with responsibility for ongoing care
  - People with ability to answer questions
  - People involved in disclosure discussion may need assistance in preparing, coordinating or conducting discussion, depending upon:
    - Communication skills
    - Rapport with patient and family
    - Language barriers
- When to inform patient and family?
  - As soon as practicable after immediate healthcare needs addressed
  - Consider patient's physical and emotional readiness
  - Patient's permission needed to discuss care with family
- Where to hold discussion?
  - Consider privacy and health needs

How To Disclose Unanticipated Outcomes

- Express empathy
  - Convey compassion for patient's and family's pain and suffering
    - "I am sorry that you…" or "I am sorry for your…"
    - Focus on patient's and family's needs
    - Avoid "I am sorry that I…"
  - Extend sympathy to family of deceased patient

        - May express verbally or in writing
        - May send flowers
        - May attend funeral
- Communicate only "known facts"[6]
    - What to communicate
        - Objective information
            - Documented in medical record
            - Learned through the Event Analysis[7] UNLESS "confidential"[8]
            - Adequate to ensure patient's understanding of unanticipated outcome and prognosis
            - The nature of the problem
            - The plan for corrective action
        - If Event Analysis reveals systems errors and/or involvement of multiple healthcare team members
            - Contact Event Analysis Team for advice on individual vs. group discussion and appropriate participants
            - Clarify what is "confidential" and who will discuss what with the patient/family
    - What not to communicate
        - Subjective information
        - Conjectures or beliefs
        - "Confidential" information, determined by state and/or federal law —possible examples include:
            - Results of protected Peer Review, Quality Assurance, Performance Improvement, or Risk Management Committees
            - Information provided in confidence by a third party
            - Confidential information about a healthcare organization or its operations
            - Health or employment information about a provider or employee
        - If asked to disclose "confidential" information
            - Inform patient/family that certain "confidential" information cannot be disclosed
                - "I know how important it is to you to understand what happened. Some information is confidential and can't be disclosed. What I can tell you is…"
        - If asked to comment on role/responsibility of other healthcare team members and/or possible systems errors
            - Inform patient that you can only comment on your own care.
                - "I am not knowledgeable enough to discuss that aspect of your care…"
                - Contact Event Analysis Team/Risk Manager/malpractice carrier for guidance on what is "confidential" and who will disclose specific information about another provider's care or systems issues

- Avoid speculation and blame
    - Causes of unanticipated outcome may not yet be known
    - Unanticipated outcome not always preventable
    - Unanticipated outcome may be result of disease process or risky life-saving treatment, or not preventable (e.g., some falls)
    - Unanticipated outcome not always a result of negligence
    - Error, if one occurred, may not be the cause of unanticipated outcome
- Solicit and respond to patient's/family's feelings and questions
    - Contain your own emotional response
        - Focus on patient's needs
    - Convey receptive attitude
        - Open posture: arms uncrossed, concerned expression, eye contact, empathetic listening
    - Name and validate patient's concerns and feelings ("I can understand your anger…")
    - Avoid defensive or accusatory reaction if your care is questioned
- Respond to patient's complaints
    - Assure patient that the healthcare providers are dedicated to quality care and that they take patients' complaints seriously
    - Depending on size of practice/organization, refer to Patient Relations Department or other responsible person in the practice/organization
    - Explain how to lodge complaint, and provide forms if available
    - Do not offer opinion on need for lawsuit or monetary value of a settlement for injury
- Respond to patient's questions about remedies and refer settlement demands
    - Discuss immediately with organization's Risk Manager and with malpractice carrier
    - Inform patient that you are not in charge of claim resolution process but that you will contact appropriate people
- Verify patient's/family's understanding of outcome and prognosis
    - "This is upsetting news. I want to make sure that I have clearly communicated what we know so far. What is your understanding of what happened? About your current condition?"
    - Address misunderstandings, confusion, information gaps as needed
- Plan for follow-up care and more discussions, and communicate the plan
    - If cause of unanticipated outcome or prognosis is not yet known, assure patient/family that additional facts will be shared when available
        - Give estimate of how long analysis process may take
        - Patient expectations may not be realistic
    - If expectations are not met, this can lead to breakdown of trust, fear of abandonment or cover-up, patient dissatisfaction, lawsuit
    - Make appointment for phone call and/or visit to update patient
        - For example, "I will call you in two weeks to give you an update."

