CANADIAN DENTAL ASSOCIATION
L'ASSOCIATION DENTAIRE CANADIENNE

DISCLOSURE OF UNANTICIPATED OUTCOMES:

A TOOLKIT FOR DENTISTS

COMMITTEE ON CLINICAL AND SCIENTIFIC AFFAIRS

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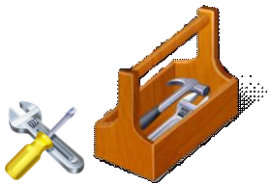
Disclosure of Unanticipated Outcomes:

A Toolkit for Dentists



Patients are entitled to know the facts about their treatment and care. Honesty is a core ethical obligation and trust is one of the key underpinnings of the dentist-patient relationship. Research has shown that patients desire an acknowledgment of even minor errors related to their care, and that clinicians want to inform patients, but barriers such as inadequate training in the disclosure process and fear of lawsuits often prevent disclosure.

Much of the current research relates to physicians or hospital based care. Many existing guidelines and supportive processes have been developed for health care settings with sophisticated management structures. This toolkit seeks to facilitate the disclosure process for community based dentists practicing in private offices.

What is disclosure?

Disclosure is the process of imparting, by health-care workers to patients or their significant others, of information pertaining to any health-care event affecting (or likely to affect) the patient's interests. Following an incident related to their care, disclosure involves an honest and uniform approach in clearly communicating to a patient and/or their support persons:

- acknowledgement of the incident
- the known facts about what has happened
- expression of regret and concern for the patient
- steps that will be taken to minimize harm
- what will be done to prevent similar occurrences in the future

Why is disclosure important?

First and foremost, patients have the right to know about incidents related to their care, so that harm can be addressed in the most appropriate and timely fashion and future potential harm can be recognized and properly managed. Disclosure of adverse events, whether critical or not, is

required as part of the duty of all Regulated Healthcare Professionals, to inform patients about events that have affected or may affect their health in the future. Consistent with the view that health care is a partnership between the patient and the provider, disclosure preserves the trusting relationship between the patient and the dentist. Disclosure often confirms what the patient suspects, and articulates what may be self-evident in a respectful and compassionate manner. Patients cannot provide informed consent for procedures intended to correct the error, if they are unaware of the facts. The disclosure process provides the opportunity to examine what happened and prevent similar occurrences in other patients. Finally, research suggests that patients want to know about even minor errors and that disclosure may reduce the risk of punitive actions by patients.

What is an adverse event?

An adverse event is an unexpected and undesired incident which results in unintended harm to the patient, and is related to the care provided to the patient rather than to the underlying medical or dental condition.

Why do Canadian Guidelines avoid the use of the term "error"?

Although much of the disclosure literature uses the term "error", one of the primary objectives in engaging in disclosure is to create a safer health care system for Canadians through openness, transparency, reflection and quality improvements. Adverse events are most often the result of a series of events, rather than one "error" on the part of a clinician. In gathering the facts following an adverse event, examination of all aspects of practice may reveal a number of factors — administrative policies, support staff training, equipment maintenance, facilities design, for example — that contributed to the adverse event. While dentists are responsible for the quality of their work and will be held accountable when warranted, learning from adverse events and improvements in patient care are unlikely to happen in a "shame and blame" culture.

What is the "threshold for disclosure"

Disclosure should occur when harm has occurred, when there is potential for harm after an incident or when a reasonable person would want to know about the incident under the circumstances. For example, would you want to know if a similar incident occurred during your own care or during the care of your child or elderly parent?

It is recognized that adverse events will vary in gravity. The complexity of the disclosure process will depend on the potential seriousness of the consequences.

The disclosure process at a glance

Initial disclosure should occur as soon as is reasonably possible, after the immediate clinical and emotional needs of the patient are met. Depending on the circumstances, initial disclosure will

take place at the time of the event, or in a planned disclosure meeting. Prior to disclosure, determine the facts as known at the time, plan what you will say, and decide who will be present.

During the initial disclosure, the dentist should:

- give a narrative account of the event, relating only the facts as known at the time, without speculation or blame
- describe the consequences, actual or expected, regarding the adverse event and its impact upon the patient and the implications for treatment
- discuss the cause of the event as far as is known and the steps that will be taken to prevent the adverse event from recurring or affecting others
- express regret for what has happened
- plan and explain the next steps

Following a thorough analysis of the event, a post-analysis disclosure meeting may be warranted, at which time further facts and information are provided, regret expressed again, and if appropriate, an apology offered. Patients and families often express the sentiment that they do not want this to happen to someone else. It is appropriate to share information about plans to prevent this from happening in the future.

All meetings related to disclosure should occur in a private setting, and planned so that interruptions do not occur. The patient or family member should be given the opportunity to have a support person present.

