

BEST PRACTICES

RISK MANAGEMENT RESOURCE

DISCLOSURE OF UNANTICIPATED OUTCOMES

ABOUT NORCAL GROUP

The NORCAL Group of companies provide medical professional liability insurance, risk management solutions and provider wellness resources to physicians, healthcare extenders, medical groups, hospitals, community clinics, and allied healthcare facilities throughout the country. They share an A.M. Best “A” (Excellent) rating for their financial strength and stability. NORCAL Group includes NORCAL Mutual Insurance Company and its affiliated insurance companies. Please visit norcalsgroup.com/companies for more information.

The information contained in this document is intended as risk management advice. It does not constitute a legal opinion, nor is it a substitute for legal advice. Legal inquiries about topics covered in this document should be directed to an attorney.

Recommendations contained in this document are not intended to determine the standard of care, but are provided as risk management advice. Recommendations presented should not be considered inclusive of all appropriate risk management strategies or exclusive of other strategies reasonably directed to obtain the same results. The ultimate judgment regarding the propriety of any specific procedure must be made by the physician/ healthcare provider in light of the individual circumstances presented by the patient.

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 informed healthcare decisions in the event of an unanticipated outcome. Not only is disclosure the ethical thing to do, 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 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

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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. Some of the steps may even occur simultaneously. 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.

Apology Laws

If it is established that an error occurred, an apology may be part of the disclosure conversation. Many 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. Most state laws protect expressions of sympathy, compassion or regret, but few protect statements of fault.

The definition of apology is not consistent among the different states' apology laws, and the legal definition of "apology" may be at odds with a clinician's definition of apology. Additionally, apologizing for an unanticipated outcome without admitting fault can be difficult. For this reason, it is probably best not to think of sympathetic statements associated with disclosing unanticipated outcomes as apologies. A simple rule of thumb is that empathy is always appropriate when discussing an unanticipated outcome; and apology is appropriate when an investigation proves an error was made. (Bailey KJ, Parraz DC, Plant MD. "Sorry, Not Sorry": Tension between Transparency and Liability? Presented at: American Society for Healthcare Risk Management 2016 Annual Conference; September 27, 2016; Orlando, FL.)

Essential Elements of Disclosure

The nature of the problem and the plan for corrective action to be taken should be stated as clearly and simply as possible. 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.

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:

- Setting
- Empathy
- Education
- Documentation

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 and is not insensitive to the outcome.

If an unanticipated outcome was not the consequence of an error, compassion can be expressed without apologizing or taking on blame. 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 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

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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 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 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. These types of statements do not reflect well on the physician and can affect the physician's credibility.

For additional details about how to conduct a disclosure discussion, see the Appendix: Nine Steps to Respond to Unanticipated Outcomes

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

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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.

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 clinicians or the patient.
- Do NOT include or mention 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. If disclosure occurs in a facility not operated by the group, cooperate with the facility's risk manager.
- 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.
- 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 non-punitive approach to handling errors in care, i.e. a “just culture” philosophy.

Additional Resources

- NORCAL *Claims Rx* Responding to Unanticipated Outcomes: The First Conversation. November 2017.
- 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 9/27/2017).
- The Collaborative for Accountability and Improvement offers information about Communication and Resolution Programs (CRPs). These programs are designed to promote empathetic communication, accountability, and application of learning to prevent similar incidents from recurring. Additional information is available at: <http://communicationandresolution.org/> (accessed 9/27/17).
 - Learn more about CRPs at: http://communicationandresolution.org/pix/Collaborative_CRP_Essentials.pdf (accessed 9/27/17).
- Ideas about approaches to disclosure and resolution strategies can be drawn from early resolution programs operating in a number of states. Examples include:
 - Oregon EDR Program: <https://oregonpatientsafety.org/edr/about-edr/> (accessed 9/5/2017)
 - Massachusetts CARE Model: www.macrmi.info/providers/#sthash.AoPrFExf.dpbs (accessed 9/5/2017)
 - Michigan Model: www.uofmhealth.org/michigan-model-medical-malpractice-and-patient-safety-umhs (accessed 9/5/2017)
- New England Journal of Medicine article *Talking with Patients About Other Clinicians’ Errors*, available at www.nejm.org/doi/full/10.1056/NEJMsb1303119 (accessed 9/27/2017).

