



The American College of  
Obstetricians and Gynecologists  
WOMEN'S HEALTH CARE PHYSICIANS

# COMMITTEE OPINION

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## Committee on Patient Safety and Quality Improvement

*This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Patient Safety and Quality Improvement in collaboration with committee member Edward P. Denious, MD.*

*This document reflects emerging concepts on patient safety and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.*

## Disclosure and Discussion of Adverse Events

**ABSTRACT:** Adverse outcomes, preventable or otherwise, are a reality of medical care. Most importantly, adverse events affect patients, but they also affect health care practitioners. Disclosing information about adverse events has benefits for the patient and the physician and, ideally, strengthens the patient–physician relationship and promotes trust. Studies show that after an adverse outcome, patients expect and want timely and full disclosure of the event, an acknowledgment of responsibility, an understanding of what happened, expressions of sympathy, and a discussion of what is being done to prevent recurrence. Surveys have shown that patients are less likely to pursue litigation if they perceive that the event was honestly disclosed. Barriers to full disclosure are many and include fear of retribution for reporting an adverse event, lack of training, a culture of blame, and fear of lawsuits. To reduce these concerns, it is recommended that health care facilities establish a nonpunitive, blame-free culture that encourages staff to report adverse events and near misses (close calls) without fear of retaliation. Health care institutions should have written policies that address the management of adverse events. Having a responsive process to inform and aid the patient, loved ones, and practitioners is required. A commitment on the part of all health care practitioners and institutions to establish programs and develop the tools needed to help patients, families, health care practitioners, and staff members deal with adversity is essential.

### Recommendations

The disclosure and discussion of adverse events are critical to create and maintain high-quality health care and to preserve the integrity of the patient–physician relationship. The American College of Obstetricians and Gynecologists makes the following recommendations:

- Health care facilities should establish a nonpunitive, blame-free culture that encourages staff to report adverse events and near misses (close calls) without fear of retaliation.
- Health care institutions should have written policies that address the management of adverse events.
- Coordinated responses to adverse events also must include identification and treatment of the health care practitioners and ancillary staff who become “second victims.”

### Introduction

Adverse outcomes, preventable or otherwise, are a reality of medical care. Most importantly, these events affect patients, but they also affect health care practitioners. Thus, health care practitioners and institutions should understand how to best disclose and discuss adverse events with patients and their families. Beyond disclosure, health care teams also must look to each other, identifying and assisting health care practitioners and ancillary staff who become deeply affected by the adverse outcomes—the so-called second victims.

Disclosing information about adverse events has benefits for the patient and the physician and, ideally, strengthens the patient–physician relationship and promotes trust. Studies show that after an adverse outcome, patients expect and want timely and full disclosure of the event, an acknowledgement of responsibility, an understanding of what happened, expressions of sympathy, and

a discussion of what is being done to prevent recurrence (1, 2). Surveys have shown that patients are less likely to pursue litigation if they perceive that the event was honestly disclosed (3, 4). Research demonstrates that disclosure of adverse events is associated with higher ratings of quality by patients, an improved rate of recovery, a decrease in the number of malpractice suits, and a decrease in the average settlement amount (5, 6).

The call for health care organizations to develop processes for full disclosure is broad based. Patient advocacy groups, patient safety experts, ethicists, policy makers, accrediting organizations, and physician groups all advocate the adoption of policies related to the disclosure and discussion of adverse events (7).

Barriers to full disclosure are many and include fear of retribution for reporting an adverse event, lack of training, a culture of blame, and fear of lawsuits (8–10). To reduce these concerns, health care facilities should establish a nonpunitive, blame-free culture that encourages staff to report adverse events and near misses (close calls) without fear of retaliation. Removing blame, however, does not eliminate individual responsibility. Promoting a just culture enables frontline personnel to feel comfortable disclosing errors while maintaining professional accountability. A just culture recognizes that competent professionals make mistakes and acknowledges that even competent professionals may develop unhealthy norms, but has zero tolerance for reckless behavior (11).

