Kommunikasjon med pasienter og pårørende i etterkant av uønskede hendelser.

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Nasjonalt kunnskapssenter for helsetjenesten fremskaffer og formidler kunnskap om effekt av metoder, virkemidler og tiltak og om kvalitet innen alle deler av helsetjenesten. Målet er å bidra til gode beslutninger slik at brukerne får best mulig helsetjenester. Kunnskapsenteret er formelt et forvaltningsorgan under Helsedirektoratet, men har ingen myndighetsfunksjoner og kan ikke instrueres i faglige spørsmål.

Nasjonalt kunnskapssenter for helsetjenesten
Oslo, september, 2012

Hovedfunn

Uønskede hendelser i helsetjenesten kan få alvorlige konsekvenser for pasienter, pårørende og helsepersonell. I dette notatet har vi gjort et systematisk søk etter forskningslitteratur som har undersøkt ulike aspekter ved kommunikasjon mellom helsepersonell og pasienter og pårørende i etterkant av uønskede hendelser. Formålet med notatet er å gi en oversikt over forskningen.

- Vi inkluderte fem systematiske oversikter og to usystematiske oversiktsartikler. Oversiktene fant at uønskede hendelser opplevdes tungt for både pasienter, pårørende og helsepersonell, men at god kommunikasjon i om hendelsen kunne føre til mindre frustrasjon hos alle parter. Åpenhet om hendelsen var viktig for både pasienter, pårørende og helsepersonell. Pasientene ønsket å vite hva som hadde skjedd og de ville vite hva som skulle gjøres for å forebygge lignende hendelser i fremtiden. De ønsket også en oppriktig beklagelse. Få pasienter hadde fått tilstrekkelig informasjon eller en beklagelse fra helsepersonellet i etterkant av hendelsen. Helsepersonellet følte at de ikke hadde kompetanse til å kommunisere godt nok med pasienten og at de hadde behov for støtte, opplæring og godt forankrede retningslinjer for å håndtere en slik samtale. Mange fryktet at åpenhet om hendelsen skulle få rettslige konsekvenser. Ifølge oversiktene finner noen studier at åpenhet kan føre til færre erstatningssaker og anmeldelser, mens andre ikke finner denne sammenhengen.
- Oversiktene påpeker at det er behov for å forske mer på effekten av ulike tiltak, som for eksempel kommunikasjonsopplæring og retningslinjer for pasientkommunikasjon.
- Vi inkluderte 47 enkeltstudier publisert f.o.m. 2009. Resultatene fra studiene ble ikke oppsummert.

I dette notatet har vi avgrenset oss til publisert internasjonal forskningslitteratur og overføringsverdien fra utenlandske studier kan være begrenset. For å finne ut av hvilke behov norske pasienter har og hvilke tiltak som bør innføres i Norge, er det viktig å trekke på erfaringer fra norsk eller nordisk helsetjeneste.

Tittel:

Kommunikasjon med pasienter og pårørende i etterkant av uønskede hendelser.

Publikasjonstype:

Systematisk litteraturliste

En systematisk litteraturliste er resultatet av å

- søke etter relevant litteratur ifølge en søkestrategi og
- eventuelt sortere denne litteraturen i grupper presentert med referanser og vanligvis sammendrag

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Svarer ikke på alt:

- Ingen kritisk vurdering av studienes kvalitet
- Ingen analyse av studiene
- Ingen anbefalinger

Hvem står bak denne publikasjonen?

Kunnskapssenteret har gjennomført oppdraget etter forespørsel fra Nasjonal enhet for pasientsikkerhet, Kunnskapssenteret

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Når ble litteratursøket utført?

Søk etter studier ble avsluttet februar, 2012.

Key messages (English)

Adverse events in healthcare can cause serious consequences for patients, families and healthcare professionals. In this paper, we have performed a systematic search for studies that have examined various aspects of communication between health personnel and patients and their families in the aftermath of adverse events. The purpose of this paper is to provide an overview of the research.

- We included five systematic and two unsystematic reviews. The reviews found that involvement in an adverse event in many cases was a tough experience for both patients, their families and healthcare professionals, but that good communication about the incident could lead to less frustration for all parties. Open disclosure about the event was important for both patients and health personnel. Patients wanted to know what had happened and they also wanted to know what would be done to prevent similar incidents in the future. Although the patients wanted a sincere apology, they had rarely received sufficient information or an apology after the incident. Healthcare professionals felt that they lacked the skills to communicate well enough with the patient and that they themselves needed support, training and firmly anchored communication guidelines. Many feared that transparency about the incident would lead to legal consequences. Some studies summarised in the reviews found evidence that openness could decrease the amount of law suits and patient claims but on the other hand some studies did not find evidence for this connection.
- The reviews pointed out the need for more research on the effects of various interventions, such as communication training and guidelines for patient communication.
- We included 47 primary studies published as of 2009. The results of the studies were not summarised.

We have limited the search to published international research literature and the transfer value of international studies may be limited. To identify the needs of Norwegian patients and what interventions should be introduced in Norway, it is important to draw on the experiences from the healthcare in Norway and the other Nordic countries.

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Forord

I juli 2012 lanserte Nasjonalt kunnskapssenter for helsetjenesten ved Nasjonal enhet for pasientsikkerhet Meldeordningen og nettsiden www.melde.no. I den forbindelse har vi søkt etter tilgjengelig forskning om temaer som kan være relevante for målgruppene til Meldeordningen. I dette notatet presenteres resultatet fra et søk etter litteratur som handler om helsepersonells kommunikasjon med pasienter og pårørende etter uønskede hendelser. Notater om forskning på andre temaer finnes på www.melde.no og på www.kunnskapssenteret.no/nasjonalenhetforpasientsikkerhet.

Prosjektgruppen har bestått av:

- Ingvild Kirkehei, Kunnskapssenteret
- Marianne Tinnå, Kunnskapssenteret

Innledning

Uønskede hendelser i helsetjenesten kan få alvorlige konsekvenser for både pasienter, pårørende og helsepersonell. I tillegg til å rette opp i selve hendelsen, er det viktig å være bevisst på hvordan man kommuniserer og informerer om det som har skjedd. Både i Norge og internasjonalt er det en økt forståelse for viktigheten av åpenhet i forbindelse med uønskede hendelser. Men hvor åpen bør man være? Bør man si unnskyld for det som har skjedd og i så fall, hvem bør gjøre det og hvordan? Det er mange spørsmål som er relevante i denne sammenhengen og det kan være vanskelig å vite hvordan man som involvert helsepersonell bør håndtere en slik situasjon.

I dette notatet har vi gjort et systematisk søk etter forskningslitteratur som besvarer ulike spørsmål relatert til temaet:

- Hvilke konsekvenser har uønskede hendelser på pasienter og pårørende, foruten selve skaden?
- Hva slags oppfølging og informasjon ønsker eller trenger pasienter og pårørende i etterkant av en uønsket hendelse?
- Hvilke holdninger har helsepersonell til å kommunisere med pasienten etter en uønsket hendelse?
- Blir pasientenes og de pårørendes ønsker og behov imøtekommet i praksis?
- Hva er barrierene for å kommunisere åpent med pasientene om uønskede hendelser og å beklage det som har hendt?
- Hvilken effekt kan åpenhet om uønskede hendelser (inkludert beklagelser) ha på helsepersonell, pasienten og pårørende?

Vi har søkt etter systematiske oversikter og nyere enkeltstudier som muligens kan besvare spørsmålene. Formålet er å gi en oversikt over forskningen på området.

Metode

Litteratursøk

Vi utførte systematiske søk i MEDLINE, EMBASE, PsycINFO, Cochrane Library (alle databaser), CINAHL, ISI Web of Knowledge, SveMed og PubMed. Søket var sammensatt av emneord og tekstord for uønskede hendelser eller feil (for eksempel ”error” eller ”adverse events”) og avgrenset med søkeord for kommunikasjon (for eksempel ”communication” or ”disclosure”) eller beklagelser (”apology”). Søkene ble til sist avgrenset med søkeord for systematiske eller usystematiske oversiktsartikler eller primærstudier. Vi gjennomgikk også referanselister fra relevante publikasjoner og gjorde et enkelt søk i Google. Søket ble utført i februar 2012. Detaljert søkestrategi er gjengitt i vedlegg 1.

Inklusjonskriterier

En person gikk gjennom søketreffet og valgte ut relevant litteratur. Vi var interesserte i alle systematiske oversikter eller studier som undersøkte ulike aspekter ved det å informere pasienter eller pårørende om uønskede hendelser. I en systematisk oversikt er det brukt systematiske og eksplisitte metoder for å identifisere, utvelge og kritisk vurdere relevant forskning, samt for å innsamle og analysere data fra studiene som er inkludert i oversikten.

Alle publikasjoner som handlet om kommunikasjon med pasienter eller pårørende i etterkant av uønskede hendelser, ble nærmere vurdert for relevans. Vi hadde ingen begrensninger med hensyn til type uønskede hendelser, spesielle pasientgrupper eller spesielle yrkesgrupper, som for eksempel leger eller sykepleiere. Vi hadde ingen begrensninger i studiedesign. Alle typer av primærstudier var av interesse; kontrollerte studier, observasjonsstudier, tverrsnittstudier, kvalitative studier, spørreundersøkelser og case studier.

Utvelgelse og oppsummering

I første omgang ble alle søketreffene gjennomgått og sortert for å få en oversikt over omfanget av systematiske oversikter og enkeltstudier. Dette ble gjort av én person. Samme person valgte deretter ut og leste relevante systematiske oversikter i fulltekst. Oversiktene ble kvalitetsvurdert ved hjelp av Kunnskapssenterets sjekkliste for vurdering av oversiktsartikler (vedlegg 2) og funnene fra oversiktene ble kort

oppsummert. Usystematiske oversiktsartikler som fokuserte spesielt på beklagelser ble også inkludert.
Deretter valgte vi ut alle relevante enkeltstudier som var publisert etter det siste søket i de systematiske oversiktene. Studiene ble kun referert og ikke kvalitetsvurdert eller gjennomgått i fulltekst.

Resultat

Litteratursøket resulterte i 1231 referanser hvorav 219 ble vurdert som potensielt relevante for temaet. Fem av disse var systematiske oversikter og alle ble gjennomgått i fulltekst. I tillegg ble to usystematiske oversiktsartikler inkludert fordi de hadde spesielt fokus på beklagelser. Vi inkluderte referanser til 47 enkeltstudier publisert fra og med 2009.

Oversiktsartikler og systematiske oversikter

Vi fant fem systematiske oversikter som hadde som formål å oppsummere forskning omkring det å kommunisere med pasienter og pårørende om uønskede hendelser (på engelsk ble ordet ”disclosure” brukt). Nedenfor presenteres referanser med sammendrag kopiert fra kildene hvor de ble identifisert.

1. O'Connor E, Coates HM, Yardley IE, Wu AW. Disclosure of patient safety incidents: A comprehensive review. International Journal for Quality in Health Care 2010 22(5): 371-379. http://intqhc.oxfordjournals.org/content/early/2010/08/13/intqhc.mzq042.abstract
   Purpose: Adverse events are increasingly recognized as a source of harm to patients. When such harm occurs, problems arise in communicating the situation to patients and their families. We reviewed the literature on disclosure across individual and international boundaries, including patients', healthcare professionals' and other stakeholders' perspectives in order to ascertain how the needs of all groups could be better reconciled. Data sources: A systematic review of the literature was carried out using the search terms 'patient safety', 'medical error', 'communication', 'clinicians', 'healthcare professionals' and 'disclosure'. All articles relating to either patients' or healthcare professionals' experiences or attitudes toward disclosure were included. Results: Both patients and healthcare professionals support the disclosure of adverse events to patients and their families. Patients have specific requirements including frank and timely disclosure, an apology where appropriate and assurances about their future care. However, research suggests that there is a gap between ideal disclosure practice

and reality. Although healthcare is delivered by multidisciplinary teams, much of the research that has been conducted has focused on physicians' experiences. Research indicates that other healthcare professionals also have a role to play in the disclosure process and this should be reflected in disclosure policies. Conclusions: This comprehensive review, which takes account of the perspectives of the patient and members of the care team across multiple jurisdictions, suggests that disclosure practice can be improved by strengthening policy and supporting healthcare professionals in disclosing adverse events. Increased openness and honesty following adverse events can improve provider-patient relationships. The Author 2010. Published by Oxford University Press in association with the International Society for Quality in Health Care; all rights reserved

2. Fallowfield L. Communication with patients after errors. Journal of Health Services & Research Policy 2010; 15(Suppl 1):56-59. http://jhsrp.rsmjournals.com/content/15/suppl_1/56.long
   The study, published in 2003, looks at more than 120 sources of existing research, studies, and policies to consider errors and adverse incidents, particularly involving doctors, and the quality of communication with patients after an incident has happened. The researchers, however, said the research evidence was inadequate and nothing was clear cut.

