

How to Disclose



Michael A. Gentile, DPM, FACFAS

If a medical error or adverse event occurs during foot and ankle surgery, how it is disclosed can make all the difference in reaching a resolution that allows both the doctor and patient to move forward.

For Michael A. Gentile, DPM, FACFAS, copresenter of the ACFAS 75 HUB session *How Much Disclosure Is Necessary for Closure?* with Meagan M. Jennings, DPM, FACFAS, disclosure first starts with informed consent. “This ensures that the patient has a reasonable understanding of the risks, benefits and goals of surgery,” he explains.

Disclosure also depends on where an error or adverse event took place. For example, if an error or adverse event happens to occur in the OR, Dr. Gentile lists it under the complications section of the operative report and describes what was done about it. He discloses the error or adverse event in the progress note as well for the first postoperative visit. “I let

the patient know what happened, why it happened, what we did or will do about it and the implications associated with both the problem and the solution,” he says.

When speaking with the patient, clear and compassionate communication is key. “Show sympathy and empathy, use terms the patient understands and state just the facts with no speculation,” Dr. Gentile advises. He also recommends working closely with a professional liability carrier when reporting and documenting any error or adverse event that could result in a claim or legal action taken on the patient’s behalf.

Yet even with these measures, the strongest foot and ankle surgeon may still struggle with disclosure. Fears of being sued, looking incompetent or losing credibility among peers, patients and other surgeons can loom heavy. The psychological and emotional impact of an error or adverse event can

also have a lasting effect on how the surgeon practices in the future. “A surgeon’s approach to patients and delivery of care may change,” notes Dr. Gentile. “S/he may be hesitant to enter into a scenario where the error or event could recur, and his or her surgical skills might suffer.”

He says the best way to move forward from an error or adverse event is to critically analyze why it happened and to determine if it was avoidable or unavoidable. Analysis of an avoidable error or event can help the surgeon employ safeguards to prevent a repeat. However, analysis of an unavoidable event requires one to accept that, in Dr. Gentile’s words, surgery is an art performed by humans. “We are imperfect,” he closes. “We do the best we can.”

For more information on medical disclosure, visit communicationandresolution.org.

“This ensures that the patient has a reasonable understanding of the risks, benefits and goals of surgery.” — Michael A. Gentile, DPM, FACFAS

3 TIPS FOR HANDLING DISCLOSURE

1. Be forthright in disclosing adverse event or error.
2. Communicate clearly.
3. Approach the situation with sympathy and empathy.

Learn how the University of Michigan's *Michigan Model* and Stanford's *Process for Early Assessment, Resolution and Learning (PEARL)* can help you better address medical errors and adverse events:

Michigan Model
uofmhealth.org

PEARL
theriskauthority.com/solutions/pearl



Make sure you understand why the adverse event or error happened. Ask yourself, “Was it avoidable, and if so, how?”

Seek guidance from your malpractice carrier if an error or adverse event occurs.

“I let the patient know what happened, why it happened, what we did or will do about it and the implications associated with both the problem and the solution.” — Michael A. Gentile, DPM, FACFAS