Health care institutions should have written policies that address the management of adverse events. The Institute for Healthcare Improvement's white paper on the management of serious clinical adverse events is an excellent resource for developing or improving these policies. It contains the information necessary to form a crisis management plan, establish a crisis management team, and organize the internal and external communication needed for success (12). After policies are developed, health care organizations should work with health care practitioners to assess the need for additional resources and training such as disclosure coaching, mediation, and emotional support for health care workers involved in harmful medical errors (9, 13). Conducting programs in team training also may be useful. Individual physicians and physician practice groups may contact their local hospitals, liability carriers, specialty organizations, or medical societies for disclosure assistance training and resources available to them. Anyone involved in disclosure should be instructed not to make promises they cannot guarantee. For example, a patient should not be told that she will not incur expenses, only to later receive a bill. Rather, she should be advised that the hospital finance department or the physician's office will work with her to address these charges.

Patients who experience adverse events have an interest in seeing that what happened to them does not happen to someone else. Most patients and families are unaware of standard quality protocols that are used, such

as root cause analysis, peer review, and educational conferences and reviews. Initial conversations should include discussion of these processes that are in place to review the care and potentially, when possible, prevent future such events. Beyond disclosure, the health care practitioner or institution may inform the patient and family to provide closure. At the completion of an investigation, patients and families benefit from the discussion that the event has been reviewed and that corrective changes are implemented. Knowing that changes were made and that some good came of their experience may help the patient and family cope with their pain or loss (14).

Several organizations have reported on the success of their disclosure programs. One of the oldest programs advocating full disclosure of medical errors is the Veterans Affairs Medical Center in Lexington, Kentucky. In 1999, after their full disclosure policy had been in place for 10 years, they reported that their facility's median liability payments were one fifth of the median liability settlements for the private sector (15). The University of Michigan Health System reported a 50% reduction in legal fees and actions since implementing a policy in 2001 that encouraged disclosure and apology (16, 17), and the Illinois Medical Center at Chicago noted an average 50% decrease in legal costs per case (18).

A number of health care organizations, insurance carriers, and states have developed programs to educate physicians about disclosure. One example is the consensus statement of the Harvard Hospitals, *When Things Go Wrong: Responding to Adverse Events* (14). These programs can provide valuable guidance and education about the specifics of disclosure and apology. Physicians may wish to refer to other resources before meeting with a patient and her family (12, 19) (Box 1). To frame the process of a timely and accurate disclosure, it is helpful to understand and remember the who, what, when, where, and how (5):

- **Who**—The attending physician should lead the discussion. If the physician cannot be present, it is preferable to have a senior member of the health care team lead the discussion. The circumstances of the adverse event often will dictate what other members of the health care team also must be present. Whenever possible, at least two members of the health care team should be involved in any discussion of an adverse event with the patient and her family.
- **What**—Only factual information must be communicated to the patient. Patients must be reassured that as additional, reliable information is obtained, they will be notified promptly.
- **When**—Even if all details of the incident are not known, disclosure must be timely. Disclosure should occur as soon as reasonably possible, while emphasizing to patients that it is an ongoing process of communication.

- **Where**—Disclosure should occur in a quiet and confidential setting that will be most comfortable to the patient.
- **How**—Patient dignity must always be respected. A disclosure conversation should include empathy for what patients and their families have experienced.

It is important to understand the difference between expressions of sympathy (acknowledgement of suffering) and apology (accountability for suffering). Expressions of sympathy are always appropriate. The appropriateness of an apology, however, will vary from case to case. When considering whether an apology is appropriate, the physician should seek advice from the hospital's risk

manager and the physician's liability carrier. Among other matters, the issue of appropriateness of recording the conversation with the patient or her family can be discussed with these entities. It also is important to be knowledgeable about the state's laws on apology and disclosure because these laws vary and may have an effect on the way in which the disclosure is conducted.

## The Second Victim

Disclosure and discussion can be important for the patient's and the health care team's healing process (20). When adverse events occur, health care practitioners involved may develop emotional and functional deficits that lead them to become "second victims." Having a responsive process to inform and aid the patient, loved ones, and practitioners is required. Recognizing and assisting the "second victim" is vital to protect the stability and longevity of the health care practitioners and staff who participate in the adverse events. The *second victim* has been defined as a health care practitioner who is involved in an unanticipated adverse patient event, medical error, or patient-related injury and who is traumatized by the event (21).