3. Massó Guijarro P, Aranaz Andrés JM, Mira JJ, Perdiguero E, Aibar C. Adverse events in hospitals: the patient's point of view. Qual Saf Health Care 2010; 19:144-147. http://qualitysafety.bmj.com/content/19/2/144.long
   BACKGROUND: The publication of the report "To err is human: building a safer system" by the Institute of Medicine incited a profuse research addressing improvements in healthcare safety. However, there is still little acknowledgement of the key role of the patient in preventing adverse events of medical care. The aim of this review is to analyse and compare studies about patient's perception and opinion about care safety in hospitals. METHODS: We searched 10 databases (EMBASE, MEDLINE, PsychINFO, SCOPUS, Science Citation Index Expanded, Social Science Citation, IME, Sociological Abstracts, LILACS and The Cochrane Library) to identify articles and reports on patient's safety perception published between 1989 and 2006. RESULTS: From the 699 articles, 18 were selected: eight determined the frequency of experiences related to adverse events and the safety perception reported by patients, seven focused on the impact of the adverse events regarding the communication to the patient, and three included patient's opinions about the management and disclosure of adverse events and proposals to prevent them. CONCLUSIONS: The incidence of adverse events reported by patients was similar to that estimated by other procedures. The patient's concept of adverse events was different from that of the physician. The quality of

communication from the physician influenced the patient's perception of adverse events, and the majority wanted adverse events to be disclosed. Patients emphasised emotional consequences of the adverse events. The majority supported system modifications to prevent adverse events and to sanction the physicians when an adverse event occurs.

4. Camire E, Moyen E, Stelfox HT. Medication errors in critical care: Risk factors, prevention and disclosure. CMAJ 2009 180(9): 936-943.
   Sammendrag ikke tilgjengelig.

5. Mazor KM, Simon SR, Gurwitz JH. Communicating with patients about medical errors: A review of the literature. Archives of Internal Medicine 2004; 164(15): 1690-1697.
   http://archinte.jamanetwork.com/article.aspx?articleid=760546
   Background: Ethical and professional guidelines recommend disclosure of medical errors to patients. The objective of this study was to review the empirical literature on disclosure of medical errors with respect to (1) the decision to disclose, (2) the process of informing the patient and family, and (3) the consequences of disclosure or nondisclosure. Methods: We searched 4 electronic databases (MEDLINE, CINAHL, PsycINFO, and Social Sciences Citations Index) and the reference lists of relevant articles for English-language studies on disclosure of medical errors. From more than 800 titles reviewed, we identified 17 articles reporting original empirical data on disclosure of medical errors to patients and families. We examined methods and results of the articles and extracted study designs, data collection procedures, populations sampled, response rates, and definitions of error. Results: Available research findings suggest that patients and the public support disclosure. Physicians also indicate support for disclosure, but often do not disclose. We found insufficient empirical evidence to support conclusions about the disclosure process or its consequences. Conclusions: Empirical research on disclosure of medical errors to patients and families has been limited, and studies have focused primarily on the decision stage of disclosure. Fewer have considered the disclosure process, the consequences of disclosure, or the relationship between the two. Additional research is needed to understand how disclosure decisions are made, to provide guidance to physicians on the process, and to help all involved anticipate the consequences of disclosure.

To usystematiske oversiktsartikler hadde spesielt fokus på beklagelser og ble også inkludert:

1. Robbennolt JK. Apologies and medical error. Clin Orthop Relat Res 2009; 467(2): 376-382.
   http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2628492/?tool=pubmed

One way in which physicians can respond to a medical error is to apologize. Apologies--statements that acknowledge an error and its consequences, take responsibility, and communicate regret for having caused harm--can decrease blame, decrease anger, increase trust, and improve relationships. Importantly, apologies also have the potential to decrease the risk of a medical malpractice lawsuit and can help settle claims by patients. Patients indicate they want and expect explanations and apologies after medical errors and physicians indicate they want to apologize. However, in practice, physicians tend to provide minimal information to patients after medical errors and infrequently offer complete apologies. Although fears about potential litigation are the most commonly cited barrier to apologizing after medical error, the link between litigation risk and the practice of disclosure and apology is tenuous. Other barriers might include the culture of medicine and the inherent psychological difficulties in facing one's mistakes and apologizing for them. Despite these barriers, incorporating apology into conversations between physicians and patients can address the needs of both parties and can play a role in the effective resolution of disputes related to medical error.

2. Gallagher TH, Lucas MH. Should we disclose harmful medical errors to patients? If so, how? Journal of Clinical Outcomes Management 2005; 12(5): 253-259. http://www.turner-white.com/pdf/jcom_may05_patients.pdf
   Objective: To assess the strength of the evidence for disclosing errors to patients, focusing on patients' and physicians' attitudes toward disclosure and disclosure's effect on malpractice claims, and to present practical suggestions for disclosing medical errors. * Methods: Review of the literature. * Results: A gap exists between patients' preferences for disclosure and current clinical practice. Patients have consistently expressed a desire to be told about harmful medical errors, and want to know why the error happened, how recurrences will be prevented, and to receive an apology. However, current data suggests that as few as 30% of harmful errors are disclosed to patients. Physicians support the general principle of disclosure, but hesitate to share the information patients want about errors. Physicians identify fear of liability as one important barrier to error disclosure and experience significant emotional distress after a harmful medical error. Limited data suggests that some institutions have adopted policies of more open disclosure without adverse malpractice consequences. The current disclosure literature contains important but unanswered questions, such as how patients' preferences for disclosure vary along cultural and other dimensions, and whether recommended disclosure strategies improve patient trust and the likelihood of lawsuits. In the absence of definitive evidence about the outcomes of disclosure, practical suggestions for talking with patients about errors can be derived from the literature on doctor-patient communication, breaking bad news, and conflict resolution. * Conclusion: Patients want to be told about harmful errors in their care, but at present such disclosure is uncommon. Closing gaps in the existing

disclosure literature could help clinicians communicate more effectively with patients following harmful medical errors.

Kort oppsummering av oversiktene

En av de nyeste oversiktene, O'Connor 2010, undersøkte ønsker og erfaringer hos pasienter, pårørende og helsepersonell og hvordan de forskjellige behovene kunne imøtekommes. Guijarro 2010 avgrenset oversikten til studier som undersøkte pasientens perspektiv og ønsket blant annet å få svar på hvordan kommunikasjonen mellom pasienter og helsepersonell påvirker pasientenes oppfatning av pasientsikkerhet. Camire 2009 avgrenset temaet til kommunikasjon med voksne pasienter innlagt på intensivavdelingen. Mazor 2004 undersøkte dokumentasjonsgrunnlaget for pasienter og helsepersonells behov for å snakke om uønskede hendelser, selve kommunikasjonsprosessen og konsekvensene av ulike kommunikasjonsstrategier og tiltak. Fallowfield 2010 gir et sammendrag av en tidligere publisert oversikt fra 2003.

Oversiktene hadde varierende metodisk kvalitet. O'Connor 2010 og Guijarro 2010 ble vurdert å ha mangelfull kvalitet, primært på grunn av uklar søkestrategi, uklare inklusjonskriterier og ingen vurdering av primærstudienes kvalitet. Camire 2009 ble vurdert å ha høy metodisk kvalitet. De fleste kriterier fra sjekklisten var oppfylt, men oversikten hadde strenge inklusjonskriterier med hensyn til studiedesign og fant derfor ingen studier som besvarte spørsmålet som var relevant for oss. Det ble likevel referert til relevante studier med andre studiedesign. Mazor 2004 hadde moderat metodisk kvalitet. Oversikten manglet eksplisitte kriterier for kvalitetsvurdering av de inkluderte studiene. Fallowfield 2010 kunne ikke vurderes for kvalitet da det ikke var mulig å få tak i originalartikkelen fra 2003 hvor metoden for litteraturinnhentingen var beskrevet.

To usystematiske oversikter ble også inkludert da de var relevante for temaet og hadde egne avsnitt med fokus på beklagelser. Disse oversiktene ble ikke kvalitetsvurdert. I usystematiske oversiktartikler har forfatterne ikke brukt eksplisitte kriterier for søk, inklusjon, kvalitetsvurdering og analyse av studier og det kan være store skjevheter i studieutvalg og resultater.

Oversiktene refererer til ulike typer primærforskning. De fleste primærstudiene som er omtalt i oversiktene ser ut til å være basert på spørreundersøkelser av pasienter, pårørende eller helsepersonell. Studiene har målt deres erfaringer, holdninger eller ønsker. Oversiktene inkluderte også noen kvalitative studier i form av for eksempel intervjuer eller fokusgrupper. De refererte også til noen observasjonelle oppfølgingsstudier som har undersøkt effekter av ulike tiltak. Det var en del

overlapp mellom oversiktene med tanke på inkluderte primærstudier. Samtidig hadde alle oversiktene inkludert studier som ikke var med i de andre oversiktene.

Resultater fra oversiktene

I de følgende avsnitt følger sammendrag av resultatene fra oversiktene. Resultatene er ikke systematisk oppsummert og på grunn av varierende, og i noen tilfeller, lav kvalitet på oversiktene, kan det være flere forbehold ved funnene. Vi henviser til originalpublikasjonene for flere detaljer om enkeltstudiene og resultatene.

Hvilke konsekvenser har uønskede hendelser for pasienter og pårørende, foruten selve skaden?

Pasienter som har vært utsatt for feilbehandling får ofte fysiske, emosjonelle og økonomiske problemer. De kan føle angst, nedstemthet og frustrasjon. Mange frykter at det skal oppstå flere skader og mange pårørende har skyldfølelse for det som har skjedd. Også for helsepersonell kan det å være involvert i en uønsket hendelse være svært tungt.

Det ser ut til at god kommunikasjon i etterkant av hendelsen kan føre til bedre forhold mellom pasient og helsepersonell og mindre frustrasjon hos alle parter. Flere av oversiktene fant at det var sammenheng mellom graden av frustrasjon hos pasientene og hvordan kommunikasjonen med helsepersonellet i etterkant av hendelsen hadde foregått. De pasientene som rapporterte at de hadde hatt en god kommunikasjon med helsepersonellet etter hendelsen, rapporterte også mindre etterfølgende frustrasjon. I en studie fremkom det at pasientene og de pårørende ofte ble mer opprørte over hvordan de ble behandlet i etterkant av hendelsen enn selve hendelsen.

Hva slags oppfølging og informasjon ønsker eller trenger pasienter og pårørende i etterkant av en uønsket hendelse?

Alle oversiktene konkluderte med at både pasienter, pårørende og helsepersonell mente det var viktig med åpenhet omkring uønskede hendelser. Pasientene ønsket å vite hva som hadde skjedd og de ville vite hva som skulle gjøres for å forebygge lignende hendelser i fremtiden. De ønsket også en oppriktig beklagelse. Mange av pasientene i studiene som ble inkludert i oversiktene, hadde behov for å få vite at helsepersonellet var lei for det som hadde skjedd. Ærlighet og medfølelse førte til mindre engstelse og økt tiltro til personellet. Ufullstendige og unnvikende forklaringer førte til økt engstelse.

Med hensyn til nestenhendelser var det i følge oversiktene, noe sprikende resultater. Noen pasienter følte at informasjon om nestenhendelser kunne forberede dem på eventuelle nye hendelser mens andre fryktet at det ville gjøre dem mer engstelige. Spørreundersøkelser av hva pasientene ville foretrekke i en tenkt situasjon, viste at en stor andel av pasientene ønsket å bli informert om hendelser som ikke hadde ført til skader, mens en enda større andel ønsket å vite om hendelser som faktisk hadde ført til skader.

"Beklager" eller "unnskyld" kan oppfattes på forskjellige måter; som uttrykk for anger ("expression of regret") eller som uttrykk for at man påtar seg ansvaret for det som har skjedd ("expression of responsibility")[1]. Gallagher 2005 skriver at det ikke finnes dokumentasjon for at pasientene foretrekker den ene typen beklagelse fremfor den andre. For de fleste pasienter er oppriktigheten i beklagelsen det aller viktigste, fremfor hvilke ord som blir brukt.

Det er i følge O'Connor 2010 usikkert hva som er det ideelle tidspunktet for å informere pasienten om hendelsen. Noen studier finner at informasjonen bør gis like etter at hendelsen har oppstått mens andre finner at det kan være best å vente til man har mer oversikt over hva som har hendt. Dette forutsetter at man kommuniserer ordentlig med pasienten underveis i prosessen. Mazor 2004 diskuterer temaet i sin oversiktsartikkel. For tidlig informasjon, hvor hendelsesforløpet og årsaken til hendelsen ikke er klarlagt, kan føre til unødig bekymring hos pasienten. For sen informasjon kan øke pasientens frykt og sinne. Robbenolt 2009 refererer til at flere studier har funnet at beklagelser i etterkant av uønskede hendelser fungerer mest hensiktsmessig når den som skal fremføre beklagelsen har fått tid til å sette ord på hva som har skjedd og hvilke konsekvenser hendelsen kan ha hatt.

Hvilke holdninger har helsepersonell til det å kommunisere med pasienten etter en uønsket hendelse?

Helsepersonell mener også at åpen kommunikasjon om hendelsen er viktig, men det avhenger av om det er snakk om alvorlige hendelser eller mindre alvorlige. Med hensyn til hvem som bør ha ansvaret for kommunikasjonen med pasientene, gir oversiktene ingen klare svar.

[1] Dette kan bety at man tar det moralske, men ikke det juridiske ansvar for det som har skjedd. Begrepet "ansvar" er på norsk tvetydig og kan bety både at man tar ansvar – responsibility - og at man innrømmer et juridisk ansvar - liability.

Blir pasientenes og de pårørendes ønsker og behov imøtekommet i praksis?

Alle oversiktene konkluderer med at det er et stort gap mellom pasienter og helsepersonells ønsker og holdninger og det som faktisk gjøres i praksis. Oversiktene finner at få pasienter har fått tilstrekkelig informasjon eller en beklagelse i etterkant av en uønsket hendelse. Dette er vist gjennom studier på både pasienters og helsepersonells erfaringer.