- Encourage patient/family to call if he/she/they have questions or haven't heard back from you or other disclosure team member
- Give name of contact person in hospital or practice

7. ANALYZE: Analyze Unanticipated Outcome to Prevent Recurrence and/or Improve Future Outcomes

- Patient safety goal: make it hard for unanticipated outcomes to occur, easy to detect them, easy to respond and report
- Conduct Event Analysis. If in group, hospital, or clinic, refer to individual or committee responsible for analyses
- Identify all causes of an event or "near miss"
- Develop and implement Corrective Action Plan (CAP) or refer to individual/committee responsible for CAP
- Keep Event Analysis documents and discussions "confidential"
- Do not include or refer to Event Analysis in medical record
- Do not photocopy Event Analysis documents
- If the Event Analysis confirms that an error contributed to the injury, the patient and the family or representative should receive a truthful explanation about the error. See the American Medical Association Code of Ethics, Opinion 8.6 – Promoting Patient Safety, available at www.ama-assn.org/about-us/code-medical-ethics (accessed 11/23/2016).

8. FOLLOW THROUGH: Subsequent Disclosure Discussions

- Goal: meet ongoing healthcare needs and continue to address patient's/family's questions and concerns
- Keep promises: call back as promised or as needed
- Keep promises: hold subsequent disclosure discussions as promised or as needed
  - Determine the "Who, When, and Where" of the disclosure discussion based on current patient needs and latest results of Event Analysis
  - Begin subsequent disclosure discussions by informing patient/family that care has been reviewed and that you are interested in continuing to discuss patient's/family's questions and concerns
  - Follow guidelines on disclosure in Step 6
- Don't make promises that cannot be kept
  - Cannot provide Event Analysis documents
  - Cannot disclose "confidential" information
  - Cannot discuss others' roles and responsibilities unless authorized to do so by Event Analysis Team: don't speculate or blame

9. HEAL: Heal the Healthcare Team

- Acknowledge effects of unanticipated outcome on healthcare team members
  - Unanticipated outcomes are disturbing to all involved
  - Recognize need to discuss feelings about outcome/analysis with your family, friends, and colleagues
  - Identify resources to help in healing
  - Allow time for resolution of feelings
  - Participate in litigation stress workshops or groups, if available
- Distinguish between discussion of your feelings and discussion of facts of outcome/analysis
- Discuss facts of outcome/analysis only with:
  - Other members of patient's healthcare team for provision of care
  - Patient/family UNLESS "confidential"
  - Participants in Event Analysis, Peer Review, Quality Assurance, Risk Management and other activities designed to improve quality of care
  - Malpractice carrier
  - Defense attorney in the event of litigation
- Avoid informal discussions of facts of outcome/analysis with colleagues, family, friends
- You may share feelings about outcome/analysis with colleagues, family, friends

References

1. By "family," we mean family members, significant others, domestic partners, and close friends with whom a patient chooses to share health information.

2. Many more facts may eventually be known than can be disclosed. By "known facts," we refer to those objective facts, known to date, which are either documented in the medical record or learned through the Event Analysis (see footnote 3) and which can be disclosed without violating "confidentiality" (see footnote 4).

3. "Event Analysis" includes any activity designed to evaluate the causes of unanticipated outcomes and improve patient outcomes in the future. Any incident with the potential to cause harm, including "near misses" and "close calls," should be analyzed. Event Analysis activities include: completing and analyzing incident reports, Peer Review, Quality Assurance and Performance Improvement, Risk Management, and Morbidity and Mortality Conferences. Depending upon state and/or federal law, documents and discussions produced during the Event Analysis may be legally confidential. For that reason, care should be taken to limit discussions to a "need to know" basis for the purposes of the Event Analysis, to avoid photocopying documents, and to refrain from referring to the analysis in the medical record.

4. Laws determining what discussions and documents are considered legally confidential — and thus not discoverable as evidence — vary from state to state; federal laws may also apply. We refer to such information as "confidential." You may want to contact the Claims Department of

your professional liability carrier for assistance. You should contact an attorney if you need legal guidance.

5. American Medical Association. Chapter 8: Opinions on Physicians and the Health of the Community (8.6 Promoting Patient Safety). 2016. Available at www.ama-assn.org/about-us/code-medical-ethics (accessed 11/23/2016).
6. See note 2.
7. See note 3.
8. See note 4.