Coordinated responses to adverse events also must include identification and treatment of the health care practitioners and ancillary staff who become "second victims" (22). Although enhanced communication, openness, and disclosure of medical errors are encouraged when dealing with the patient, family, or both, paradoxically, health care practitioners often are counseled not to discuss adverse events. Emotional distress precipitated by adverse events can be significant among these health care professionals regardless of the presence of a medical error (23). The consequences of this distress, especially if left unaddressed, can be profound. Initial feelings of guilt, shame, isolation, and self-doubt can lead to long-term sequelae like withdrawal, depression, posttraumatic stress disorder, poor clinical performance, leaving the practice of medicine, and even suicide (24). The health care institution also should help guide the practitioners affected by the incident through a process similar to a hospital-initiated rapid response to a patient (25). This should be provided in a blame-free environment that is capable of continuing to support the health care practitioners as they recover (21). Ideally, adverse outcomes and human errors should provide an opportunity for forgiveness, growth, and improvement in systems-based practices.

Although a prompt and thorough disclosure offers the greatest benefit to the patient and family, a discussion at a later time bolsters the recovery of the potential second victim. Initial debriefings should include guidance to the team members about their own potential recovery issues and an offer of nonpunitive help. Offering help after some time has passed may assist those in the various stages of recovery and those reluctant to admit that they are suffering. Maintaining and demonstrating an open and fair culture in the organization will allow an

### Box 1. Discussions With Patients on Adverse Events ↵

These general guidelines regarding disclosure conversations with a patient or her family may be helpful:

- If possible, before the disclosure, the facts of the error should be gathered and investigated so that the most accurate information can be shared with the patient.
- Disclosure, especially if the event is serious, should be done as soon as possible. If all the facts are not yet known, promise to return when these facts are known.
- Confidentiality must be preserved. The meeting with the patient should take place in a private setting. Determine whether a support person or guardian should be present with the patient.
- The disclosure itself should be done by the treating physician or someone with whom the patient has developed a relationship and trust who can begin the conversation. Depending on your facility's policy, the risk manager or facility's attorney, the nurse manager, and others may be present during disclosure.
- The focus should be on the patient's condition, concerns, and treatment plan, and the patient should be told that her treatment and care are the utmost concern.
- Try to convey the information in terms that are understandable to the patient and that minimizes the patient's stress. Explain what happened and how it happened; it may not be possible to explain why it happened. Let the family and patient know what will be done to prevent the error from occurring again, and work with the patient to develop a treatment plan to remedy/mitigate the effects of any injury resulting from the error.
- Make sure to express appropriate regret for the error and the concern for the patient and/or the family.

Data from Pelt JL, Faldmo LP. Physician error and disclosure. *Clin Obstet Gynecol* 2008;51:700–8. Reproduced with the permission of Wolters Kluwer Health.

**Table 1.** Stages of Recovery for Second Victim After Adverse Patient Events ↵

| Stages 1–3<br>Realization of Event           |                                     |   | Stage 4                       | Stage 5                             | Stage 6<br>Moving On    |                      |                     |
|--|-------------------------------------|---|-------------------------------|-------------------------------------|-------------------------|----------------------|---------------------|
| Stage 1<br>Chaos and<br>accident<br>response | Stage 2<br>Intrusive<br>reflections | Stage 3<br>Restoring<br>personal<br>integrity | Enduring the<br>investigation | Obtaining<br>emotional<br>first aid | Stage 6<br>Dropping out | Stage 6<br>Surviving | Stage 6<br>Thriving |

Modified from Scott SD, Hirschinger LE, Cox KR, et al. The natural history of recovery for the health care provider “second victim” after adverse patient events. *BMJ Qual Saf Health Care* 2009;18:325–30. Reproduced with the permission of BMJ Publishing Group Ltd.

easier navigation of the second victim’s role in disclosure. Collegial compassion and counseling even weeks or months after the event may further help affected health care practitioners move on and lead to recovery. [Table 1](#) is an adaptation of the six stages that have been identified as part of the recovery process (21).