Hva er barrierene for å kommunisere åpent med pasientene om uønskede hendelser og å beklage det som har hendt?

Leger og sykepleiere rapporterer at de synes det er vanskelig å kommunisere åpent med pasientene om hendelsen. Mange føler at de ikke har kompetanse til å kommunisere godt nok med pasienten om det som har skjedd. De har behov for støtte og opplæring i hvordan de skal håndtere en slik samtale. Det er også behov for retningslinjer for hvordan kommunikasjonen bør foregå og dette bør være forankret i ledelsen og aller helst på nasjonalt plan. Offisielt etablerte retningslinjer (”policies”) for kommunikasjon blir mer og mer vanlig i USA. Disse retningslinjene legger opp til at man gir en åpen redegjørelse av hendelsen etterfulgt av en beklagelse.

Mange frykter også at åpenhet om hendelsen skal få rettslige konsekvenser og holder derfor tilbake informasjon.

Hvilken effekt kan åpenhet om uønskede hendelser (inkludert beklagelser) ha på helsepersonell, pasienter og pårørende?

Den egentlige effekten av ulike måter å kommunisere på er ikke sikker. I følge O’Connor 2010 er det ingen dokumentasjon for at åpenhet er skadelig, og det er noe dokumentasjon for at det er bra.

Dokumentasjonen på sammenhengen mellom åpenhet og antall erstatningssaker og anmeldelser er sprikende. Noen studier finner at åpenhet kan føre til færre erstatningssaker og anmeldelser, mens andre studier ikke finner denne sammenhengen. Andre ting som kan påvirke pasientens ønske om å anmelde eller søke erstatning kan være forholdet til legen før hendelsen, skadens alvorlighet, pasientens økonomiske situasjon og legens kommunikasjonsferdigheter.

Vi har funnet to systematiske oversikter fra USA som har undersøkt sammenhengen mellom åpen kommunikasjon om feil og saksanlegg og evt. anmeldelser. Her

presenteres referanser og sammendrag. Oversiktene er ikke kvalitetsvurdert eller lest i fulltekst og overføringsverdien til norske forhold er usikker.

1. Huntoon MA, Levy RM. How to keep a bad outcome from becoming a lawsuit. Pain Med 2008;9(Suppl. 1): S128-S132. http://onlinelibrary.wiley.com/doi/10.1111/j.1526-4637.2008.00449.x/abstract
   Objective. The incidence of medical mal-occurrences associated with interventional pain procedures is increasing. This has resulted in a corresponding increase in medical malpractice tort claims. Therefore, physicians involved in performing interventional pain procedures must understand the malpractice tort system in order to both practice more safely, and to decrease litigation risk. Further, physicians must be aware of specific trends in both their own behaviors as well as the behaviors of their patients that may decrease the chances of being sued. Design. We systematically searched the Medline Database and recent electronic pain journals and websites for relevant articles on the topic of interventional pain procedures and litigation. Results. Medical errors are largely cited in the lay and medical literature. Specific ideal physician behaviors that may decrease risks of lawsuits were identified. Conclusions. Physicians cannot control all the potential contributors to errors. What can be controlled is our knowledge, skill, diligence and perseverance. Ultimately, when an unfortunate outcome results, being honest and admitting any real or potential errors, forging strong relationships, and being able to say "I'm sorry" may be the best way to mitigate blame. 2008 by American Academy of Pain Medicine

2. Kachalia A, Shojania KG, Hofer TP, Piotrowski M, Saint S. Does full disclosure of medical errors affect malpractice liability? The jury is still out. Jt Comm J Qual Saf. 2003;29(10):503-11. http://www.ingentaconnect.com/content/jcaho/jcjqs/2003/00000029/00000010/art00001
   BACKGROUND: Mandatory disclosure of medical errors has been advocated to improve patient safety. Many resist mandatory disclosure policies because of concerns about increasing malpractice exposure. It has been countered that malpractice liability actually decreases when there is full disclosure of medical errors. A comprehensive literature search was conducted to determine what is known about the impact of full disclosure on malpractice liability. METHODS: Electronic searches of multiple databases were supplemented with hand searches of bibliographies and communication with recognized experts in the field. RESULTS: Screening the titles, abstracts, and, in many cases, the full articles from more than an estimated 5,200 citations resulted in identification of one published study directly examining malpractice liability when a policy of full disclosure was implemented. DISCUSSION: Despite extensive literature on the impact of disclosure on malpractice liability, few well-designed studies have focused on the real-world impact on the volume and cost of suits following

implementation of a full disclosure policy. Many articles examine why patients sue their doctors, suggesting that some lawsuits may be averted by disclosure, but the articles do not allow us to estimate the additional suits that would be created by disclosure. Additional studies addressing the effect of disclosure on malpractice liability are needed.

Anbefalinger hentet fra de systematiske oversiktene

Fire av de systematiske oversiktene vi har gjennomgått i fulltekst, inneholder anbefalinger om hvordan helsepersonell bør kommunisere med pasienter og pårørende etter en uønsket hendelse.

O'Connor 2010 skriver:

- Informer pasienten om risikoen for at hendelser kan oppstå.
- Tilgjengeliggjør rammeverk og retningslinjer vedrørende kommunikasjon i etterkant av uønskede hendelser. Informer pasienten om retningslinjene.
- Ta høyde for pasientenes ønske om informasjon i etterkant av en uønsket hendelse. Informer om eventuell videre behandling og hvordan hendelsen skal analyseres og forebygges.
- Forsikre de ansatte om at de vil få hjelp fra institusjonen til å redegjøre for hendelsen. De bør også få støtte i form av kommunikasjonsopplæring.

Camire 2009 skriver at redegjørelsen overfor pasienten bør skje på følgende måte:

- Like etter at hendelsen har oppstått eller så snart som mulig.
- Bruk et stille rom uten forstyrrelser.
- Informer om fakta uten spekulasjoner eller snakk om skyldspørsmål.
- Bruk enkle, klare og forståelige ord.
- Uttrykk sympati overfor pasienten.
- Sett av tid til spørsmål.
- Dokumenter redegjørelsen i pasientjournalen.

Gallagher 2005 tar utgangspunkt i litteraturen om "breaking bad news" og konflikthåndtering og skriver:

- Skaff hjelp fra kollegaer eller fra tilgjengelige retningslinjer.
- Planlegg hvordan du vil gjennomføre samtalen med pasienten. Gjennomgå hva man vet om hendelsen og hva som fortsatt er usikkert. Bli enige om hvem som skal delta i samtalen med pasienten og hva deres rolle skal være. Involver gjerne noen som kan informere pasienten om hvordan hendelsen vil bli forebygget i fremtiden.
- Finn ut hva pasienten vet om hendelsen allerede.
- Gi grunnleggende informasjon om hendelsen. Informasjonen bør være faktabasert og objektiv. Hvis aktuelt, informer pasienten om at mer

utdypende informajon vil komme senere. Ikke spekuler i feil eller skyldspørsmål.
- Gi en oppriktig beklagelse, si unnskyld. Forbered deg på at pasientene kan reagere forskjellig på det å motta en beklagelse.
- Planlegg oppfølgingen av hendelsen. Forklar hva som skal gjøres for å forhindre at feilen skjer igjen og etabler en kontaktperson for videre kommunikasjon.
- Tilby støtte og henvisninger til andre nødvendige tjenester etter behov så lenge det ikke går ut over pasientsikkerheten.

Fallowfield 2010 kommer med mange av de samme anbefalingene og legger til at helsepersonell bør få støtte, opplæring og juridisk rådgiving. Pasientene bør få hjelp til å snakke med andre mennesker i samme situasjon. De bør også tilbys psykologisk veiledning hvis det er behov for det. Det er i følge Fallowfield viktig å fokusere mer på pasienter og pårørendes psykiske og sosiale problemer som følge av en uønsket hendelse. Det kan være kroniske smerter, sorg, tapsfølelse, depresjon og angst.

Forbehold ved resultatene

Mange av studiene som er oppsummert i oversiktene er tverrsnittstudier som har sammenlignet ulike faktorer men som ikke kan brukes til å trekke sikre konklusjoner om direkte årsakssammenhenger. Flere av studiene har få studiedeltagere og er basert på selvrapportering. Deltagerne kan ha blitt spurt om hva de husker fra spesielle situasjoner og det kan være forskjell på hva de husker og hva som egentlig har skjedd. I andre studier er de blitt spurt om hva de tror de ville hatt behov for eller hva de tror de ville ha gjort i en tenkt situasjon. Også disse svarene kan avvike fra det som faktisk ville ha skjedd i praksis.

I mange av studiene er det ikke tydelig definert hva som menes med ”uønskede hendelser” eller ”feil” og helsepersonell, pasienter og pårørende kan ha hatt ulike oppfatninger av hva dette betyr. Andre begreper, som for eksempel ”åpenhet”, kan også ha blitt tolket forskjellig av ulike studiedeltagere.

Kunnskapshull identifisert av de systematiske oversiktene

Mazor 2004 påpeker at dokumentasjonsgrunnlaget er begrenset og at forskningen har fokusert mest på beslutninger om å informere pasienter og pårørende om uønskede hendelser og mindre på selve prosessen og konsekvensene av ulike måter å kommunisere på. Det er behov for forskning på hvilke retningslinjer man bør implementere og hvordan man best kan hjelpe og motivere helsepersonell som er

involvert i prosessen. Det er også behov for mer forskning på effekten av ulike tiltak, som for eksempel kommunikasjonsopplæring. I mangel av direkte relatert forskning på kommunikasjon etter uønskede hendelser, oppfordrer Gallagher til å hente råd fra forskningen på "breaking bad news" og konflikthåndtering.

O'Connor 2010 påpeker at mye av forskningen på temaet omfatter leger, men at andre personalgrupper kan ha stor betydning i kommunikasjonen med pasienten. Det er fortsatt usikkert hvordan man best skal gå frem i kommunikasjonen med pasientene, hvordan man kan endre de ansattes atferd, hvordan institusjonene best kan støtte både ansatte og pasienter, hvilken rolle pasienten selv har og om det er ulike behov for informasjon i ulike pasient- og pårørendegrupper.

Nyere enkeltstudier

Det siste litteratursøket i den nyeste systematiske oversikten ble utført i 2009 og vi har hentet inn referanser til 47 enkeltstudier som har blitt publisert etter dette. Referansene er sortert etter tema, publikasjonsår og forfatter. Sorteringen er ikke gjensidig ekskluderende og det kan være overlapp mellom temaene.

Opplæring av helsepersonell

Vi fant seks nye studier som har evaluert eller undersøkt effekten av ulike opplæringsprogram. To av studiene (nummer 2 og 6) var norske.

1. Gillies RA, Speers SH, Young SE, Fly CA. Teaching medical error apologies: development of a multi-component intervention. Family Med 2011; 43(6): 400-406.
   http://www.stfm.org/fmhub/fm2011/June/Ralph400.pdf
   Apologizing is an important component in addressing medical errors; yet, offering apologies continues to challenge physicians. To address limitations of prior educational interventions, a multi-faceted, apologies intervention was developed to provide medical students with increasingly applied learning opportunities. First-year medical students taking a professionalism course at the authors' Southeastern medical school in 2008 or 2009 were eligible for the study. Data from their assigned activities and a post-intervention survey were analyzed. A total of 384 students contributed study data; 57.8% were male, 58.6% white, 10.9% Asian-Indian, 10.9% Asian-Other, and 7.6% African-American. Seventy-four percent of students considered tasks as useful or extremely useful. Student confidence in providing effective apologies increased as well as their comfort in disclosing errors to a faculty member or patient. Perceived importance of apology skills similarly increased. Apologies written by female authors were rated higher in effectiveness by peers than apologies written by male authors. Apology

evaluators adopting patient perspective were more critical than evaluators adopting peer perspective. No race differences were found. This intervention was perceived useful by students and demonstrated medium to large effect size changes in importance, confidence, and comfort around apology errors. The higher evaluations of apologies written by female authors as well as the lower evaluations by evaluators adopting patient perspective warrant further consideration. Additional research is also warranted on streamlining and implementing the intervention for other institutions and ultimately how actual student apology behaviors are later affected.

2. Jensen BF, Gulbrandsen P, Dahl FA, Krupat E, Frankel RM, Finset A. Effectiveness of a short course in clinical communication skills for hospital doctors: Results of a crossover randomized controlled trial (ISRCTN22153332). Patient Education and Counseling 2011; 84(2):163- 169. http://www.pec-journal.com/article/S0738-3991%2810%2900605-1/abstract
OBJECTIVE: To test the hypothesis that a 20-h communication skills course based on the Four Habits model can improve doctor-patient communication among hospital employed doctors across specialties. METHODS: Crossover randomized controlled trial in a 500-bed hospital with interventions at different time points in the two arms. Assessments were video-based and blinded. Intervention consisted of 20 h of communication training, containing alternating plenary with theory/debriefs and practical group sessions with role-plays tailored to each doctor. RESULTS: Of 103 doctors asked to participate, 72 were included, 62 received the intervention, 51 were included in the main analysis, and another six were included in the intention-to-treat analysis. We found an increase in the Four Habits Coding Scheme of 7.5 points (p = 0.01, 95% confidence interval 1.6-13.3), fairly evenly distributed on subgroups. Baseline score (SD) was 60.3 (9.9). Global patient satisfaction did not change, neither did average encounter duration. CONCLUSION: Utilizing an outpatient-clinic training model developed in the US, we demonstrated that a 20-h course could be generalized across medical and national cultures, indicating improvement of communication skills among hospital doctors. PRACTICE IMPLICATIONS: The Four Habits model is suitable for communication-training courses in hospital settings. Doctors across specialties can attend the same course.

