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EDITORIALS

Improving the disclosure of medical incidents

A genuine apology is only the first step in the process

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A central component of a just, patient safety culture includes the disclosure of serious medical incidents to those who are affected (open disclosure). The concept of openly disclosing the details of medical incidents has been adopted by several organisations and medical authorities including ones in Canada,[1] New Zealand,[2] the United Kingdom,[3] the United States,[4] and perhaps the earliest adopter, Australia,[5] which implemented a national open disclosure policy in 2003. The qualitative study by Iedema and colleagues (doi:10.1136/bmj.d4423) explores, from individual patients' perspectives, the successes and problems associated with the execution of the Australian open disclosure policy.[6] The study underlines many important messages for organisations that have or are considering an open disclosure policy.

The findings indicate that much work is needed to engage patients and families in open disclosure, and the study provides a long list of important activities and behaviours associated with successful open disclosure. Research and clinical experience suggest that several items from the list are central to effective disclosure,[7 8] including a true belief in the process, the timing of the process, an apology and expression of empathy, a knowledgeable and neutral person to help collect information and deal with patients' questions, and attention to the financial implications of the event.

The patient quotations suggest that it is still common for medical organisations to approach open disclosure with less than full high level commitment and belief in the process. This is not surprising: developing and maintaining a just patient safety culture requires ongoing effort, as organisations such as the Dana-Farber Cancer Institute have found.[9] The results should prompt leaders within medical organisations, particularly those in risk management, to critically examine their commitment to open disclosure.

Furthermore, the study shows that disclosure was often delayed. Disclosure should begin shortly after a medical incident is recognised, not when all the internal fact finding and analysis are complete. Those affected by a medical incident deserve specific and timely information, not just generic information that is packaged for everyone. Not surprisingly, clinicians need help in effectively delivering an apology and indicating their empathy for the patient's current situation. This may require coaching and role playing before the first disclosure meeting.[10] But it is crucial that the care team does not abandon patients or families when something goes wrong.

Disclosure needs to be viewed as a process, not a single meeting.[8] Affected people rarely understand all the components or complexities of the incident in one meeting. Organisations should expect a multi-visit process, even if the clinicians are involved only in the initial meeting. A single meeting often cannot deal with more than reviewing the event, expressing an apology, and answering questions. Subsequent meetings allow for additional questions, further information disclosure, discussion of steps taken to lessen the chance of a recurrence, and financial discussions. The number and flow of meetings vary from incident to incident, but more than one meeting is usually needed. Finally, those affected need someone who can help them collect information, find answers to questions, provide updates on future mitigation efforts, and help complete any financial support arrangements.[7] This person must be seen as someone who is supportive of those who have been affected, not someone who is seeking to play down the incident, obfuscate information, or protect the medical system or clinicians involved.[11]

Although qualitative studies are not typically used to track performance metrics, such as patient satisfaction or the success rate of an activity, Iedema and colleagues' findings are credible. Firstly, it is unlikely that their sample was biased towards dissatisfied patients. We conducted a qualitative study of patients who experienced a medical incident and found that people who were both happy and unhappy about their disclosure were willing to discuss their experiences.[7] Secondly, the multiple approaches used to recruit participants and the depth of the interviews provide an excellent view of the state of open disclosure in a country that has been a leader in collecting, analysing, and responding to medical incidents. How representative the findings are for other countries is unknown, because systematic studies in other locations are lacking. Nonetheless, the findings related to the expectations of patients and families regarding the disclosure process are likely to be universal, and the study reaffirms previous work.[12]

The COPIC Insurance Company in Colorado, US, has supported full disclosure for the past decade, and has found that effective

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open disclosure and—importantly—responding to the financial hardships related to a medical incident reduce overall liability.[11] Furthermore, patients who have been hurt by a medical incident but who are not abandoned by their clinician may choose to continue their care with that clinician. The principles of successful open disclosure are known, but the operational details need further work.

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