Health care practitioners in training are particularly vulnerable and impressionable when exposed to adverse events. Resident physicians are often hesitant to disclose their own errors to senior staff (26). Facilitating a nonpunitive culture will allow a more open and safe environment for those more novice in recognizing, disclosing, discussing, and dealing with medical adversity. Remaining open and responsive to the trainees, even long after the occurrence, can improve the trainees’ well-being and help them cope with unexpected or negative outcomes (23, 27).

## Conclusion

Disclosure and discussion of adverse events are critical to creating and maintaining high-quality health care and the integrity of the patient–physician relationship. A commitment on the part of all health care practitioners and institutions to establish programs and develop the tools needed to help patients, families, health care practitioners, and staff members through adversity is essential. The American College of Obstetricians and Gynecologists supports efforts to assist members in understanding the value of disclosure and discussion in the face of preventable and nonpreventable adverse events and to provide guidance for such conversations.

## For More Information

The American College of Obstetricians and Gynecologists has identified additional resources on topics related to this document that may be helpful for ob-gyns, other health care providers, and patients. You may view these resources at [www.acog.org/More-Info/AdverseEvents](http://www.acog.org/More-Info/AdverseEvents).

These resources are for information only and are not meant to be comprehensive. Referral to these resources does not imply the American College of Obstetricians and Gynecologists’ endorsement of the organization, the organization’s website, or the content of the resource. The resources may change without notice.

## References

- Gallagher TH, Waterman AD, Ebers AG, Fraser VJ, Levinson W. Patients’ and physicians’ attitudes regarding the disclosure of medical errors. *JAMA* 2003;289:1001–7. [[PubMed](#)] [[Full Text](#)] ↵
- Mazor KM, Simon SR, Yood RA, Martinson BC, Gunter MJ, Reed GW, et al. Health plan members’ views about disclosure of medical errors. *Ann Intern Med* 2004;140:409–18. [[PubMed](#)] [[Full Text](#)] ↵
- Vincent C, Young M, Phillips A. Why do people sue doctors? A study of patients and relatives taking legal action. *Lancet* 1994;343:1609–13. [[PubMed](#)] ↵
- Beckman HB, Markakis KM, Suchman AL, Frankel RM. The doctor–patient relationship and malpractice. Lessons from plaintiff depositions. *Arch Intern Med* 1994;154:1365–70. [[PubMed](#)] ↵
- Weiss PM, Miranda F. Transparency, apology and disclosure of adverse outcomes. *Obstet Gynecol Clin North Am* 2008;35:53–62, viii. [[PubMed](#)] ↵
- Helmchen LA, Richards MR, McDonald TB. How does routine disclosure of medical error affect patients’ propensity to sue and their assessment of provider quality? Evidence from survey data. *Med Care* 2010;48(11):955–61. [[PubMed](#)] ↵
- National Patient Safety Foundation. Lucian Leape Institute. Shining a light: safer health care through transparency. Boston (MA): NPSF; 2015. Available at: <http://www.npsf.org/?shiningalight>. Retrieved July 26, 2016. ↵
- Finkelstein D, Wu AW, Holtzman NA, Smith MK. When a physician harms a patient by a medical error: ethical, legal, and risk-management considerations. *J Clin Ethics* 1997;8:330–5. [[PubMed](#)] ↵
- Goldberg RM, Kuhn G, Andrew LB, Thomas HA Jr. Coping with medical mistakes and errors in judgment. *Ann Emerg Med* 2002;39:287–92. [[PubMed](#)] ↵
- Mello MM, Studdert DM, DesRoches CM, Peugh J, Zapert K, Brennan TA, et al. Caring for patients in a malpractice crisis: physician satisfaction and quality of care. *Health Aff (Millwood)* 2004;23:42–53. [[PubMed](#)] [[Full Text](#)] ↵
- Marx D. Patient safety and the “just culture”: a primer for health care executives. New York (NY): Trustees of Columbia University in the City of New York; 2001. Available at: [www.safer.healthcare.ucla.edu/safer/archive/ahrq/FinalPrimerDoc.pdf](http://www.safer.healthcare.ucla.edu/safer/archive/ahrq/FinalPrimerDoc.pdf). Retrieved July 26, 2016. ↵
- Conway J, Federico F, Stewart K, Campbell MJ. Respectful management of serious clinical adverse events, 2nd ed. IHI

