Letter to the Editor

Open disclosure: appropriate timing is crucial

Open, honest and timely disclosure should be the only approach to medical errors and does not appear to lead to an increased risk of lawsuit [1, 2]. Health practitioners in Australia are embracing the practice of open disclosure [3]. One guideline is that the initial disclosure discussion with the patient and their support person should occur as soon as possible after recognition of the adverse events [4]. Factors to consider when timing the disclosure include clinical condition, availability of key and support staff and patient’s support person, patient preference, privacy and comfort of the patient and emotional and psychological state of the patient [4]. We would like to highlight a previously unreported factor crucial to timing of the open disclosure.

Two incidents of non-life-threatening medication errors happened in our department. Once the errors were discovered, the senior physician and nurse practised open disclosure to the parents. Both errors entailed the need for monitoring of renal and sensory functions.

At the time of errors, one baby was 2 weeks from discharge, whereas the other baby was 2 days from being discharged. In both situations, the parents ended up being very distraught. In the first instance, the mother of the baby visited the baby and, in a ward full of other parents, openly criticized the clinicians and asked ‘how can I leave my baby here when I have lost my trust in the care given?’ In the second case, the day after open disclosure happened, six sets of parents arrived extremely distraught in the Neonatal Intensive Care Unit. Unlike the first instance where the mother was living at home, the parents of this second baby was staying in a hospital accommodation for parents of other sick babies. It transpired that after the open disclosure, these parents met up with the other parents in the hospital house and informed the other parents of the medication errors and advised them to be vigilant with the staff in the department. The attending specialist spent 3 h talking to all the parents. Many staff members were upset as they felt they were under scrutiny by the other parents during the rest of the baby’s stay. We are interested to know whether other health practitioners have had experiences similar to ours where open disclosure had adverse impacts on other patients and staff.

The above incidents highlight the ethical dilemma between being honest and still maintaining trust; this is especially so in an intensive care situation when the patient/parents will not have the possibility to change providers after an error has been disclosed. There are at least three management options, none of which is ideal, for the above situations. One is, for non-life-threatening errors, to practise open disclosure soon after discharge of the baby from the department. However, delaying the open disclosure has the inherent risks of the parents discovering the error from other sources (such an approach can be risky in a department with high staff turnover everyday) and there is also the need to inform parents of abnormal tests such as hearing screening. A second approach is to make a special request to the parents involved not to tell other parents; however, this would undermine the integrity of the open disclosure process. A last approach is to open disclose to the parents and discuss with them the option of open disclosing to all other parents of babies in the same area: this last option maintains the robustness of open disclosure, but informing other parents could be harmful. We would be interested in any other suggestions. There is therefore an obvious need for research on the timing of open disclosure and the possibility of harm to other patients/parents and staff members.

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References


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