ORIGINAL ARTICLE

What, who, when, where and how to inform patients after an adverse event: A qualitative study

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KEYWORDS
Patient safety; Adverse events; Healthcare providers; Primary care; Hospital

Abstract

Objective: To explore suggestions and recommendations for conducting open disclosure with a patient after an adverse event in a setting without professionals’ legal privileges.

Method: Qualitative study conducting focus groups/Metaplan. This study was conducted with physicians and nurses from Primary Care and Hospitals working in the public health system in Spain.

Results: Twenty-seven professionals were involved 8–30 years of experience, 15 (56%) medical and 12 (44%) nurses, 13 (48%) worked in hospitals. Consensus was obtained on: how (honesty and open and direct language), where (avoid corridors, with privacy), and when to disclose (with agility but without precipitation, once information is obtained, and after reflecting on the most suitable according to the nature of the AE). There was controversy as to what to say to the patient when the AE had serious consequences and doubts about what type of incidents must be reported; who should be required to disclose (the professional involved in the AE or other professional related to the patient, the role of the staff and the management team); and in which cases an apology can be a problem.

Conclusions: The severity of the AE determines who should talk with the patient in both hospital and primary care. The most appropriate way to convey an apology to the patient depends of the AE. An early, direct, empathetic and proactive action accompanied by information about compensation for the harm suffered could reduce the litigation intention.

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PALABRAS CLAVE
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Atención Primaria;
Hospital

Qué, quién, cuándo, dónde y cómo informar a los pacientes tras un evento adverso: un estudio cualitativo

Resumen
Objetivos: Explorar experiencias y recomendaciones para informar adecuadamente al paciente que ha sufrido un evento adverso (EA) en un contexto donde no se cuenta con leyes de disculpa. Método: Estudio cualitativo basado en las técnicas de grupo focal y Metaplan. Este estudio se realizó con médicos y enfermeros de atención primaria y hospitales del sistema público de salud en España. Resultados: Participaron 27 profesionales con entre 8 y 30 años de experiencia, 15 (56%) médicos y 12 (44%) enfermeros; 13 (48%) trabajaban en hospitales. Existió consenso en cuanto a cómo (lenguaje claro, honestidad, dónde (evitar pasillos, en espacio acondicionado, con intimidad) y cuándo informar (con agilidad pero sin precipitación, al disponer de suficiente información y tras reflexionar sobre la forma más adecuada según la naturaleza del EA). Existió controversia en cuanto a qué decirle al paciente tras EA con consecuencias graves, dudas sobre en qué casos se debía informar de lo sucedido; quién debía informar (si el profesional más directamente implicado en el EA u otro profesional, el papel del equipo directivo o de los mandos intermedios); y sobre en qué casos una disculpa podía suponer un problema. Conclusiones: La naturaleza del EA determina quién debe conversar con el paciente en hospitales y atención primaria. Debe meditarse, según los casos, la forma más apropiada para trasladarle una disculpa al paciente. Una actuación temprana, directa, empática, proactiva y acompañada de información sobre una compensación por el daño sufrido contribuiría a reducir el número de reclamaciones.

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What is known?
Not knowing how to approach disclosure of an adverse event to a patient, apprehension— if not fear—as to the consequences of giving this information, limited institutional support and a lack of support from colleagues are the most frequently cited reasons why only a very few patients who have been victims of an adverse event receive information about what has happened to them. Hardly any studies have been undertaken on this subject in primary care.

The recommendations regarding how to speak to a patient who has suffered an adverse event should encompass the nature and consequences of the incident. The event and in particular the information given to the patient should be included in their clinical history.

What does it contribute?
Insight is provided into the situation of the healthcare professional most directly involved in the adverse event and consideration as to whether they are able to cope emotionally with disclosure to the patient.

The recommendations provided to date have been developed within a different legal framework to our own; for example, with apology laws that offer professionals a mantle of legal protection.

Introduction
Disclosure to a patient about what has happened to them after an adverse event (AE), why and how it happened and its possible consequences all constitute a daunting task for health care professionals who can be apprehensive about such a conversation and its ramifications. 1-4

We know that only a third of health care professionals have received training on how to tackle this situation, 5 barely 20% in Spain. 6 We know that 18% of patients resort to legal action 6,7 and that health care professionals do not trust the level of protection that their institutions would provide in this situation. 6,8 This is why only around 30% of patients who have experienced an AE are given a clear and honest account of what has happened. 9-13 It is even more rare for them to be offered an apology. 6 Nonetheless, there are ethical, legal and practical reasons for these conversations to take place. 6,8,14

The codes of professional conduct and regulations in most countries are unequivocal on the absolute necessity to provide the patient with clear and honest information. 8,15 In addition to their rights, patients have the emotional need to know what has happened and if this information is not disclosed to them, they often use other channels to investigate. 8,15 Correct information (in style and content) has been associated with fewer complaints, even those involving legal action. 8,14,15

Several authors have made recommendations regarding the form that this conversation with the patient should take. 17-22 In some cases, these recommendations have been formulated in a setting where there are agreed protocols on how to act and/or where there is a benchmark legal framework which is different to that of the Hispanic countries.
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