3. Bell, S. K., D. W. Moorman, Delbanco T. Improving the patient, family, and clinician experience after harmful events: The "When things go wrong" curriculum. Academic Medicine 2010: 85(6):1010-1017. http://journals.lww.com/academicmedicine/pages/articleviewer.aspx?year=2010&issue=06000&article=00027&type=abstract
The emotional toll of medical error is high for both patients and clinicians, who are often unsure with whom 'and whether' they can discuss what happened. Although institutions are increasingly adopting full disclosure policies, trainees

frequently do not disclose mistakes, and faculty physicians are underprepared to teach communication skills related to disclosure and apology. The authors developed an interactive educational program for trainees and faculty physicians that assesses experiences, attitudes, and perceptions about error, explores the human impact of error through filmed patient and family narratives, develops communication skills, and offers a strategy to facilitate bedside disclosures. Between spring 2007 and fall 2008, 154 trainees (medical students/residents) and 75 medical educators completed the program. Among learners surveyed, 62% of trainees and 88% of faculty physicians reported making medical mistakes. Of those, 62% and 78%, respectively, reported they did not apologize. While 65% of trainees said they would turn to senior doctors for assistance after an error, 26% were not sure where to get help. Just 20% of trainees and 21% of physicians reported adequate training to respond to error. Following the session, all of the faculty physicians surveyed indicated they felt better prepared to address and teach this topic. At a time of increased attention to disclosure, actual faculty and trainee practices suggest that role models, support systems, and education strategies are lacking. Trainees' widespread experience with error highlights the need for a disclosure curriculum early in medical education. Educational initiatives focusing on communication after harm should target teachers and students. 2010 Association of American Medical Colleges

4. Rathert C, Phillips W. Medical error disclosure training: Evidence for values-based ethical environments. Journal of Business Ethics 2010; 97(3): 491-503. http://psnet.ahrq.gov/resource.aspx?resourceID=20072
   Disclosure of medical errors to patients has been increasingly mandated in the U.S. and Canada. Thus, some health systems are developing formal disclosure policies. The present study examines how disclosure training may impact staff and the organization. We argue that organizations that support "disclose and apologize" activities, as opposed to "deny and defend," are demonstrating values-based ethics. Specifically, we hypothesized that when health care clinicians are trained and supported in error disclosure, this may signal a values-based ethical environment, and staff may be more committed to the organization. We surveyed 325 clinical care providers employed by a large hospital that had recently begun implementing disclosure policies and training. Disclosure training explained significant variance in perceptions of the ethical environment, and the ethical environment mediated the relationship between disclosure training and organizational commitment. Although this study explored disclosure of medical errors, organizational support for error disclosure is a concept that could be relevant for many types of organizations. (PsycINFO Database Record (c) 2010 APA, all rights reserved) (journal abstract)

5. Bonnema RA, Gosman GG, Arnold RM. Teaching error disclosure to residents: a curricular innovation and pilot study. Journal of Graduate Medical Education

2009; 1(1):114-118.
http://www.jgme.org/doi/abs/10.4300/01.01.0019
OBJECTIVE: To compare change in obstetrics and gynecology residents' self-efficacy in disclosing medical errors after a formal educational session. METHODS: This was a retrospective postintervention survey to assess change in perceived preparedness to disclose medical errors. We used a 4-hour educational seminar that included a didactic component (30 minutes) and experiential learning with a trained facilitator (3 hours). Change in self-efficacy was measured using a 5-point Likert-type scale (1 is lowest, and 5 is highest) and was compared using sign test (alpha[THIN SPACE][HAIR SPACE]=[HAIR SPACE][THIN SPACE].05). RESULTS: In our pilot study, 13 of 15 residents reported having previously participated in error disclosure. After the session, residents considered themselves more prepared for the following: to know what to include in and how to introduce error discussions, to deal with a patient's emotional reaction, to respond to a patient's questions regarding how an error occurred, and to recognize one's own emotions when discussing medical errors. Residents believed that they would be likely to use the skills learned in the remainder of residency and in their future career. CONCLUSIONS: This curriculum was associated with improvement in self-efficacy regarding error disclosure. Given the unique malpractice issues that obstetricians/gynecologists face, it seems particularly useful for residents to learn these skills early in their career. In addition, this topic represents an ideal educational opportunity for residencies to improve patient care and to address other core competencies in resident education such as communication skills and professionalism.

6. Gunderson AJ, Smith KM, Mayer DB, McDonald T, Centomani N. Teaching medical students the art of medical error full disclosure: Evaluation of a new curriculum. Teaching and Learning in Medicine 2009; 21(3): 229-232.
http://www.tandfonline.com/doi/abs/10.1080/10401330903018526
Background: Despite the acknowledgment that error disclosure is essential to patient safety and the patient-provider relationship, there is little undergraduate training related to error disclosure. Description: Pilot test and evaluate an educational module designed to improve student confidence in understanding and performing medical error disclosure. The training was designed to establish competency in the four Rs of apology-recognition, responsibility, regret, and remedy-and included a 3-hr interactive discussion, training DVDs, practice of full disclosure using standardized patients, and facilitated reflection. Students were assessed pre and post using a self-administered confidence survey. Evaluations: Confidence among students improved significantly from 11.5 +/- 2.9 before to 15.3 +/- 1.3 after the module (p <.0001). Conclusions: The full disclosure educational module significantly improved students' perceived confidence in admitting medical errors and their confidence in understanding and performing

the full disclosure of a medical error. Copyright 2009, Taylor & Francis Group, LLC.

Hvem deltar, eller bør delta, i kommunikasjonen med pasienten?

Vi fant tre studier som har undersøkt hvem som deltar, eller bør delta i kommunikasjonen med pasienten. Studie nummer 2 (Hammami 2010) undersøkte i tillegg hvorvidt man burde informere om nestenhendelser.

1. Guchait P, Kim MG, Namasivayam K. Error management at different organizational levels - Frontline, manager, and company. International Journal of Hospitality Management 2012; 31(1):12-22.
   http://scholarsarchive.jwu.edu/hosp_tourism/4/
   The influence of service recovery efforts in the form of apology (error management) at three organizational levels - frontline, manager, and company - on consumer satisfaction and behavioral intentions was examined with a 2 X 2 X 2 experimental study. Results support the main effects of all three apology levels on consumer satisfaction with the service exchange (recovery) process. The results also indicate that frontline apology has greater influence on consumers' satisfaction when a manager's apology is also present. Moreover, the study identifies perceived control and fairness as mediators of the relationships between apology levels and consumer satisfaction indicating potential theoretical and managerial implications. (C) 2011 Elsevier Ltd. All rights reserved

2. Hammami MM, Attalah S. Which medical error to disclose to patients and by whom? Public preference and perceptions of norm and current practice. BMC medical ethics 2010; 11: 17.
   http://www.biomedcentral.com/1472-6939/11/17
   Disclosure of near miss medical error (ME) and who should disclose ME to patients continue to be controversial. Further, available recommendations on disclosure of ME have emerged largely in Western culture; their suitability to Islamic/Arabic culture is not known. We surveyed 902 individuals attending the outpatient's clinics of a tertiary care hospital in Saudi Arabia. Personal preference and perceptions of norm and current practice regarding which ME to be disclosed (5 options: don't disclose; disclose if associated with major, moderate, or minor harm; disclose near miss) and by whom (6 options: any employee, any physician, at-fault-physician, manager of at-fault-physician, medical director, or chief executive director) were explored. Mean (SD) age of respondents was 33.9 (10) year, 47% were males, 90% Saudis, 37% patients, 49% employed, and 61% with college or higher education. The percentage (95% confidence interval) of respondents who preferred to be informed of harmful ME, of near miss ME, or by at-fault physician were 60.0% (56.8 to 63.2), 35.5% (32.4 to 38.6), and 59.7% (56.5 to 63.0), respectively. Respectively, 68.2% (65.2 to 71.2) and 17.3% (14.7 to

19.8) believed that as currently practiced, harmful ME and near miss ME are disclosed, and 34.0% (30.7 to 37.4) that ME are disclosed by at-fault-physician. Distributions of perception of norm and preference were similar but significantly different from the distribution of perception of current practice ($P < 0.001$). In a forward stepwise regression analysis, older age, female gender, and being healthy predicted preference of disclosure of near miss ME, while younger age and male gender predicted preference of no-disclosure of ME. Female gender also predicted preferring disclosure by the at-fault-physician. We conclude that: 1) there is a considerable diversity in preferences and perceptions of norm and current practice among respondents regarding which ME to be disclosed and by whom, 2) Distributions of preference and perception of norm were similar but significantly different from the distribution of perception of current practice, 3) most respondents preferred to be informed of ME and by at-fault physician, and 4) one third of respondents preferred to be informed of near-miss ME, with a higher percentage among females, older, and healthy individuals.

3. Jeffs L, Espin S, Shannon SE, Levinson W, Kohn MK, Lingard L. A new way of relating: perceptions associated with a team-based error disclosure simulation intervention. Quality & safety in health care 2010; 19(Suppl 3):i57-i60. http://qualitysafety.bmj.com/content/19/Suppl_3/i57.long
BACKGROUND: Despite the call for open and team-based approaches to error disclosure, the participation beyond physicians and managers is not a common practice in health care settings. Moreover, within the growing literature base on error disclosure, team-based error disclosure is an emerging concept. To address this knowledge gap, a study was undertaken to explore the perceptions associated with an educational simulation intervention for team-based error disclosure. METHODS: A qualitative study that involved analysis of data obtained from semi-structured interviews with a sample of 6 physicians, 6 surgeons, and 12 nurses recruited from the three participating hospitals. RESULTS: Perceptions from study participants elucidated a tension between team-based error disclosure as an unrealistic, forced practice and as a realistic, beneficial practice. This tension was highly contextual and differentiated by study participants' perceptions of the nature of the error; patient's preferences; and prevailing cultural and professional norms. Regardless of the view, study participants described the simulation experience as a new way of relating that departed from existing practice. CONCLUSIONS: Study findings revealed that a team-based approach to disclosure is not realistic or necessary for all error situations, such as when the error involves a single discipline. However, when the error involves a variety of health care professionals interacting with the patient, a team-based approach is beneficial to them and the patient. Further work is required by researchers and administrators to develop and test out interventions that enable health care professionals to practice team-based error disclosure in a safe and supported environment

Helsepersonells holdninger og erfaringer

Vi fant 13 studier på helsepersonells holdninger og erfaringer med kommunikasjon om uønskede hendelser. Noen av studiene undersøkte også gapet mellom holdninger og praksis.

1. Ghalandarpoorattar SM, Kaviani A, Asghari F. Medical error disclosure: the gap between attitude and practice. Postgrad Med J 2012;88(1037):130-3. http://pmj.bmj.com/content/88/1037/130.long
   Background: This study aims to evaluate the attending surgeons' and residents' attitudes towards error disclosure and factors that can potentially affect these tendencies in major academic hospitals affiliated with Tehran University of Medical Sciences (TUMS). Methods and material: In a cross-sectional study, self-administered questionnaires were delivered to all attending surgeons and second to fourth year surgical residents of TUMS during October and November 2009. The questionnaire contained two clinical scenarios and questions regarding physicians' attitudes towards disclosing medical error and their actual practice in the case of their last error. Of the 63 distributed questionnaires, 53 (84.1%) were completed and returned.ResultsParticipants were less likely to disclose minor (39.6%; 21/53) than major (49.1%; 29/53) medical errors. Participants believed that their most important concerns for not disclosing errors were fear of a malpractice lawsuit (71.7%, n=38), losing patients' trust (62.3%, n=33), and emotional reactions of the patients and their relatives (56.6%, n=30). Although most physicians indicated they would disclose errors in minor and major scenarios, only 16.7% (n=8) had disclosed their last medical errors to their patients, two of which had resulted in patients taking legal action.Conclusion: There was an obvious gap between surgeons' intentions and actual practices concerning disclosure of medical error. Education in medical error management to professionally support error disclosure might help reduce the gap.

2. Dintzis SM, Stetsenko GY, Sitlani CM, Gronowski AM, Astion ML, Gallagher TH. Communicating pathology and laboratory errors: Anatomic pathologists' and laboratory medical directors' attitudes and experiences. American Journal of Clinical Pathology 2011; 135(5):760-765. http://ajcp.ascpjournals.org/content/135/5/760.long
   Physicians are urged to communicate more openly following medical errors, but little is known about pathologists' attitudes about reporting errors to their institution and disclosing them to patients. We undertook a survey to characterize pathologists' and laboratory medical directors' attitudes and experience regarding the communication of errors with hospitals, treating physicians, and affected patients. We invited 260 practicing pathologists and 81 academic hospital laboratory medical directors to participate in a

selfadministered survey. This survey included questions regarding estimated error rates and barriers to and experience with error disclosure. The majority of respondents (~95%) reported having been involved with an error, and respondents expressed near unanimous belief that errors should be disclosed to hospitals, colleagues, and patients; however, only about 48% thought that current error reporting systems were adequate. In addition, pathologists expressed discomfort with their communication skills in regard to error disclosure. Improving error reporting systems and developing robust disclosure training could help prevent future errors, improving patient safety and trust. American Society for Clinical Pathology

3. Duffy A. Study of Healthcare Professionals in Ireland to Identify the Current Culture on Open Disclosure Following An Adverse Event. Irish Journal of Medical Science 2011; 180:219-220.

