Disclosure of Adverse Events – Two-Page Summary

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Why Disclosure Matters

Patients expect and want timely, full disclosure after adverse events, including an explanation of what happened, an acknowledgment of responsibility when appropriate, expressions of sympathy, and steps to prevent recurrence. Evidence consistently demonstrates that honest disclosure improves patient trust and satisfaction, reduces litigation, and lowers settlement costs. Programs at the University of Michigan and University of Illinois saw 50–59% reductions in legal costs and actions after implementing formal disclosure processes. Poor communication and perceived lack of candor remain among the most common reasons patients pursue litigation.

Healthcare institutions should develop written policies supporting a just culture of transparency — one that encourages reporting without fear of retaliation while maintaining individual accountability for reckless behavior.

Preparing for the Disclosure Conversation

- **Gather and verify facts.** Initiate investigation (root cause or apparent cause analysis) immediately. Understand what is known and what remains uncertain before meeting with the patient.

- **Notify risk management and legal** per institutional policy. Frame disclosure as a patient-safety challenge integrated with quality improvement, not solely a legal or risk-management matter.

- **Hold a predisclosure team huddle.** Use a structured checklist (e.g., AHRQ CANDOR tools). Determine who will lead, what will be communicated, and how follow-up will be handled.

- **Identify the lead communicator.** The attending physician should lead the conversation. At least one additional team member should be present. Avoid sending social workers or risk management staff alone for the initial conversation.

- **Choose the right setting.** Arrange a quiet, private, confidential space. For hospitalized patients, ensure the patient and family have a private room if possible.

Conducting the Conversation

Explain what happened — Use plain, jargon-free language. Describe factual information about the event and the patient's current condition. Avoid speculation and blame.

Acknowledge uncertainty — If all facts are not yet known, say so directly. Reassure the patient that the investigation is ongoing and that updates will be provided as they become available.

Express sympathy or apology appropriately:

- Expressions of sympathy (e.g., "I am sorry this happened to you") acknowledge suffering and are always appropriate

- A direct apology (e.g., "I am sorry that we made this mistake in your care") accepts accountability and is appropriate when an error has been confirmed

- Many states have apology laws that protect expressions of sympathy from being used as evidence of liability — know your jurisdiction's legal protections and your institution's policy before the conversation

Focus on the patient — Address the patient's current condition, concerns, and the treatment plan going forward. Develop a care plan with the patient to remedy or mitigate the effects of any injury.

Describe corrective steps — Explain what will be done to prevent recurrence. Patients and families consistently report that knowing their experience led to safety improvements is one of the most meaningful outcomes of the process.

Allow questions and listen — Give the patient and family ample time to ask questions and be heard. Let the patient's priorities lead the discussion. Be prepared to listen at length; creating the opportunity to be heard is essential to rebuilding trust.

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After the Conversation

- **Document** the disclosure conversation in the medical record

- **Schedule follow-up meetings** as new information becomes available. Disclosure is an ongoing process, not a single conversation. Multiple contacts may be needed over days, weeks, or months.

- **Proactively communicate safety improvements.** Actively keep in touch with patients and families to share new steps taken. Consider reaching out on the anniversary of the event to update them on safety progress.

- **Address financial needs.** Where compensation is merited, offer it proactively without waiting for the patient to ask. Anticipate immediate financial stressors such as unpaid bills and offer assistance. Notify patients that they may consult an attorney.

- **Complete root cause analysis** and implement system improvements. Track outcomes and evaluate the effectiveness of corrective actions.

Supporting the Care Team

Healthcare practitioners involved in adverse events are "second victims" who experience distress, sadness, fear, and guilt. Organizations must identify and support affected clinicians and staff through:

- **Peer support programs** and mentorship from colleagues who have navigated similar events

- **Counseling resources** — employee assistance programs, chaplaincy, and mental health services

- **A nonpunitive environment** that allows team members to acknowledge and process emotions

- **Debriefings** that separate learning from blame

Supporting clinicians is essential for sustaining a culture of disclosure. Burned-out, unsupported clinicians are less likely to report adverse events or engage in transparent communication.

The CANDOR Framework (AHRQ)

The Communication and Optimal Resolution (CANDOR) toolkit provides a structured approach with two main components:

1. **Prompt and accurate disclosure to patients and families** — through staged conversations beginning with an initial acknowledgment that something went wrong, followed by scheduled updates as investigation findings emerge, and concluding with a formal disclosure that includes a full explanation, apology, and early resolution offer when appropriate

2. **Care for the caregiver** — structured support for all members of the healthcare team affected by the event

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Key Principles to Remember

1. Disclose as soon as reasonably possible — even before all facts are known

2. Disclosure is an ongoing process of communication, not a single event

3. Sympathy is always appropriate; apology is appropriate when fault is established

4. The attending physician should lead the disclosure conversation

5. Frame disclosure as a patient-safety priority, not merely a risk-management task

6. Support clinicians as "second victims" to sustain a culture of transparency

7. Offer proactive remediation — financial, clinical, and emotional — to injured patients

8. Use the term "reconciliation" rather than "resolution" to reflect the relational nature of the process