

078: DISCLOSURE OF ADVERSE INCIDENTS TO PATIENTS AND FAMILIES: A MULTI YEAR PERSPECTIVE

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Objective:

This paper will review the impact of the 12 year history of the McGill University Health Centre guidelines and subsequent policy on Disclosure of Adverse Events to Patients and Families.

Method:

In April 2001, the Board of Directors of the McGill University Health Centre (MUHC) in Montreal Canada, a university teaching hospital located on five sites, passed a policy on disclosure. The policy requires that medical error be disclosed to the patient, and outlines the mechanisms by which it should be done. This policy was prepared by and presented to the Board of Directors by its Committee on Quality, which had shepherded its passage and gained consensus through a multitude of constituencies

This was the next stage of progression in a journey that began in 1988. The intent at that time was to address the ethics surrounding adverse events and the ethics of disclosure. The Royal Victoria Hospital (RVH), a founding member of the MUHC, was a forerunner in this area. In 1989, its Board of Directors passed guidelines on disclosure, which had been prepared by the Hospital Ethics Committee

At that time, as now, there was major concern whether or not to disclose. Dr. Crelinsten, Chairman of the RVH Ethics Committee expressed the institution's view saying, "The ethical principle of telling the truth is an overriding principle." This was the driving force behind the decision to design and implement disclosure guidelines. From 1989 to 2000, the guidelines provided a framework that enabled staff to disclose incidents to patients in a helpful manner.

The next stage for the Disclosure Guidelines resulted from the 1997 merger of the Royal Victoria Hospital with 3 other hospitals (the Montreal Children's, Montreal Neurological, Montreal General Hospitals) to become the MUHC. Like many mergers, the process has not been a simple one due to different values, cultures and structures. One of the earliest initiatives to create a common approach was the Disclosure Policy. Culturally, this policy was a clear statement of values, patient focus, transparency, and the desire to evolve as a learning organization.

The establishment of a clear policy on disclosure for the MUHC was an important first step. However, the move from policy to implementation was neither straightforward nor easy. A task force, including members of Ethics Committees, professional groups, hospital lawyer, patient representatives and quality /risk management mapped out an implementation and education strategy. Conferences, Grand Rounds committees were addressed. The intention was to explain the policy, describing its objective as related to quality improvement and patient care. The consistent message transmitted was that this policy was adopted because it is morally the right thing to do and, if executed wisely, will improve the quality of services delivered to our patients. A how-to guide was prepared that includes much practical information.

Results:

In 2000 the implications of this approach were assessed. Since one of the major concerns was the threat of increased lawsuits, the RVH claims history was tracked and showed no evidence of increasing litigation. There was no apparent difference in the number of claims in the 7 years prior to guideline implementation compared to 11 years after.

Finally, in December 2003 the Province of Quebec passed a law obliging health care organizations to disclose adverse events.

Conclusions:

At the MUHC, there is no real evidence that this multi- year approach of transparency has increased the number of lawsuits. However, there is still much work necessary to fully implement this policy and this is being undertaken at both the hospital and now across the whole province of Quebec.