4. Jeffs L, Espin S, Rorabeck L, Shannon SE, Robins L, Levinson W, Gallagher TH et al. Not overstepping professional boundaries: The challenging role of nurses in simulated error disclosures." Journal of Nursing Care Quality 2011; 26(4): 320-327.
http://journals.lww.com/jncqjournal/pages/articleviewer.aspx?year=2011&issue=10000&article=00005&type=abstract
This article provides findings on the role of the nurse in simulated team-based error disclosures. Triangulation of 3 qualitative data sets revealed that a tension exists for nurses in the error disclosure process as they attempt to balance professional boundaries. Study findings point to multilevel strategies including cultural, structural, and educational approaches to enhancing the key roles that nurses need to play in error disclosure to patients and families. Copyright 2011 Wolters Kluwer Health | Lippincott Williams & Wilkins

5. Singh, V., M. Panda, et al. Disclosure and documentation of unintended medical events: What do healthcare providers believe? Journal of Investigative Medicine 2011; 59(2):538-539.
Purpose of Study: AMA-ethics: physician deal honestly with patient JCAHO, accreditation standards, "01-disclose unanticipated outcomes" Full disclosure increases patient satisfaction and physician trust. Studies suggest elements of complete disclosure, but no national standards. Purpose 1) Look for documentation of various elements of unintended medical events (UMEs) disclosure 2) Survey health care providers (HCPs) for perceptions regarding UMEs disclosure Methods Used: Chart review for disclosure elements, suggested by previous studies: who made/received disclosure; persons documenting/reporting; event facts; time-event to disclosure/documentation; locations-error/disclosure. Anonymous survey sent to HCPs. Summary of Results: 230 charts with reported UMEs Category E-I(MERP scale), 7/08-6/09,

at Southeast US hospital system reviewed. Documentation considered complete if all elements mentioned above present 192 charts included-135 adults/57 pediatrics 9.89% had disclosure documentation(Table) Survey data collected from physicians (n=65) and nonphysicians (n=48) working within the same system (total N=113, response rate 29%). 68% physicians and 48% nonphysicians indicated awareness of disclosure recommendations; 57% physicians and 35% nonphysicians reported not being aware of disclosure guidelines in this hospital. Differences observed between physicians and nonphysicians in: perception of-disclosure need; best person to provide disclosure in several example scenarios; importance of specific information within proper documentation; factors hindering proper disclosure. Conclusions: Need for HCP education regarding UME disclosure, documentation and follow-up. Areas for improvement-structured education on disclosure process; develop disclosure documentation template. Such efforts need to be tailored to address unique experiences of physician/non-physicians.

6. White AA, Bell SK, Krauss MJ, Garbutt J, Dunagan WC, Fraser VJ, Levinson W et al. How trainees would disclose medical errors: educational implications for training programmes. Medical education 2011; 45(4):372-380. http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2923.2010.03875.x/full
The disclosure of harmful errors to patients is recommended, but appears to be uncommon. Understanding how trainees disclose errors and how their practices evolve during training could help educators design programmes to address this gap. This study was conducted to determine how trainees would disclose medical errors. We surveyed 758 trainees (488 students and 270 residents) in internal medicine at two academic medical centres. Surveys depicted one of two harmful error scenarios that varied by how apparent the error would be to the patient. We measured attitudes and disclosure content using scripted responses. Trainees reported their intent to disclose the error as 'definitely' (43%), 'probably' (47%), 'only if asked by patient' (9%), and 'definitely not' (1%). Trainees were more likely to disclose obvious errors than errors that patients were unlikely to recognise (55% versus 30%; $p < 0.01$). Respondents varied widely in the type of information they would disclose. Overall, 50% of trainees chose to use statements that explicitly stated that an error rather than only an adverse event had occurred. Regarding apologies, trainees were split between conveying a general expression of regret (52%) and making an explicit apology (46%). Respondents at higher levels of training were less likely to use explicit apologies (trend $p < 0.01$). Prior disclosure training was associated with increased willingness to disclose errors (odds ratio 1.40, $p = 0.03$). Trainees may not be prepared to disclose medical errors to patients and worrisome trends in trainee apology practices were observed across levels of training. Medical educators should intensify efforts to enhance trainees' skills in meeting patients' expectations for the open disclosure of harmful medical errors. Blackwell Publishing Ltd 2011

7. Carmack HJ. Bearing witness to the ethics of practice: storying physicians' medical mistake narratives. Health communication 2010; 25(5): 449-458. http://www.tandfonline.com/doi/abs/10.1080/10410236.2010.484876?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%3dpubmed&
Medical mistakes are often referred to as the "hidden epidemic" of health because doctors, patients, and hospital administrators remain silent about mistakes. This study relies on in-depth interviews to explore how physicians story their medical mistake experiences. Narrative theory is used to understand how these physicians story the complexity of medical mistakes, highlighting how these physicians bear witness to medical mistakes by sharing and listening to medical mistake narratives. Moreover, this study showcases the implications of how practitioners and scholars bear witness to the oft-times emotional telling and retelling of health narratives.

8. Coffey M, Thomson K, Tallett S, Matlow A. Pediatric residents' decision-making around disclosing and reporting adverse events: the importance of social context. Academic Medicine 2010; 85(10): 1619-1625. http://journals.lww.com/academicmedicine/pages/articleviewer.aspx?year=2010&issue=10000&article=00020&type=abstract
PURPOSE: Although experts advise disclosing medical errors to patients, individual physicians' different levels of knowledge and comfort suggest a gap between recommendations and practice. This study explored pediatric residents' knowledge and attitudes about disclosure. METHOD: In 2006, the authors of this single-center, mixed-methods study surveyed 64 pediatric residents at the University of Toronto and then held three focus groups with a total of 24 of those residents. RESULTS: Thirty-seven (58%) residents completed questionnaires. Most agreed that medical errors are one of the most serious problems in health care, that errors should be disclosed, and that disclosure would be difficult. When shown a scenario involving a medical error, over 90% correctly identified the error, but only 40% would definitely disclose it. Most would apologize, but far fewer would acknowledge harm if it occurred or use the word "mistake." Most had witnessed or performed a disclosure, but only 40% reported receiving teaching on disclosure. Most reported experiencing negative effects of errors, including anxiety and reduced confidence. Data from the focus groups emphasized the extent to which residents consider contextual information when making decisions around disclosure. Themes included their or their team's degree of responsibility for the error versus others, quality of team relationships, training level, existence of social boundaries, and their position within a hierarchy. CONCLUSIONS: These findings add to the understanding of facilitators and inhibitors of error disclosure and reporting. The influence of social context warrants further study and should be considered in medical curriculum design and hospital guideline implementation.

9. Loren DJ, Garbutt J, Dunagan WC, Bommarito KM, Ebers AG, Levinson W, Waterman AD et al. Risk managers, physicians, and disclosure of harmful medical errors. Joint Commission journal on quality and patient safety / Joint Commission Resources 2010; 36(3):101-108. http://www.ingentaconnect.com/content/jcaho/jcjqs/2010/00000036/00000003/art00002
BACKGROUND: Physicians are encouraged to disclose medical errors to patients, which often requires close collaboration between physicians and risk managers. METHODS: An anonymous national survey of 2,988 healthcare facility-based risk managers was conducted between November 2004 and March 2005, and results were compared with those of a previous survey (conducted between July 2003 and March 2004) of 1,311 medical physicians in Washington and Missouri. Both surveys included an error-disclosure scenario for an obvious and a less obvious error with scripted response options. RESULTS: More risk managers than physicians were aware that an error-reporting system was present at their hospital (81% versus 39%, p < .001) and believed that mechanisms to inform physicians about errors in their hospital were adequate (51% versus 17%, p < .001). More risk managers than physicians strongly agreed that serious errors should be disclosed to patients (70% versus 49%, p < .001). Across both error scenario, risk managers were more likely than physicians to definitely recommend that the error be disclosed (76% versus 50%, p < .001) and to provide full details about how the error would be prevented in the future (62% versus 51%, p < .001). However, physicians were more likely than risk managers to provide a full apology recognizing the harm caused by the error (39% versus 21%, p < .001). CONCLUSIONS: Risk managers have more favorable attitudes about disclosing errors to patients compared with physicians but are less supportive of providing a full apology. These differences may create conflicts between risk managers and physicians regarding disclosure. Health care institutions should promote greater collaboration between these two key participants in disclosure conversations

10. Gallagher TH, Cook AJ, Brenner RJ, Carney PA, Miglioretti DL, Geller BM, Kerlikowske K et al. Disclosing harmful mammography errors to patients. Radiology 2009; 253(2): 443-452. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2770115/?tool=pubmed
Purpose: To assess radiologists' attitudes about disclosing errors to patients by using a survey with a vignette involving an error interpreting a patient's mammogram, leading to a delayed cancer diagnosis. Materials and Methods: We conducted an institutional review board-approved survey of 364 radiologists at seven geographically distinct Breast Cancer Surveillance Consortium sites that interpreted mammograms from 2005 to 2006. Radiologists received a vignette in which comparison screening mammograms were placed in the wrong order,

leading a radiologist to conclude calcifications were decreasing in number when they were actually increasing, delaying a cancer diagnosis. Radiologists were asked (a) how likely they would be to disclose this error, (b) what information they would share, and (c) their malpractice attitudes and experiences. Results: Two hundred forty-three (67%) of 364 radiologists responded to the disclosure vignette questions. Radiologists' responses to whether they would disclose the error included "definitely not" (9%), "only if asked by the patient" (51%), "probably" (26%), and "definitely"(14%). Regarding information they would disclose, 24% would "not say anything further to the patient," 31% would tell the patient that "the calcifications are larger and are now suspicious for cancer," 30% would state "the calcifications may have increased on your last mammogram, but their appearance was not as worrisome as it is now," and 15% would tell the patient "an error occurred during the interpretation of your last mammogram, and the calcifications had actually increased in number, not decreased. "Radiologists' malpractice experiences were not consistently associated with their disclosure responses. Conclusion: Many radiologists report reluctance to disclose a hypothetical mammography error that delayed a cancer diagnosis. Strategies should be developed to increase radiologists' comfort communicating with patients. (C) RSNA, 2009

11. Greene, D. A. Nurses' experiences with the disclosure of errors to patients. Dissertation. Georgia State University; 2009. Nursing Dissertations. (Paper 19). http://digitalarchive.gsu.edu/nursing_diss/19/
The 1999 Institute of Medicine report, To Err is Human, raised awareness about the multitude of errors that occur in healthcare. Frequently, errors are not disclosed to patients or their families. While several studies have examined patient and physician perspectives on disclosure, limited research on nurse perspectives exist. In hospitals, nurses are often the last line of defense before errors reach the patient. Because nurses are often present when errors occur, nurses' experiences with disclosure are integral to understanding the issues that surround the disclosure of errors. The purpose of this study was to gain an understanding of nurse experiences with both disclosure and nondisclosure of errors to patients. An interpretive approach was used to guide the study, combined with a feminist perspective to illuminate the issues of power and gender. Registered nurses (n=17) employed in hospitals and caring for adult medical/surgical patients participated in semi-structured interviews. After the audio-recorded interviews were transcribed, they were reviewed for accuracy by participants. Analysis consisted of an eight-step process including use of a research team and peer debriefing. Three major themes and 6 sub-themes were identified. Major themes were: (a) disclosing errors, (b) perceiving expectations for disclosure, and (c) not disclosing errors. Some nurses provided constant information to the patient, so a disclosure decision was not necessary when errors occurred. Many of these nurses felt that full disclosure was the right thing to do.

Other nurses based disclosure decisions on their perceptions of the culture or policies of the work environment. Disclosing events, but not errors was a method used to vaguely disclose while others overtly concealed errors. Some nurses felt that disclosure was a professional responsibility, while others felt that nurses should align themselves with institutional expectations. Still others indicated that disclosure should be determined on a case-by-case basis depending on the context. This study contributes to nursing science by illuminating the experiences of nurses with disclosure, describing nurses' ways of being truthful when errors occur, and examining the contextual factors that surround nurses' practices of disclosure. Recommendations of the study for nursing practice, education and research were identified.

12. Maurer M. Nurses' perceptions of and experiences with medication errors, Dissertation, University of Toledo; 2010.
http://etd.ohiolink.edu/send-pdf.cgi/Maurer%20Mary%20Jo.pdf?toledo1279243109
The purpose of this study was to explore the relationship between nurse characteristics and medication errors. The study examined nurses' perceptions of factors which contribute to medication errors; barriers to reporting and factors that increase the reporting of medication errors; whether medication errors should be reported to the patient, family or an outside agency; and, medication administration technology for reducing medication errors. A survey was mailed to a random sample of 800 registered nurses (RN) from across the United States who were members of the American Nurses Association. A response rate of 49% was achieved using a three-wave mailing. The primary causes of medication errors identified were interruptions during medication pass, short RN staffing, nurses caring for high acuity patients, nurses working more than 12 hours in one shift, and nurses' knowledge of medications dispensed. Approximately one-fourth of nurses reported they had made at least one error that had resulted in some type of harm to a patient in the past 12 months, while approximately 60% of nurses reported making one or more medication errors that did not cause harm to a patient. Rank ordering identified three major barriers to reporting medication errors: fear of consequences that may result if a medication error is reported, fear of blame if something happens to the patient due to a medication error, and fear of a reprimand if they reported a medication error had been made. Nurses perceived that medication administration technologies would decrease medication errors in their hospital. The majority of nurses overwhelmingly agreed that medication errors should be communicated to patients or families, as well as hospitals being responsible for communicating their error rates to the public. Results of this study have serious implications for individual staff nurses, nurse administrators, as well as hospital administration and hospital systems in terms of error reduction and patient safety.