Appendix – Nine Steps to Respond to Unanticipated Outcomes

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. Some of the steps may even occur simultaneously. In every instance, however, caring for the patient's immediate needs should always come first. When faced with the need to have a disclosure conversation with a patient or family, the physician may want to reach out to the facility risk manager or a risk management representative from his or her professional liability insurance carrier for assistance in preparing for the conversation.

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

- Convey compassion for the patient's situation, focusing on the patient's needs
- Be available (or make sure an appropriate person is available) to the patient for questions in the immediate aftermath of the incident or event
- 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 family¹ 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 those present for the discussion
 - Treatment and follow-up plans
- What not to include:
 - Subjective feelings or beliefs
 - Speculation or blame
 - References to incident report forms or Event Analysis³
 - “Confidential”⁴ information
 - References to communications with malpractice carrier or attorney

4. REPORT: Complete Mandatory Reports if Required

- 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
- Inform hospital Risk Management, Department Chief, Peer Review as needed or if required
- Inform FDA if medical device or medication is involved
- Inform coroner as needed
- Inform Public Health Department and/or other governmental agencies as needed or if required

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?

- Why disclose unanticipated outcomes?
 - Patients have a right to know about their condition and to make informed healthcare decisions
 - Improves doctor/patient relationship
 - Rebuilds trust
 - Improves quality of care
 - AMA Professional Code of Ethics calls for disclosure (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 9/26/17).)
 - 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
 - Diminishes liability risk
- 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
 - Choose a time that is convenient for the patient
 - Discussion should take as long as necessary; allot enough time in the physician's schedule to accommodate the discussion
 - Patient's permission needed to discuss care with family

Where, How and What To Disclose?

- Prepare for the conversation
 - Consider asking someone skilled in this type of conversation to accompany you or seek coaching to improve your communication skills
 - Consider consulting with the hospital's risk management or patient safety department or your liability insurance company for assistance
 - Prepare "talking points" that include (as appropriate):
 - The nature of the original medical problem and why treatment was pursued
 - Any information pertinent to the risk of a procedure that was provided to the patient during the informed consent discussion prior to the procedure being performed
 - A description of the procedure or treatment itself, including what (if anything) went wrong and how the healthcare team responded
 - An explanation of what has been done to care for the patient since the incident or event
 - Bring tools to describe how the unanticipated outcome occurred (e.g., diagrams, images, medical records, white board, etc.)
 - Anticipate difficult questions (e.g., "Did a medical device contribute to this injury? Why didn't you do [X]? Why did the other doctor tell me someone made a mistake?")
- Consider the "SEED" method – Setting, Empathy, Education, Documentation

Setting

- Consider privacy and the patient's health needs
- Select a location that will provide for the patient's and family's comfort
- The physical area between the patient and the physician should be as open as possible (i.e., not should not be sitting across a table from one another)

Empathy

- Exhibit "attending" behavior and actively listen to the patient
 - Sit at eye level with the patient
 - Keep an open posture, lean slightly forward; relax without crossing your arms, hunching your shoulders or bending your head down.

- Talk in a voice and tone that the patient understands, try to soothe the patient and empathetically relate to what is being said.
- Maintain eye contact.
- Indicate responsiveness with your facial expressions and gestures (nod, raise your eyebrows, smile, frown, etc. when appropriate)
- Respond to the topics raised by the patient before you pursue your own disclosure agenda.
- Listen for at least a minute before interrupting
- 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 or criticized
- 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

Education

- Communicate only "known facts"⁵
 - What to communicate
 - Objective information
 - Documented in medical record
 - Learned through the Event Analysis⁶ UNLESS "confidential"⁷
 - 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
 - “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...”
 - Avoid blaming other providers
 - 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 conjecture, speculation and opinions
 - 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
- 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

Documentation

- See step 3 above for details on what to document in the medical record
- See steps 4 and 5 above for other mandatory reporting

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 an 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 9/26/17).

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

Endnotes/Definitions

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. See note 2.
6. See note 3.
7. See note 4.