Program Profile

Empathic Disclosure of Adverse Events to Patients

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A simulation-based disclosure training program prepares health care providers to do the right thing and inform patients.

In 1987, the chief of staff of the Lexington VAMC and the staff attorney for the VA Regional Counsel Office in Lexington, Kentucky, discovered that a recent patient death was due to a mistake made in the medical care provided at their facility. They decided to disclose what happened to the family who had no knowledge of this mistake in care because "it was the right thing to do."

The Lexington Model for disclosure, as it became known worldwide, continued to flourish under the leadership of Kraman and Hamm.[1,2] The VA National Center for Ethics in Health Care adopted these principles of disclosure in drafting a national VHA policy directive in 2008, which was updated in 2012.[3] However, despite the ethical and professional imperatives, disclosing adverse events (AEs) to patients and family members has continued to be one of the most difficult challenges in the practice of medicine.

VHA policy has made a distinction between *clinical disclosure*, conducted by a clinician with a patient as a routine professional practice, and *institutional disclosure*, conducted by institutional leadership for an AE rising above a threshold of serious patient harm. According to VHA Director of Risk Management Yuri Walker in a 2013 personal communication, the frequency of institutional disclosure reports from VAMCs since 2011 have reflected significant variation in disclosure practice among facilities of similar size and complexity.

In this report, the authors share their experience developing and delivering a simulation-based disclosure training program in the VHA intended to close the gap between policy expectations and practical challenges for providers and institutions when facing the task of disclosing an AE to patients and families.

MEDICAL ERROR DISCLOSURE

It is not difficult to understand why health care providers (HCPs) are uncomfortable about disclosing AEs to patients. The study by Delbanco and Bell describes physicians experiencing guilt, shame, and fear of retribution after a patient experiences an AE. The resulting silence and avoidance of the patient only compounds patient harm.[4] Many HCPs believe disclosure will lead to tort claims, provide evidence against their defense, encourage reporting to the National Practitioners' Databank, and damage their reputations with a potentially negative impact on their careers.[5-7]

In a 2009 survey of 1,891 practicing physicians in the U.S., one-third did not agree with disclosing serious medical errors to patients.[8] Another survey of physicians reported wide variations in responses about whether they would offer an apology after making a medical mistake.[9] Therefore, a gap between patient expectations and HCP communication when a medical mistake occurs should be expected.[10]

Few HCPs receive training in empathic communication skills for effective disclosure of AEs to patients and families.[11] In a survey of 3,171 physicians in the U.S. and Canada, Waterman and colleagues found that only 10% of physicians believed they had adequate support from their health care organizations (HCOs)

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after an AE occurred, even though 86% expressed significant interest in receiving training on the disclosure of AEs.[12] Despite this gap, some medical educators, such as Katie Watson at Northwestern University, are successfully demonstrating the power of teaching medical students improvisational acting skills to enhance professionalism and communication in future physician–patient interaction.[13]

DISCLOSURE TRAINING PROGRAM

In 2010, the Lexington VAMC was awarded a 3-year VA Systems Improvement Capability Grant, which funded the development of a Disclosure Training Program (DTP). A team of investigators designed a 2-day workshop based on principles of experiential learning. Each workshop incorporated interactive teaching techniques using filmed clinical vignettes to provide a context for facilitated small-group disclosure simulations with professional actors.[14] A total of 14 workshops were conducted for 346 participants from December 2011 to September 2012.

The DTP workshop integrates focused didactic sessions with interactive audience-workshop facilitator discussion, debriefing of teaching films, and disclosure simulations, with the majority of time spent on the conducting and debriefing of simulations. Core content addressed during workshop activities included the following:

1. Historical origins of disclosure policy at the VHA
2. Ethical obligation, professional duty, and legal mandates for disclosure
3. Empathic communication–cognitive and emotive
4. VHA Handbook 1004.08, Disclosure of Adverse Events to Patient
5. Institutional and Clinical Disclosure of AEs
6. Psychological and physical needs of patients after an AE
7. Disclosure linking risk management to patient safety in a health care system
8. Legal implications for disclosure
9. State apology laws
10. Implementing disclosure programs in health care facilities
11. Facility support for providers after a patient AE

The principles of empathic communication and the core elements of AE disclosure to patients are reinforced during small-group simulations with actors portraying patients or family members. Each small-group simulation typically involves 3 to 4 workshop participants and 1 to 2 actors. Participants are given the task of conducting a clinical or institutional disclosure.

