Contact your on-site risk management designee whenever you have questions about clinical issues that are risk management related.

Shands at AGH (352)733-0115 or 733-0111 x71113
Shands at Lake Shore (386) 754-8180
Shands at Live Oak (386) 362-0800
Shands at Starke (904) 368-2300
Shands at Vista/Rehab (352) 265-5491 x70022
Shands at the University of Florida (352) 265-0002
Shands Jacksonville (904) 244-3477
Shands Clinics/Gainesville (352) 265-0002
Shands Clinics/Jacksonville (904) 244-3477
~~UF Clinics/Gainesville (352)~~ 265-8067
UF Clinics/Jacksonville (904) 244-4094
UF Dental Clinics (352) 392-2911

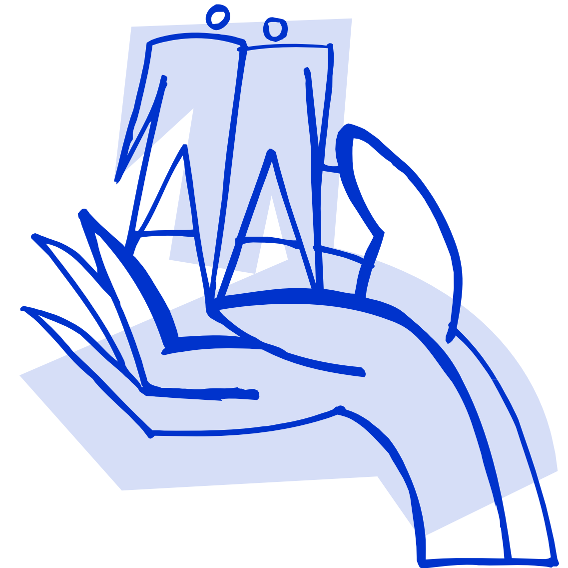
Please continue to refer patients with concerns to your facility Patient Representative.

Additional educational programs can be obtained through the Gainesville UF Self-Insurance Program office.

- Basics in Risk Management
- Basics in Consent
- Good Care Bad Documentation
- Capacity to Consent
- Credentialing, Peer Review and Medical Staff Monitoring
- Wrong Site Surgery

University of Florida
Self-Insurance Program
Risk Management and Loss Prevention
P. O. Box 112735
Gainesville, FL 32611
Phone: (352) 273-7006
Fax: (352) 273-7287
Website: www.sip.ufl.edu
e-mail: rmeduc@shands.ufl.edu

A Strategy for Disclosure of Adverse Events



04/06/09

A Strategy for Disclosure

This strategy uses the mnemonic **C-O-N-E-S** as a guide (**C**ontext, **O**pening, **N**arrative, **E**motions, and **S**ummary) developed by R. Buckman, R.L. Wears, and S.J. Perry (*How to Deal with Anger and Other Emotions in Adverse Event and Error Disclosure*).

C – CONTEXT. The first step is to ensure the context of the discussion is appropriate. This means getting both the physical and the emotional environment right.

a. *Physical environment. The conversation should take place in a private area, away from distractions and interruptions. The seating should be arranged so there are no barriers between you (and other health professionals, if present) and the patient or family. In particular, this means that you should not be seated on opposite sides of a desk or table. Your eyes should be on the same level as theirs, or lower – never higher.*

b. *Emotional environment. First, "take your own pulse;" take a deep breath and identify your own emotional state, which is likely to be a mixture of fear, discomfort, distaste, and embarrassment. It is good to make eye contact unless there is strong anger or emotion in the air, when it might seem either aggressive or intrusive. Discipline yourself to focus on listening. You will often know what the patient or family members are going to say, but do not interrupt – plan to keep quiet and allow them to say it.*

O – OPENING. Begin with an initial statement that sets both agenda and tone for what is coming, for example, "I have something difficult and important to discuss with you…." If the circumstances warrant, now is an appropriate point to insert the "S" word: "I'm sorry to say that…." (Sometimes in the immediate aftermath of an adverse event, it will not be known exactly how it happened, whether there was an error, etc. It is just as important not to fall on your sword prematurely as it is to apologize sincerely when an apology is due.)

There are many alternatives to this warning shot (e.g., "I've discovered something I have to talk to you about…."), and it is important not to try to memorize a set speech. Find a way to express this content in words that sound natural coming from you. It is often useful to pause here to allow some response.

N – NARRATIVE. Set out events in order, to your best knowledge. Go slow! This material will be difficult for the patient or family to understand and absorb, given the circumstances. It may need to be repeated several times. Explain the uncertainties, thinking, and decisions at each important juncture. Sit close and talk softly. Remember that often the initial theories of how things went wrong are borne out by a fuller analysis, so be careful not to speculate or leap to conclusions. Stick closely to the facts and admit knowledge gaps and uncertainties, but assure the patient or family that you will update them with more information as the analysis proceeds.

E – EMOTIONS. All emotional expressions need to be acknowledged. Health professionals often feel uncomfortable with emotional responses, but failing to acknowledge them makes everyone even more uncomfortable. If no emotional response is forthcoming, it is often useful to be silent for a while. This acknowledges that you recognize it is "their turn" to speak; most people will eventually speak up to fill a long silence. If this does not work, you may probe a little, not by direct questions (e.g., "How do you feel about that?), but rather by indirect suggestion (e.g., "You must be shocked to hear this?). Acknowledge the emotion in an empathic response involving the following steps:

a. *Identify the emotion. Is it fear, anger, shock, embarrassment, etc.?*

b. *Identify the source – is it coming from the patient or family, or is it your own emotion you are recognizing? It is okay to refer to your own feelings, especially when at a loss – "I don't know what to say…."*

c. *Respond in a way that connects the two. You do not need to feel the emotion yourself or even agree with it or think it is legitimate, but you must acknowledge it: "Hearing this must be a terrible shock, be terribly frightening, disturbing, must be awful for you."*

Some interviewers can skillfully use a repetition technique to acknowledge what the patient or family is feeling. Use a word from the subject's last sentence in your next sentence, especially if you can "match up" sensory modes. (e.g., if the patient says they cannot ***see*** *how this happened, you respond that you* ***see*** *what they mean.) It goes without saying that you should never say something like, "I know how you feel." Even if you do (which is unlikely), the patient or family will not know that and will not believe you.*

d. *Talking is an important way, but not the only way, to acknowledge emotion. Simple gestures, such as offering a tissue for crying, also acknowledge and legitimize emotional distress.*

The goal in all this is to legitimize the emotion and to make it possible to talk about disappointment, shock, and anger. The conversation now focuses on feelings rather than the facts of the case.

S – SUMMARY. Begin closing the conversation with a plan for the future. Establish a time for the next contact and ways to get in touch when new information (e.g., results of an autopsy or further investigation) becomes available. The next contact should be reasonably soon, even if there is not likely to be any substantive new information at that point. This allows the patient or family to digest the information already given and raise questions that do not need to wait for further results. Plans for future care, if required, are especially important at this point. Give the patient and family your contact information and also a contact for the institution's representative. This should be convenient for the patient and family – it should NOT be the main switchboard number or the pager of the resident on call! Finally, elicit questions in a way that does not make the patient or family feel that this is their last chance to ask. For example, "Any questions *for now*? We will talk again later, but anything *for now*?" Many people can not formulate their most important questions at the initial disclosure meeting, so it is important to leave the door open. Sometimes, the questions "for now" will lead you to recapitulate the narrative and emotion steps of the strategy again. Several iterations may be required until the conversation can be closed.