- Innovation Series white paper [after login]. Cambridge (MA):Institute for Healthcare Improvement;2011. Available at: <http://www.ihl.org/resources/Pages/IHIWhitePapers/RespectfulManagementSeriousClinicalAEsWhitePaper.aspx>. Retrieved July 26, 2016. ↩
13. Liebman CB, Hyman CS. A mediation skills model to manage disclosure of errors and adverse events to patients. *Health Aff (Millwood)* 2004;23:22–32. [PubMed] [Full Text] ↩
  14. Massachusetts Coalition for the Prevention of Medical Errors. When things go wrong: responding to adverse events. A consensus statement of the Harvard Hospitals. Burlington (MA): MCPME; 2006. Available at: <http://www.macoalition.org/documents/respondingToAdverseEvents.pdf>. Retrieved July 26, 2016. ↩
  15. Kraman SS, Hamm G. Risk management: extreme honesty may be the best policy. *Ann Intern Med* 1999;131:963–7. [PubMed] [Full Text] ↩
  16. Gallagher TH, Levinson W. Disclosing harmful medical errors to patients: a time for professional action. *Arch Intern Med* 2005;165:1819–24. [PubMed] [Full Text] ↩
  17. Boothman RC, Blackwell AC, Campbell DA Jr, Commiskey E, Anderson S. A better approach to medical malpractice claims? The University of Michigan experience. *J Health Life Sci Law* 2009;2:125–59. [PubMed] ↩
  18. McDonald TB, Helmchen LA, Smith KM, Centomani N, Gunderson A, Mayer D, et al. Responding to patient safety incidents: the “seven pillars.” *Qual Saf Health Care* 2010;19:e11. [PubMed] [Full Text] ↩
  19. Woods JR, Rozovsky FA. What do I say? Communicating intended or unanticipated outcomes in obstetrics. San Francisco (CA): Jossey-Bass; 2003. ↩
  20. Allan A, McKillop D. The health implications of apologizing after an adverse event. *Int J Qual Health Care* 2010;22: 126–31. [PubMed] [Full Text] ↩
  21. Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall LW. The natural history of recovery for the healthcare provider “second victim” after adverse patient events. *Qual Saf Health Care* 2009;18:325–30. [PubMed] [Full Text] ↩
  22. Wu AW. Medical error: the second victim. The doctor who makes the mistakes needs help too. *BMJ* 2000;320:726–7. [PubMed] [Full Text] ↩
  23. West CP, Huschka MM, Novotny PJ, Sloan JA, Kolars JC, Habermann TM, et al. Association of perceived medical errors with resident distress and empathy: a prospective longitudinal study. *JAMA* 2006;296:1071–8. [PubMed] [Full Text] ↩
  24. Waterman AD, Garbut J, Hazel E, Dunagan WC, Levinson W, Fraser VJ, et al. The emotional impact of medical errors on practicing physicians in the United States and Canada. *Jt Comm J Qual Patient Saf* 2007;33:467–76. [PubMed] ↩
  25. Scott SD, Hirschinger LE, Cox KR, McCoig M, Hahn-Cover K, Epperly KM, et al. Caring for our own: deploying a systemwide second victim rapid response team. *Jt Comm J Qual Patient Saf* 2010;36:233–40. [PubMed] ↩
  26. Lawton R, Parker D. Barriers to incident reporting in a healthcare system. *Qual Saf Health Care* 2002;11:15–8. [PubMed] [Full Text] ↩
  27. Engel KG, Rosenthal M, Sutcliffe KM. Residents’ responses to medical error: coping, learning, and change. *Acad Med* 2006;81:86–93. [PubMed] [Full Text] ↩
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