Documentation of disclosure should be thorough and confidential. Details of the adverse event and a record of follow-up visits and discussions with the patient and his/her family should be recorded in the patient record. Documentation should include:

- Time, place and date of meetings
- Identities of all attendees
- Facts presented
- Offers of assistance and responses
- Questions raised and answers given
- Plans for follow up and key contacts

In dental practice, there may be financial implications for ongoing or corrective care. As with all aspects of disclosure, decisions about financial implications should be considered judiciously and advice should be sought if there is uncertainty about the appropriate course of action. Dentists should not include monetary promises in these discussions as this might compromise their insurers' ability to defend them if a lawsuit or demand for monetary compensation arises. In such

cases, the dentist might state that he or she would like to help, but will require some advice before responding.

The document Communicating With Your Patient about Harm written for physicians by the Canadian Medical Protective Association provides valuable guidance that can be applied to the dental practice setting.

Expressing regret

Offering an apology or expressing regret is a **key component** of the disclosure process. The apology should include an expression of sympathy or regret and genuine concern for the harm done to the patient. Medical and dental jargon should be avoided. Plain and unemotional (neutral) language should be used, such as "I am very sorry that this has happened to you" or " I realize that this has caused you pain [anxiety, distress, worry]" or "I wish things had turned out differently". Statements of apology and accountability are not admissions of liability or guilt and cannot, on their own, be used in a court of law against a practitioner.

Support for dental staff

Depending on the nature of the incident, the dentist should call his or her professional insurer. If in doubt about any matter related to the incident, call for advice. The disclosure process should not be unduly delayed, but at the same time should be planned. The initial disclosure might be brief, until all the facts are gathered and understood. Be prepared for an angry or emotional response from the patient or family.

It is also important to recognize the need for support for both the dentist and support staff. Dentists and staff may feel upset, guilty, anxious and fearful after an adverse event. While maintaining confidentiality, discussion of the event in a staff meeting, as well as with colleagues, provides needed support, promotes learning and fosters a culture of patient safety. These discussions provide the opportunity to plan and communicate changes that will prevent future similar situations.

Canadian Resources

Background Paper for the Canadian Disclosure Guidelines

Canadian Disclosure Guidelines

Communicating With Your Patient about Harm

Medical Errors, Apologies and Apology Laws

The Impact of Disclosure on Litigation: A Review for the Canadian Patient Safety Institute

Uniform Apology Act

Recommended Reading

The following Perspectives and Commentaries from the US Agency for Healthcare Research and Quality are brief papers on disclosure, apology and patients ' perspectives.

Guilty, Afraid, and Alone — Struggling with Medical Error
Removing Insult from Injury—Disclosing Adverse Events
The Wrong Shot: Error Disclosure.

Research and Review Papers

Patients' and physicians' attitudes regarding the disclosure of medical errors.
Focus groups held with patients and academic and community physicians revealed that patients want disclosure and an apology, as well as information as to why the errors happened and how recurrences would be prevented. Physicians agreed with disclosure, but worried that apologies might create legal liability. Both patients and physicians had unmet needs after an error occurred.

Choosing your words carefully: how physicians would disclose harmful medical errors to patients.
This study surveyed 2637 medical specialists and surgeons regarding how they would disclose harmful medical errors to patients.

An empirically derived taxonomy of factors affecting physicians' willingness to disclose medical errors
A structured literature review was used to identify diverse factors that facilitate and impede the disclosure process.

Who's Sorry Now?
Physicians and patients responding to two national surveys say apologizing for medical errors should be commonplace—and shouldn't be done just to avoid lawsuits.

The art of apology: when and how to seek forgiveness.
This article offers practical advice on how to determine when an error has occurred and discusses the elements of an appropriate apology.

Newspaper/Magazine Articles:

Learning words they rarely teach in medical school: 'I'm Sorry.'
New York Times. July 26, 2005.

When doctors say, "We're sorry."
Time Magazine. August 15, 2005

Coming clean on medical mistakes.
Toronto Star. March 19, 2007.

Doctors say 'I'm sorry' before 'See you in court.'
New York Times. May 18, 2008

Hospitals shine light on mistakes by publicly saying: "we're sorry."
American Medical News. August 11, 2008

Websites:

Canadian Patient Safety Institute

AHRQ Patient Safety Network (USA)

Video Training Tools:

When Things Go Wrong: Voices of Patients and Families $$$

Removing Insult from Injury: Disclosing Adverse Events $

Appendix A. Provincial Apology Acts

British Columbia
Apology Act: http://www.leg.bc.ca/38th2nd/3rd_read/gov16-3.htm

Alberta
Evidence Amendment Act:
http://www.qp.alberta.ca/546.cfm?page=CH11_08.CFM&leg_type=fall

Saskatchewan
The Evidence Act (section 23.1):
http://www.qp.gov.sk.ca/documents/english/Statutes/Statutes/e11-2.pdf

Manitoba
Apology Act: http://www.canlii.org/mb/laws/sta/a-98/20090324/whole.html

Ontario
Apology Act: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_09a03_e.htm

Nova Scotia
Apology Act: http://www.gov.ns.ca/legislature/legc/bills/60th_2nd/3rd_read/b233.htm

Newfoundland and Labrador
Apology Act: http://www.assembly.nl.ca/Legislation/sr/Annualstatutes/2009/A10-1.c09.htm

Yukon
Apology Act: http://www.legassembly.gov.yk.ca/pdf/bill103_32.pdf