13. Shannon SE, Foglia MB, Hardy M, Gallagher TH.Disclosing errors to patients: perspectives of registered nurses. Jt Comm J Qual Patient Saf. 2009 Jan;35(1):5-12.
http://www.ingentaconnect.com/content/jcaho/jcjqs/2009/00000035/00000001/art00002
BACKGROUND: Disclosure of medical errors has been conceptualized as occurring primarily in the physician-patient dyad. Yet, health care is delivered by interprofessional teams, in which nurses share in the culpability for errors, and hence, in responsibility for disclosure. This study explored nurses' perspectives on disclosure of errors to patients and the organizational factors that influence disclosure. METHODS: Between October 2004 and December 2005, 11 focus groups were conducted with 96 registered nurses practicing in one of four health care organizations in the Puget Sound region of Washington State. Focus groups were analyzed using qualitative content analysis. FINDINGS: Nurses reported routinely independently disclosing nursing errors that did not involve serious harm, but felt the attending physician should lead disclosures when patient harm had occurred or when errors involved the team. Nurses usually were not involved in the error disclosure discussion among the team to plan for the disclosure or in the actual disclosure, leading to ethically compromising situations in nurses' communication with patients and families. Awareness of existing error disclosure policies was low. Nonetheless, these nurses felt that hospital policies that fostered a collaborative process would be helpful. Nurse managers played a key role in creating a culture of transparency and in being a resource for error disclosures. DISCUSSION: Nurses conceived of the disclosure process as a team event occurring in the context of a complex health care system rather than as a physician-patient conversation. Nurses felt excluded from these discussions, resulting in their use of ethically questionable communication strategies. The findings underscore the need for organizations to adopt a team disclosure process. Health care organizations that integrate the entire health care team into the disclosure process will likely improve the quality of error disclosure.

Konsekvenser av åpenhet og beklagelser

Vi fant to studier som undersøkte konsekvensen av å informere om og beklage uønskede hendelser.

1. Helmchen, L. A., M. R. Richards, et al. How does routine disclosure of medical error affect Patients' propensity to sue and their assessment of provider quality? Evidence from survey data. Medical Care 2010 48(11): 955-961.
http://journals.lww.com/lww-medicalcare/pages/articleviewer.aspx?year=2010&issue=11000&article=00004&type=abstract
Background: Although strongly favored by patients and ethically imperative for providers, the disclosure of medical errors to patients remains rare because

providers fear that it will trigger lawsuits and jeopardize their reputation. To date little is known how patients might respond to their providers' disclosure of a medical error even when paired with an offer of remediation. Research Design: A representative sample of Illinois residents was surveyed in 2008 about their knowledge about medical errors, their confidence that their providers would disclose medical errors to them, and their propensity to sue and recommend providers that disclose medical errors and offer to remedy them. We report the response patterns to these questions. As robustness checks, we also estimate the covariate-adjusted distributions and test the associations among these dimensions of medical-error disclosure. Results: Of the 1018 respondents, 27% would sue and 38% would recommend the hospital after medical error disclosure with an accompanying offer of remediation. Compared with the least confident respondents, those who were more confident in their providers' commitment to disclose were not likely to sue but significantly and substantially more likely to recommend their provider. Conclusions: Patients who are confident in their providers' commitment to disclose medical errors are not more litigious and far more forgiving than patients who have no faith in their providers' commitment to disclose. 2010 by Lippincott Williams & Wilkins

2. Bolkan S, Daly J. Organizational responses to consumer complaints: An axamination of effective remediation tactics. Journal of Applied Communication Research 2009; 37(1): 21-39. http://www.tandfonline.com/doi/abs/10.1080/00909880802592656
Mistakes are common in business and can lead to negative repercussions for organizations. However, through the use of explanations, firms can diminish the negative consequences of their errors. The current study used a field stimulation to examine organizational explanations (excuses, justifications, and excuses) and their components (believable, appropriate, considerate, and responsible) to determine which factors make a difference in consumer satisfaction following organizational failures. Results, interpreted through the lens of expectancy violations theory, suggest that various components of explanations and the form of explanations used in remedial responses influence people's perceptions of organizations and organizational responses following complaints about failures.

Konsekvensen av ekstratiltak

Én studie undersøkte viktigheten av det å tilrettelegge for en tilhelingsprosess hos pasienter og pårørende (”remediation”) i tillegg til å være åpen og gi en beklagelse.

1. Helmchen LA, Richards MR, McDonald TB. Successful remediation of patient safety incidents: A tale of two medication errors. Health Care Management Review 2011 36(2):114-123.

http://journals.lww.com/hcmrjournal/pages/articleviewer.aspx?year=2011&issue=04000&article=00003&type=abstract
Background: As patient safety acquires strategic importance for all stakeholders in the health care delivery chain, one promising mechanism centers on the proactive disclosure of medical errors to patients. Yet, disclosure and apology alone will not be effective in fully addressing patients' concerns after an adverse event unless they are paired with a remediation component. Purpose: The purpose of this study was to identify key features of successful remediation efforts that accompany the proactive disclosure of medical errors to patients. Approach: We describe and contrast two recent and very similar cases of preventable medical error involving inappropriate medication at a large tertiary-care academic medical center in the Midwestern United States. Findings: Despite their similarity, the two medical errors led to very different health outcomes and remediation trajectories for the injured patients. Although one error causing no permanent harm was mismanaged to the lasting dissatisfaction of the patient, the other resulted in the death of the patient but was remediated to the point of allowing the family to come to terms with the loss and even restored a modicum of trust in the providers' sincerity. Practice Implications: To maximize the opportunities for successful remediation, as soon as possible after the incident, providers should pledge to injured patients and their relatives that they will assist and accompany them in their recovery as long as necessary and then follow through on their pledge. As the two case studies show, it takes training and vigilance to ensure adherence to these principles and reach an optimal outcome for patients and their relatives.

Pasienter og pårørendes ønsker og erfaringer

Vi fant fem studier som undersøkte hvorvidt åpenhet og beklagelser er viktig for pasienter og pårørende og hvilken erfaring de har med dette i praksis.

1. De Cremer D, Pillutla MM, Folmer CR. How important is an apology to you? Forecasting errors in evaluating the value of apologies. Psychological Science 2011; 22(1):45-48.
   http://pss.sagepub.com/content/22/1/45.long
   Apologies are commonly used to deal with transgressions in relationships. Results to date, however, indicate that the positive effects of apologies vary widely, and the match between people's judgments of apologies and the true value of apologies has not been studied. Building on the affective and behavioral forecasting literature, we predicted that people would overestimate how much they value apologies in reality. Across three experimental studies, our results showed that after having been betrayed by another party (or after imagining this to be the case), people (a) rated the value of an apology much more highly when they imagined receiving an apology than when they actually received an apology and (b) displayed greater trusting behavior when they imagined receiving an

apology than when they actually received an apology. These results suggest that people are prone to forecasting errors regarding the effectiveness of an apology and that they tend to overvalue the impact of receiving one. The Author(s) 2011

2. Iedema R, Allen S et al. Patients' and family members' views on how clinicians enact and how they should enact incident disclosure: the "100 patient stories" qualitative study. BMJ (Clinical research ed.) 2011; 343:d4423. http://www.bmj.com/content/343/bmj.d4423
   To investigate patients' and family members' perceptions and experiences of disclosure of healthcare incidents and to derive principles of effective disclosure. Retrospective qualitative study based on 100 semi-structured, in depth interviews with patients and family members. Nationwide multisite survey across Australia. 39 patients and 80 family members who were involved in high severity healthcare incidents (leading to death, permanent disability, or long term harm) and incident disclosure. Recruitment was via national newspapers (43%), health services where the incidents occurred (28%), two internet marketing companies (27%), and consumer organisations (2%). Participants' recurrent experiences and concerns expressed in interviews. Most patients and family members felt that the health service incident disclosure rarely met their needs and expectations. They expected better preparation for incident disclosure, more shared dialogue about what went wrong, more follow-up support, input into when the time was ripe for closure, and more information about subsequent improvement in process. This analysis provided the basis for the formulation of a set of principles of effective incident disclosure. Despite growing prominence of open disclosure, discussion about healthcare incidents still falls short of patient and family member expectations. Healthcare organisations and providers should strengthen their efforts to meet patients' (and family members') needs and expectations.

3. Lazare A, Levy RS. Apologizing for humiliations in medical practice. Chest 2011; 139(4): 746-751. http://chestjournal.chestpubs.org/content/139/4/746.long
   Apologizing to patients and their families for medical mistakes is an increasingly accepted practice. Overlooked is the need to apologize to other members of the treatment team or patients for humiliations inflicted in medical practice, independent of medical mistakes. A humiliated treatment team member or patient is apt to undermine optimal care, particularly when teamwork or patient adherence to treatment is required. This article describes the psychology of humiliation and the history of humiliation in medical practice, including why doctors and patients are vulnerable to being humiliated. Several humiliation narratives are presented. This article presents empirical data based on a sample of 355 subjects that analyze what the offended party seeks in an apology and the magnitude of the importance of each of these desires. The restoration of dignity in response to humiliation emerges as one of the most important functions of

apologies. Finally, this article identifies 15 healing forces of apology, a combination of which is necessary for healing any given offense. The final challenge is educating individuals as to how to apply these findings to healing after a humiliating offense.

4. Mazor KM, Greene SM, Roblin D, Lemay CA, Firneno CL, Calvi J, Prouty CD et al. More than words: Patients' views on apology and disclosure when things go wrong in cancer care. Patient Educ Couns 2011; Aug 6. [Epub ahead of print] http://www.pec-journal.com/article/S0738-3991%2811%2900377-6/abstract
OBJECTIVE: Guidelines on apology and disclosure after adverse events and errors have been in place for over 5 years. This study examines whether patients consider recommended responses to be appropriate and desirable, and whether clinicians' actions after adverse events are consistent with recommendations. METHODS: Patients who believed that something had gone wrong during their cancer care were identified. During in-depth interviews, patients described the event, clinicians' responses, and their reactions. RESULTS: 78 patients were interviewed. Patients' valued apology and expressions of remorse, empathy and caring, explanation, acknowledgement of responsibility, and efforts to prevent recurrences, but these key elements were often missing. For many patients, actions and evidence of clinician learning were most important. CONCLUSION: Patients' reports of apology and disclosure when they believe something has gone wrong in their care suggest that clinicians' responses continue to fall short of expectations. PRACTICE IMPLICATIONS: Clinicians preparing to talk with patients after an adverse event or medical error should be aware that patients expect their actions to be congruent with their words of apology and caring. Healthcare systems need to support clinicians throughout the disclosure process, and facilitate both system and individual learning to prevent recurrences.

5. Matlow AG, Moody L, Laxer R, Stevens P, Goia C, Friedman JN. Disclosure of medical error to parents and paediatric patients: Assessment of parents' attitudes and influencing factors. Archives of Disease in Childhood 2010; 95(4): 286-290. http://adc.bmj.com/content/95/4/286.long
Objective: To assess parental preferences for medical error disclosure and evaluate associated factors. Design: Prospective survey. Setting: Hospital for Sick Children, Toronto, Canada. Participants: Parents of inpatients and outpatients. Main exposure: Anonymous questionnaire administered on May to August 2006, surveying demographic characteristics and identifying parents' thresholds for disclosure using a vignette with six levels of harm. Main outcome measures: Preferred thresholds for parent and patient disclosure and associated factors. Results: 99% of 431 parents (181 inpatients, 250 outpatients) wanted disclosure if there was potential or actual harm versus 77% if there was none ($p<0.0001$). Most parents (71% vs 41%) wanted their child similarly informed ($p<0.0001$).

Parental age, education, experience with error and child's age did not affect preferences for disclosure. Parents of inpatients (p=0.03, OR 1.65, 95% CI 1.04 to 2.62) and those born in Asia (vs North America) had a lower disclosure threshold (p=0.014, OR 2.4, 95% CI 1.2 to 4.9), and administering the survey with increasing harm had a higher disclosure threshold (p<0.0001, OR 2.46; 95% CI 1.58 to 3.83). Experience with error: (p=0.05, OR 1.5, 95% CI 1 to 2.2) and child age (eg, <=6 years vs >= 11 years (p<0.0001, OR 2.74, 95% CI 1.73 to 4.33)) directly affected preferences for informing the child. Asian parents had a lower threshold for informing the child than North American parents. Conclusions: Most parents want disclosure and want their child informed of errors with harm. While parental birth country, experience with error and patient age influenced parents' desire for disclosure to their child, the details of disclosure warrant study.

Barrierer for åpenhet om uønskede hendelser

Tre studier undersøkte hva som hindrer helsepersonell i å åpent informere pasienter og pårørende om uønskede hendelser.

1. "Study Examines Barriers to Adverse-Event Disclosure." Joint Commission Perspectives on Patient Safety 2011; 11(11): 2-2.