A facilitator manages each simulation, based on a scripted scenario or teaching film viewed by workshop participants. In the simulations attendees assume the roles of hospital staff that might be realistically involved in disclosure conversations, including executive leaders, physicians, nurses, risk managers, pharmacists, chaplains, and social workers.

Simulations average 5 to 7 minutes and are followed by a debriefing, including simulation participants, workshop facilitators, and the professional actor, who remain in character. By the end of each 2-day workshop, all attendees have participated in multiple small-group simulations of both clinical and institutional disclosures. Pre- and postworkshop knowledge questions and program evaluation data are collected with immediate-response polling technology used throughout the workshop.

Between 20 and 40 HCPs attended each workshop, which was designed for clinical and administrative leaders as well as others supporting the disclosure process, such as nurse managers, patient safety managers, social workers, chaplains, and pharmacists. The facility director, chief of staff, risk manager, and lawyers from the Regional Counsel office all play an important role in institutional

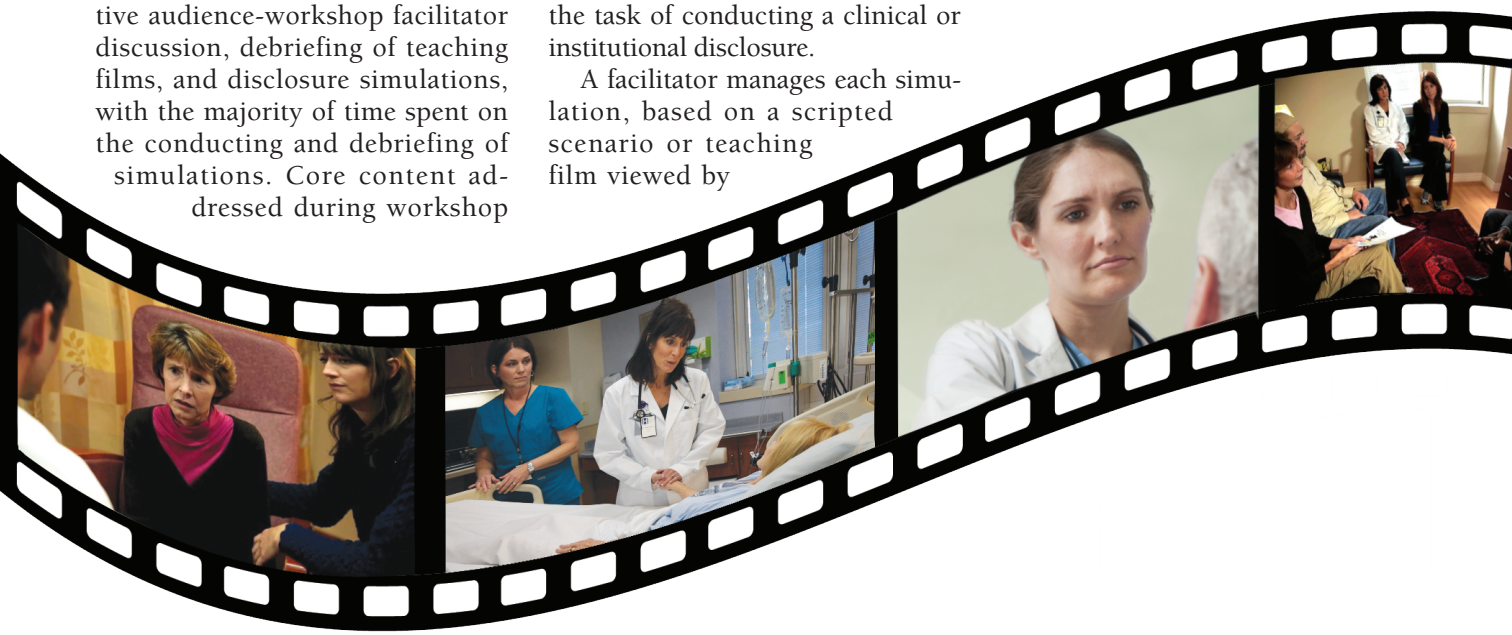

Table. Pre/post Workshop Test of Knowledge Questions

1. How comfortable are you conducting a clinical disclosure?
2. How likely is your facility to conduct institutional disclosures for AEs?
3. Which of the following is NOT part of the Lexington Model of humanistic risk management?
4. The Lexington open disclosure program is associated with which of the following?
5. In addition to autonomy, justice, and beneficence, the generally accepted ethical norms in health care include which of the following?
6. The professional duty to disclose AE to patients is based upon which of the following?
7. Clinical disclosure of an AE is indicated for all except which of the following?
8. A clinical disclosure should be documented in a CPRS template note entitled "Disclosure of Adverse Events." T/F
9. An institutional disclosure of an AE is conducted for which of the following?
10. An institutional disclosure is documented in a CPRS template note entitled: "Disclosure of Adverse Events." T/F
11. Open Disclosure programs in the US have demonstrated which of the following?
12. Disclosure of an AE violates the "Cooperation Clause" in medical malpractice insurance contracts. T/F
13. How many states have apology laws?
14. What percentage of AEs in healthcare are due to a breach in the standard of care?
15. A clinical disclosure of an AE should occur only when the standard of care has NOT been met? T/F
16. On average, how long does it take for physicians to interrupt patients during a conversation?

AE = adverse event.

disclosures and all were strongly encouraged to attend. The DTP facilitators observed the importance of senior executive leadership—participation, which enhanced dialogue in the large group sessions and small-group simulation-based learning.

DTP WORKSHOP RESULTS

Fourteen workshops were conducted for 346 employees from 26 VAMCs in 2012. Audience response technology was used to elicit participant feedback regarding workshop quality and effectiveness. Additional questions were asked as a pre/post-test of subject matter knowledge. Following the workshop, the participants showed a 30% overall improvement over preworkshop tests (Table), and 95% of participants favorably rated the workshop for quality and effectiveness.