2. Iedema R, Allen S, Sorensen R, Gallagher TH. What prevents incident disclosure, and what can be done to promote it? The Joint Commission Journal on Quality and Patient Safety 2011; 37(9):409-417. http://www.hadassah.org.il/NR/rdonlyres/407D0D4A-699A-4C0A-89B2-7E05E3069AB1/26769/Barrierstoincidentdisclosure.pdf
   BACKGROUND: Adverse-event incident disclosure is gaining international attention as being central to incident management, practice improvement, and public engagement, but those charged with its execution are experiencing barriers. Findings have emerged from two large studies: an evaluation of the 2006-2008 Australian Open Disclosure Pilot, and a 2009-2010 study of patients' and relatives' views on actual disclosures. Clinicians and patients interviewed in depth suggest that open disclosure communication has been prevented by a range of uncertainties, fears, and doubts. METHODS: Across Australia, 147 clinical staff were interviewed (mostly over the phone), and 142 patients and relatives were interviewed in their homes or over the phone. Interviews were recorded, transcribed, and analysed by three independent investigators. Transcription analyses yielded thematic domains, each with a range of ancillary issues. RESULTS: Analysis of interview transcripts revealed several important barriers to disclosure: uncertainty among clinicians about what patients and family members regard as requiring disclosure; clinicians' assumption that those harmed are intent on blaming individuals and not interested in or capable of understanding the full complexity of clinical failures; concerns on the part of

clinicians about how to interact with (angry or distressed) patients and family members; uncertainties about how to guide colleagues through disclosure; and doubts surrounding how to manage disclosure in the context of suspected litigation risk, qualified-privilege constraints, and risk-averse approaches adopted by insurers. CONCLUSIONS: Disclosure practices appear to be inhibited by a wide range of barriers, only some of which have been previously reported. Strategies to overcome them are put forward for frontline clinicians, managerial staff, patient advocates, and policy agencies.

3. Studdert DM, Donella P, Iedema R. Legal aspects of open disclosure II: attitudes of health professionals - findings from a national survey. Medical Journal of Australia 2010; 193(6):351-355. https://www.mja.com.au/journal/2010/193/6/legal-aspects-open-disclosure-ii-attitudes-health-professionals-findings-national
   Objective: To assess the attitudes of health care professionals engaged in open disclosure (OD) to the legal risks and protections that surround this activity Design and participants: National cross-sectional survey of 51 experienced OD practitioners conducted in mid 2009. Main outcome measures: Perceived barriers to OD, awareness of and attitudes towards medicolegal protections, recommendations for reform. Results: The vast majority of participants rated fears about the medicolegal risks (45/51) and inadequate education and training in OD skills (43/51) as major or moderate barriers to OD. A majority (30/51) of participants viewed qualified privilege laws as having limited or no effect on health professionals' willingness to conduct OD, whereas opinion was divided about the effect of apology laws (state laws protecting expressions of regret from subsequent use in legal proceedings). In four states and territories (Western Australia, South Australia, Tasmania and the Northern Territory), a majority of participants were unaware that their own jurisdiction had apology laws that applied to OD. The most frequent recommendations for legal reform to improve OD were strengthening existing protections (23), improving education and awareness of applicable laws (11), fundamental reform of the medical negligence system (8), and better alignment of the activities of certain legal actors (eg, coroners) with OD practice (6). Conclusions: Concerns about both the medicolegal implications of OD and the skills needed to conduct it effectively are prevalent among health professionals at the leading edge of the OD movement in Australia. The ability of current laws to protect against use of this information in legal proceedings is perceived as inadequate.

Studier på konsekvenser av ”apology laws”

Tre studier undersøkte konsekvensene av å innføre lover som skal hindre at åpenhet (”open disclosure”) og beklagelser i etterkant av en uønsket hendelse kan få uheldige rettslige konsekvenser for helsepersonell eller helsetjenesten. I praksis har bl.a. flere

stater i USA innført lovgivning som innebærer at beklagelser ikke kan brukes som bevis i en rettssak om feilbehandling. Slike lover kalles "apology laws".

1. Ho B, Liu E. What's an apology worth? Decomposing the effect of apologies on medical malpractice payments using state apology laws. Journal of Empirical Legal Studies 2011; 8:179-199.
   http://onlinelibrary.wiley.com/doi/10.1111/j.1740-1461.2011.01226.x/abstract
   Past studies find that apologies affect the outcomes of medical malpractice litigation, but such studies have largely been limited to laboratory surveys or case studies. Following Ho and Liu (2010), we use the passage of state-level apology laws that exclude apologies from being used as evidence in medical malpractice cases, and estimate that apologizing to a patient in cases of medical malpractice litigation reduces the average payout by $32,000. This article seeks to unpack the mechanism of apologies by examining the differential impact of apologies laws by various subsamples. We find that apologies are most valuable for cases involving obstetrics and anesthesia, for cases involving infants, and for cases involving improper management by the physician and failures to diagnose.

2. Studdert DM, Richardson MW. Legal aspects of open disclosure: a review of Australian law. Medical Journal of Australia 2010: 193(5):273-276.
   https://www.mja.com.au/journal/2010/193/5/legal-aspects-open-disclosure-review-australian-law
   Health professionals worry that information about adverse events conveyed to patients in open disclosure (OD) may be used against them in medicolegal proceedings. Whether and how strongly state and federal laws in Australia protect against such uses is unclear. Our analysis concludes that existing laws do not prohibit the sharing of most types of information on adverse events with patients. However, none of these laws was enacted with OD in mind and, in general, the protections they provide are quite weak. If policymakers want OD to become a routine part of medical practice, law reform may be needed in the form of stronger protections directed specifically at the contents of OD communications.

3. Ho B, Liu E. Does sorry work? The impact of apology laws on medical malpractice. University of Houston; 2010.
   http://irving.vassar.edu/faculty/bh/Ho-Liu-Apologies-and-Malpractice-nov15.pdf
   Apologies made by physicians for adverse medical events have been identified as a mitigating factor in whether patients decide to litigate. However, doctors are socialized to avoid apologies because apologies admit guilt and invite lawsuits. An apology law, which specifies that a physician's apology is inadmissible in court, is written to encourage patient-physician communication. Building on a simple model, we examine whether apology laws at the State level have an impact on

malpractice lawsuits and settlements. Using a difference-in-differences estimation, we find that State-level apology laws could expedite the settlement process. Using individual level data, we also find that apology laws have the greatest reduction in average payment size and settlement time in cases involving more severe patient outcomes.

Evalueringer og effekter av ulike strategier for å ta hånd om pasienter og pårørende i etterkant av en uønsket hendelse.

Vi fant seks evalueringer av eksisterende programmer for å kommunisere med pasienter etter uønskede hendelser.

1. Doucette E, Fazio S, LaSalle V, Malcius C, Mills J, Archer T. Full disclosure of adverse events to patients and families in the ICU: wouldn't you want to know? Dynamics (Pembroke, Ont.) 2010; 21(3): 16-19.
   http://www.caccn.ca/en/pdfs/7B%20Full%20Disclosure.pdf
   In the past several years, there has been an increasing focus in our Canadian health care system related to patient safety. The Canadian Disclosure Guidelines, which were released in May 2008, discuss various patient safety initiatives underway across Canada. They emphasize the importance of a clear and consistent approach to disclosure, regardless of the variability in the definitions and interpretations across health care institutions. In addition, they highlight that all patients have the right to be informed about all aspects of their care, and all harm must be communicated to patients regardless of the reason (Disclosure Working Group, 2008). In this article, the authors describe and share our learning experiences, as nurses and students, while working in critical care settings when these guidelines were needed to communicate a harmful incident. Often, health care practitioners only become aware of specific guidelines regarding the disclosure of an adverse event once the incident has occurred. A case study will be discussed to illustrate the benefits of having a policy and a systematic framework in place to support a critical care environment in disclosing errors and adverse events to affected patients and their families

2. McDonald TB, Helmchen LA, Smith KM, Centomani N, Gunderson A, Mayer D, Chamberlin WH. Responding to patient safety incidents: the "seven pillars". Quality & safety in health care 2010, 19(6):e11.
   http://qualitysafety.bmj.com/content/19/6/1.31.long
   Background: Although acknowledged to be an ethical imperative for providers, disclosure following patient safety incidents remains the exception. The appropriate response to a patient safety incident and the disclosure of medical errors are neither easy nor obvious. An inadequate response to patient harm or an inappropriate disclosure may frustrate practitioners, dent their professional

reputation, and alienate patients. Methods: The authors have presented a descriptive study on the comprehensive process for responding to patient safety incidents, including the disclosure of medical errors adopted at a large, urban tertiary care centre in the United States. Results: In the first two years post-implementation, the "seven pillars" process has led to more than 2,000 incident reports annually, prompted more than 100 investigations with root cause analysis, translated into close to 200 system improvements and served as the foundation of almost 106 disclosure conversations and 20 full disclosures of inappropriate or unreasonable care causing harm to patients. Conclusions: Adopting a policy of transparency represents a major shift in organisational focus and may take several years to implement. In our experience, the ability to rapidly learn from, respond to, and modify practices based on investigation to improve the safety and quality of patient care is grounded in transparency.

3. Kachalia A, Kaufman SR, Boothman R, Anderson S, Welch K, Saint S, Rogers MA. Liability claims and costs before and after implementation of a medical error disclosure program. Annals of Internal Medicine 2010 153(4): 213-221. http://annals.org/article.aspx?volume=153&page=213
Background: Since 2001, the University of Michigan Health System (UMHS) has fully disclosed and offered compensation to patients for medical errors. Objective: To compare liability claims and costs before and after implementation of the UMHS disclosure-with-offer program. Design: Retrospective before-after analysis from 1995 to 2007. Setting: Public academic medical center and health system. Patients: Inpatients and outpatients involved in claims made to UMHS. Measurements: Number of new claims for compensation, number of claims compensated, time to claim resolution, and claims-related costs. Results: After full implementation of a disclosure-with-offer program, the average monthly rate of new claims decreased from 7.03 to 4.52 per 100 000 patient encounters (rate ratio [RR], 0.64 [95% CI, 0.44 to 0.95]). The average monthly rate of lawsuits decreased from 2.13 to 0.75 per 100 000 patient encounters (RR, 0.35 [CI, 0.22 to 0.58]). Median time from claim reporting to resolution decreased from 1.36 to 0.95 years. Average monthly cost rates decreased for total liability (RR, 0.41 [CI, 0.26 to 0.66]), patient compensation (RR, 0.41 [CI, 0.26 to 0.67]), and non-compensation-related legal costs (RR, 0.39 [CI, 0
.22 to 0.67]). Limitations: The study design cannot establish causality. Malpractice claims generally declined in Michigan during the latter part of the study period. The findings might not apply to other health systems, given that UMHS has a closed staff model covered by a captive insurance company and often assumes legal responsibility. Conclusion: The UMHS implemented a program of full disclosure of medical errors with offers of compensation without increasing its total claims and liability costs. Primary Funding Source: Blue Cross Blue Shield of Michigan Foundation. 2010 American College of Physicians

4. Piper D, Manias E, Williams A, Tuckett A. Disclosing clinical adverse events to patients: can practice inform policy? Health expectations 2010; 13(2): 148-159. http://onlinelibrary.wiley.com/doi/10.1111/j.1369-7625.2009.00569.x/full
OBJECTIVES: To understand patients' and health professionals' experience of Open Disclosure and how practice can inform policy. BACKGROUND: Open Disclosure procedures are being implemented in health services worldwide yet empirical evidence on which to base models of patient-clinician communication and policy development is scant. DESIGN, SETTING AND PARTICIPANTS: A qualitative method was employed using semi-structured open-ended interviews with 154 respondents (20 nursing, 49 medical, 59 clinical/administrative managerial, 3 policy coordinators, 15 patients and 8 family members) in 21 hospitals and health services in four Australian states. RESULTS: Both patients and health professionals were positive about Open Disclosure, although each differed in their assessments of practice effectiveness. We found that five major elements influenced patients' and professionals' experience of openly disclosing adverse events namely: initiating the disclosure, apologizing for the adverse event, taking the patient's perspective, communicating the adverse event and being culturally aware. CONCLUSIONS: Evaluating the impact of Open Disclosure refines policy implementation because it provides an evidence base to inform policy. Health services can use specific properties relating to each of the five Open Disclosure elements identified in this study as training standards and to assess the progress of policy implementation. However, health services must surmount their sensitivity to revealing the extent of error so that research into patient experiences can inform practice and policy development.

5. Iedema R., Jorm C, Wakefield J, Ryan C, Sorensen R. A new structure of attention?: Open disclosure of adverse events to patients and their families. Journal of Language and Social Psychology 2009; 28(2): 139-157. http://jls.sagepub.com/content/28/2/139.abstract
This article presents an inquiry into how clinicians realize a health policy reform initiative called Open Disclosure. Open Disclosure mandates that discussions with patients/family and team staff about "adverse events" are now no longer ad hoc, individualized, and without consequences for how the work is done, but planned, collaborative, and leading to systems change. The article presents an empirical analysis of a corpus of interviews about the impact of Open Disclosure on clinicians' practices. It situates Open Disclosure in the context of arguments that health care workers are increasingly expected to do "emotional labor" with patients and their families, in that staff are advised to practice "reflexive listening" as a means of managing patients' and family members' emotions in response to incidents. The analysis suggests that thanks to the intensity of Open Disclosure interactions, clinicians may be introduced to an affective-interactive space that they were hitherto unaware of and unable to enter or attain what Nigel

Thrift calls "a new structure of attention." (PsycINFO Database Record (c) 2010 APA, all rights reserved) (journal abstract)

6. Peto RR, Tenerowicz LM, Benjamin EM, Morsi DS, Burger PK. One system's journey in creating a disclosure and apology program. Jt Comm J Qual Patient Saf 2009; 35(10):487-496. http://www.ingentaconnect.com/content/jcaho/jcjqs/2009/00000035/00000010/art00001
   BACKGROUND: Patients experience adverse events more frequently than the public appreciates. A number of health systems have led the movement toward open, prompt, and compassionate disclosure of adverse events. IMPLEMENTATION: In 2006 Baystate Health (BH) formed a disclosure advisory committee to design and implement an enhanced program to support prompt and skillful disclosure of adverse events. The proposed model for a disclosure and apology program resembled a consultation service, similar to a hospital ethics consultation service. BH hired an outside trainer to teach coaches/facilitators. Emotional support services were formalized and expanded not only for patients and families but also clinicians. THE EXPERIENCE SO FAR: Implementation of a formal disclosure and apology program has placed internal pressure on the organization to more promptly determine causality of adverse events and to respond to patient/family requests for information and/or assistance. Root causes and degree of system culpability are often not clear early after an event and sometimes are debated among the clinical team and the trained coaches/facilitators and risk managers. DISCUSSION: After a medical error, patients and families expect the organization to make changes to the system to prevent other patients from being harmed by the same mistake. To minimize the chance that patients and families feel that their suffering has been "in vain," health care systems will need to put systems in place to deliver on the promise to reduce the risk of future harm. Some of the challenges in sustaining such a program include the ability to promptly investigate, to accurately determine liability, to communicate empathetically even if unable to meet all patient/family expectations, and to ensure establishment of a just culture.

Ikke-verbal kommunikasjon om uønskede hendelser

1. Hannawa, AF. Shedding light on the dark side of doctor-patient interactions: Verbal and nonverbal messages physicians communicate during error disclosures. Patient Education and Counseling 2011; 84(3): 344-351. http://www.pec-journal.com/article/S0738-3991%2811%2900218-7/abstract
   Objective: Existing investigations on medical error disclosures have neglected the fact that a disproportionately large amount of the meaning in messages is derived from nonverbal cues. This study provides an empirical assessment of the verbal

and nonverbal messages physicians communicate when disclosing medical errors to standardized patients. Methods: Sixty hypothetical error disclosures by a volunteer sample of attending physicians were videotaped, coded, and statistically analyzed. Results: Physicians used friendly, smooth, approaching and invested nonverbal styles as they disclosed medical errors to standardized patients. Female physicians smiled more and were more attentive to patients than male physicians, and physicians tended to exhibit more positive affect in the form of facial pleasantness toward angry female patients than toward angry male patients. Furthermore, physicians touched and smiled at patients more frequently at the beginning and at the end of their error disclosures, and displayed decreased attentiveness and interactional fluency. Conclusion: Future research needs to examine which disclosure styles patients perceive as competent, and to assess their causal impacts on objective and relational disclosure outcomes. Practice implications: This study provides an important baseline understanding of medical error disclosures that is essential for the successful implementation of empirically based training programs. 2011 Elsevier Ireland Ltd

Utvikling av en modell for å kommunisere om uønskede hendelser

1. Hannawa AF. Negotiating medical virtues: toward the development of a physician mistake disclosure model." Health communication 2009; 24(5): 391-399. http://www.tandfonline.com/doi/abs/10.1080/10410230903023279
   Statistics show that nearly 98,000 patients die each year because of preventable medical mistakes. Despite legal obligations, a majority of physicians either fail to disclose a mistake or disclose it in an incompetent manner, causing detrimental outcomes. This article is the first to synthesize existing research on medical mistakes into an integrative physician mistake disclosure model. The proposed model theorizes that physicians conduct a cost-benefit analysis prior to deciding whether or not to disclose a medical mistake. In the event of disclosure, informational and relational disclosure competence is hypothesized to mediate the inherent detrimental effects of physician defensiveness on immediate and long-term outcomes. The article provides detailed directions for future research and discusses practical implications of the physician mistake disclosure model for physicians and health-care institutions. Most important, the model implies that a supportive organizational climate is needed to curb destructive physician defensiveness, optimize disclosure competence, and minimize detrimental outcomes. Physicians and health-care institutions are advised to collaborate in their attempts to enhance long-term error management and reduce the current number of fatal medical mistakes. The physician mistake disclosure model adds to our current understanding of medical mistake disclosure, and represents a heuristic research and training tool that has the potential to save lives.

Kommentar

Litteraturen er innhentet ved hjelp av et omfattende systematisk søk i flere relevante kilder, men søket er avgrenset til litteratur som omhandler kommunikasjon i etterkant av feil og uønskede hendelser. Kunnskap om verbal og ikke-verbal kommunikasjon generelt kan også være relevant for temaet, men det har vi gått glipp av i søket vårt. Studier som har undersøkt effekten av feilhåndtering- og rapportering generelt kan også inneholde elementer relatert til pasientkommunikasjon og kan ha falt utenfor søket.

For å finne litteratur som ikke er publisert i vitenskapelige tidsskrift, har vi gjort ekstra søk i Google og sett gjennom referanselister i relevante artikler. Likevel kan vi ha gått glipp av studier som kun er publisert på institusjoners hjemmesider eller i tidskrift som ikke er indeksert i de kildene vi har brukt.

Formålet med notatet har vært å gi en oversikt over forskningen, presentere hovedfunn fra systematiske oversikter og referere til relevante enkeltstudier. Notatet oppfyller derfor ikke kravene til en fullstendig systematisk oversikt. En person har valgt ut relevante referanser og oppsummert innholdet i de systematiske oversiktene. Ideelt sett burde dette gjøres av to personer på bakgrunn av en forhåndsbestemt protokoll. I oppsummeringen har vi plukket ut noen relevante funn men har ikke gjort en systematisk rapportering av innholdet.

Fordelen med å basere seg på systematiske oversikter slik vi har gjort her, er at andre allerede har gjort jobben med å søke, kvalitetsvurdere og oppsummere funnene fra enkeltstudiene. Ulempen kan være at vi er prisgitt oversiktenes søkestrategier, rapportering og konklusjoner. De systematiske oversiktene vi fant hadde manglende rapportering av søkestrategier og kvalitetsvurdering av enkelstudier. Dette trekker ned kvaliteten på oversiktene og vi vet ikke om de gir et dekkende bilde av forskningen.

Når det er snakk om hvilken effekt åpenhet og beklagelser kan ha, er det viktig å være klar over hva som måles, for eksempel pasientenes livskvalitet, deres tilfredshet, antallet klager, anmeldelser eller erstatningssaker. Dette fremgår ikke alltid like tydelig i de systematiske oversiktene.

I dette notatet har vi avgrenset oss til publisert internasjonal forskningslitteratur og overføringsverdien fra utenlandske studier kan være begrenset. For å finne ut av hva har mest nytte i Norge, vil det være viktig å trekke på erfaringer og evalueringer fra norsk eller nordisk helsetjeneste.

Vedlegg

Vedlegg 1 Søkestrategi

Ovid Embase 1980 to 2012 Week 04

Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations and Ovid MEDLINE(R) 1946 to Present

Ovid PsycINFO 1806 to January

1.2.2012

1. ((harmful adj2 event*) or (adverse adj2 event*) or error* or incident* or malpractice* or mistake* or failure*).tw.
2. Medical Errors/ use prmz or exp malpractice/ use prmz or exp Medication Errors/ use prmz
3. Errors/ use psyh
4. exp medical error/ use emez or malpractice/ use emez
5. or/1-4 [Uonskede hendelser]
6. exp Health Personnel/ use prmz or exp administrative personnel/ use prmz or exp foreign professional personnel/ use prmz
7. professional personnel/ use psyh or clinicians/ use psyh or exp health personnel/ use psyh or exp therapists/ use psyh
8. *health care personnel/ use emez or exp *hospital personnel/ use emez or exp *medical personnel/ use emez or exp *mental health care personnel/ use emez
9. (personnel or staff or employee*).tw.
10. (Doctor* or Nurse* or physician* or surgeon* or clinician* or trainee* or house officer* or health care professional* or resident*).tw.
11. or/6-10 [Helsepersonell]
12. ((systematic adj2 review*) or (evidence adj2 review*) or meta-analys*).mp,pt. or ((review.pt. or review/) and (electr* search* or database* search* or literature search* or systematic* search* or pubmed or medline or embase).tw.)
13. (study or studies or trial* or qualitative or focus group* or interview* or survey* or questionnaire* or cross-sectional or cohort or prospective anal* or retrospective anal* or follow-up anal* or pretest or posttest or longitudinel).mp,pt.
14. review.pt,ti,kw.
15. disclosure/ use prmz or truth disclosure/ use prmz
16. Forgiveness/
17. Incident report/
18. (disclosure or disclosing or disclose or apolog* or sorry or openness or being open or excuse*).tw.
19. exp Professional-Patient Relations/ use prmz or Professional-Family Relations/ use prmz or exp doctor patient relation/ use emez or exp nurse patient relationship/ use emez
20. "Attitude of Health Personnel"/ use prmz or exp health personnel attitudes/ use psyh or exp health personnel attitude/ use emez
21. communication/ use prmz or interpersonal communication/ use emez,psyh
22. patients/ use prmz or patient/ use emez or exp patients/ use psyh
23. 20 and 21 and 22
24. ((patient* or famil*) adj2 communication*).tw.

25. ((accept* or declar* or admit* or take or claim) adj2 responsib*).tw.
26. or/15-19,23-25
27. 5 and 11 and 26 and 12 [Systematiske oversikter]
28. remove duplicates from 27
29. *disclosure/ use prmz or *truth disclosure/ use prmz
30. (disclosure or disclosing or apolog* or sorry or openness or being open).tw.
31. 29 or 30
32. (5 and 11 and 13 and 31) not 27 [Primærstudier]
33. remove duplicates from 32
34. (((harmful adj2 event*) or (adverse adj2 event*) or error* or incident* or malpractice* or mistake* or failure*) and (disclosure or disclosing or apolog* or sorry or openness or being open)).ti.
35. 34 not (27 or 32)
36. remove duplicates from 35 [Supplerende tittelsøk]
37. (5 and 11 and 14 and 31) not (27 or 32 or 36) [Usystematiske oversiktsartikler]

Cochrane Library

Dato: 1.2.2012

#1 ((harmful near/2 event*) or (adverse near/2 event*) or error* or incident* or malpractice* or mistake*):ti,ab,kw
#2 MeSH descriptor Medical Errors explode all trees
#3 MeSH descriptor Malpractice, this term only
#4 (#1 OR #2 OR #3)
#5 MeSH descriptor Disclosure, this term only
#6 MeSH descriptor Truth Disclosure, this term only
#7 (disclosure or disclosing or apolog* or sorry or openness or "being open"):ti,ab,kw
#8 (accept* or declar* or admit* or take or claim*) near/2 responsib*
#9 (#5 OR #6 OR #7 OR #8)
#10 (#4 AND #9)

ISI Web of Knowledge

Dato: 1.2.2012

# 2 Topic=("harmful event*" or "adverse event*" or error*) AND Topic=((disclosure or disclosing or apolog* or sorry or openness or "being open") not "Financial Disclosure*") AND Topic=(review* or "meta-analysis")
Databases=SCI-EXPANDED, SSCI, A&HCI Timespan=All Years
Lemmatization=Off

# 1 Topic=("harmful event*" or "adverse event*" or error*) AND Topic=((disclosure or disclosing or apolog* or sorry or openness or "being open") not "Financial Disclosure*") AND Topic=(study or trial or survey* or questionnaire* or qualitative or "focus group")
Databases=SCI-EXPANDED, SSCI, A&HCI Timespan=All Years
Lemmatization=Off

SveMed
Dato: 1.2.2012

apolo$ or unnskyld$ or undskyld$ or ursäkt$ or beklagelse$

PubMed

Dato: 16.8.212

(adverse event* OR error*) AND (disclos* OR apolog*) AND (review OR study OR trial) AND publisher [sb]

Vedlegg 2 Sjekkliste for vurdering av systematiske oversikter

Sjekkliste for systematiske oversikter*		Ja	Uklart	Nei
1	**Beskriver forfatterne klart hvilke metoder de brukte for å finne primærstudiene?**			
Kommentar				
2	**Ble det utført et tilfredsstillende litteratursøk? (bruk hjelpespørsmål på neste side for å besvare dette spørsmålet)**			
Kommentar				
3	**Beskriver forfatterne hvilke kriterier som ble brukt for å bestemme hvilke studier som skulle inkluderes (studiedesign, deltakere, tiltak, ev. endepunkter)?**			
Kommentar				
4	**Ble det sikret mot systematiske skjevheter (bias) ved seleksjon av studier (eksplisitte seleksjonskriterier brukt, vurdering gjort av flere personer uavhengig av hverandre)?**			
Kommentar				
5	**Er det klart beskrevet et sett av kriterier for å vurdere intern validitet?**			
Kommentar				
6	**Er validiteten til studiene vurdert (enten ved inklusjon av primærstudier eller i analysen av primærstudier) ved bruk av relevante kriterier?**			
Kommentar				
7	**Er metodene som ble brukt da resultatene ble sammenfattet, klart beskrevet?**			
Kommentar				
8	**Ble resultatene fra studiene sammenfattet på forsvarlig måte?**			
Kommentar				
9	**Er forfatternes konklusjoner støttet av data og/eller analysen som er rapportert i oversikten?**			
Kommentar				
10	**Hvordan vil du rangere den vitenskapelige kvaliteten i denne oversikten?**			
Kommentar				

**Basert på EPOC Checklist for Refereeing Protocols for Reviews. EPOC, Effective Practice and Organisation of Care group, Guide for review authors. www.epoc.cochrane.org*