There was a positive association between workshops with facility directors and actively engaged chiefs of staff in attendance and higher improvement scores in the test of knowledge. Among the top 7 performers on this test, 6 were individual facilities hosting the workshops and 1 VISN hosting for several facility representatives. Eleven of the 14 workshops with these characteristics (3 of which included VISN directors) evidenced more than 20% improvement on the test knowledge. These findings confirmed the original program design intended for individual facilities with leadership in attendance.

Iterative improvements were made to the program throughout 2012 based on feedback from workshop attendees, the National Office of Risk Management, the National Center for Ethics in Health Care and participating VA facilities and VISNs.

Despite these encouraging results, the DTP has some significant limitations: It is expensive, labor intensive, and dependent on faculty with expertise in clinical medicine, bioethics, and the law. Considering tight federal budgets, justifying the expenses to host a training program is difficult for a VAMC compared with that of other spending priorities. The actual and opportunity costs of travel to host sites for several facilitators and a group of professional actors to conduct a 2-day workshop for busy HCPs is not trivial.

Another limitation is the use of immediate response technology for data collection. Although this method maximizes response rates and seems to keep attendees engaged in presentations and discussions, technical failures could result in dropped responses, and ul-

timately the choice to respond is dependent on participant willingness to use the device.

CONCLUSION

Encouraging results suggest a bright future for the DTP, which has relevance for any health care organization, including the VA, academic affiliates, or those in the private sector. Wherever health care is delivered, providers will have the difficult task of disclosing AEs to meet their duty of care when patients experience harm. Learning empathic communication skills and successful strategies for disclosure will enhance this interaction and contribute to the maintenance of trust that is critical to the provider–patient relationship.

The DTP workshop has a flexible design and can be packaged to accommodate host medical centers for workshops of 1 to 2 days' duration. The didactic presentations are constant, whereas the number of simulations will vary, depending on the length of the workshop (2-3 simulations for 1 day and 5-7 for two days). Participants from every workshop consistently cite that the simulations with professional actors are a powerful learning experience of significant personal value.

The DTP was developed as a unique, simulation-based program for clinicians, administrators, and allied health care personnel to enhance the effective disclosure of AEs to patients. Feedback from participants in 14 workshops in 2012 cited the value of the program with a high favorability rating. In a test of knowledge, participants also demonstrated an increase in learning. This feedback from the health care professionals who have attended the workshops has validated the pedagogic design of the program, which leverages adult learning principles of learning through experience. This approach was described by Aristotle in his best-known work on ethics, *Nicomachean Ethics*, "For the things we have to learn before we can do them, we learn by doing them."[15] ●

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