Page to Practice - Lecture

Trauma Informed Strategies to Support Patients and Families During and After Severe Maternal Morbidity

Advancing ob-gyn care for all.

Monday

April 20, 2026

11 am – 12:15 pm ET

Before We Get Started

This webinar will be recorded

If you need help during the call, please private chat an ACOG staff member

Submit your questions throughout this session using the Q&A box

Any questions following this webinar can be sent to obgynsafety@acog.org

ACOG FOUNDATION

Who are we?

Quality in Action

AN ACOG FOUNDATION PATIENT SAFETY ORGANIZATION

A Partner in Quality and Patient Safety

Combining ACOG's trusted expertise with real-world services to help hospitals and health systems deliver safer, more equitable care.

- Safety event review
- Plan to support review of patient safety work
- Tailored support for frontline teams
- Designed for measurable impact

Let's improve ob-gyn care–together.

What is “Page to Practice”?

A deep dive into clinical topics held in **a 2-session format**:

Conversation

A casual, virtual conversation between an ACOG host and guidance document or article’s author(s) to introduce the topic and context.

Lecture

A teaching-style CME offering on the same or closely related topic to the previous offering, providing actionable take aways by national experts.

Journal Club (CE)

A Perinatal Psychiatry Access Program to Address Rural and Medically Underserved Populations Using Telemedicine

April 28th, 2026
11:00am-12:00pm ET

A Mother's Day Conversation on Black Maternal Health Equity

May 11th, 2026
11:30am – 1:00pm ET

Join us!!!

From Trial to Practice: The Current Impact of the ARRIVE Trial

June 17th, 2026
1:00-1:45pm ET

The ARRIVE Trial: Evidence, Outcomes, and Counseling for the 39-Week Conversation

June 24th, 2026
1:00-2:15pm ET

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Page to Practice

Continuing Medical Education

We are excited to offer **CME credit** to attendees of this live session

To receive your certificate:

1. **Complete the evaluation following this activity**

2. You need to create an ACOG account to complete the survey

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The American College of Obstetricians and Gynecologists is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

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Today's Speakers

Tracey Vogel, MD

Leslie Carranza, MD, MHS, FACOG

ACOG FOUNDATION

Trauma-informed Strategies to Support Patients and Families During and After Severe Maternal Morbidity

Dr. Tracey Vogel

Disclaimers and Disclosures

- This activity has not received any commercial support.
- I have disclosed the following financial relationships. Any real or apparent conflicts of interest related to conflict of this presentation have been reviewed.
  - NOMA.AI -- Consultant
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The faculty, committee members, and staff who are in position to control the content of this activity are required to disclose to ACOG and to learners any financial relationship(s) of the individual that have occurred within the last 24 months with any ineligible entities whose products are related to the continuing education content. Financial relationships are defined by remuneration in any amount from the ineligible entities in the form of grants; research support; consulting fees; salary; ownership interest (e.g., stocks, stock options, or ownership interest excluding diversified mutual funds); honoraria or other payments for participation in speakers' bureaus, advisory boards, or boards of directors; or other financial benefits. The intent of this disclosure is not to prevent planners with relevant financial relationships from planning or delivering content, but rather to provide learners with information that allows them to make their own judgments of whether these financial relationships may have influenced the educational activity with regard to exposition or conclusion. ACOG has reviewed all disclosures and resolved or managed all identified conflicts of interest, as applicable.

Objectives:

- Recognize the emotional, psychological, and physical effects of SMM on patients and families
- Learn strategies to reduce immediate distress and foster resilience during and after the SMM
- Explore effective ways to communicate with patients and families to build trust and support recovery
- Understand the importance of coordinated support among patients and families in healing processes

Case Vignette

- G2 P1001 at 39 weeks, attempting a TOLAC
- Urgent cesarean delivery for FHR issues and arrest of descent
- Cesarean delivery: adequate epidural anesthesia/significant uterine extension with hemorrhage/PRBCx1 unit in the OR/hemostasis achieved prior to closing
- Patient reported severe pain in the PACU over the next 1-2 hours-fundal checks challenging due to pain and patient refusal
- Changes in mental status prompted a rapid response/STAT exploratory laparotomy / hysterectomy for refractory uterine atony
- Patient to step down ICU for monitoring/refusing to speak with her providers

Kilpatrick, Sarah K., Jeffrey L. Ecker, and American College of Obstetricians and Gynecologists. "Severe maternal morbidity: screening and review." *American journal of obstetrics and gynecology* 215.3 (2016): B17-B22.

Defining Severe Maternal Morbidity

- Unintended outcomes of the process of labor and delivery that result in significant short-term or long-term consequences to a woman's health
- The Joint Commission defines a sentinel event as "a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following: death, permanent harm, or temporary harm."
- Defined currently in only physical categories:
  - Hemorrhage
  - Neurologic/HTN
  - Cardiovascular/Pulmonary
  - ICU Admission/Invasive monitoring
  - Renal
  - Sepsis
  - Surgical/bladder/bowel complications
  - Anesthesia complications

Defining Severe Maternal Morbidity

Preventable Harm :"The definition of preventable harm caused by health care has expanded over recent years to include physical, **psychological, emotional,** moral, economic, and societal harm to patients and the workforce..." [1]

Adverse event: "An incident that results in harm to a patient that may be physical, social, or **psychological"** [1]

1 Together, Safer. "A National Action Plan to Advance Patient Safety." *Institute for Healthcare Improvement. URL:'https://f. hubspotusercontent30. net/hubfs/241684/N ational% 20Action% 20Plan* 20 (2020).

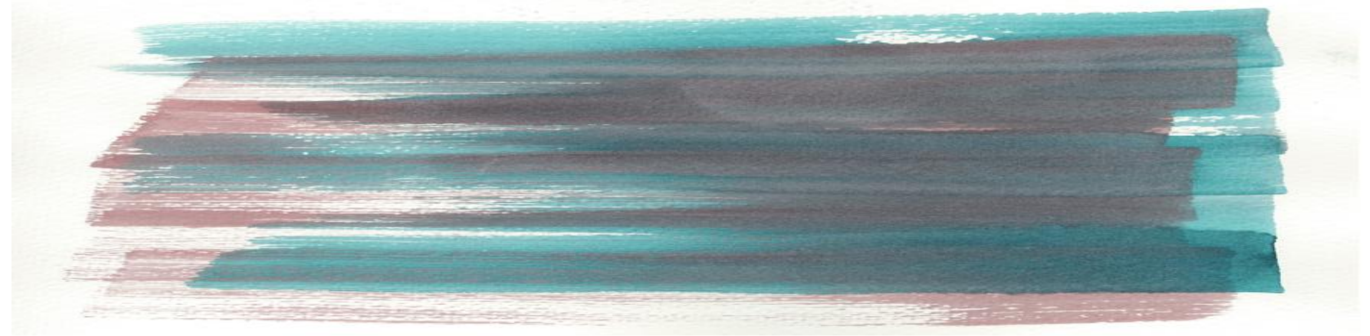
Events that meet criteria for severe maternal morbidity are often traumatic events...

However, not all complications result in psychological trauma, and psychological trauma can occur without physical complications

"Psychological trauma is an affliction of the powerless. At the moment of trauma, the victim is rendered helpless by overwhelming force. When the force is that of nature, we speak of disasters. When the force is that of other human beings, we speak of atrocities. ***Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning….*** *Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life…. They confront human beings with the extremities of helplessness and terror and evoke the responses of catastrophe."*

- Judith Lewis Herman, *Trauma and Recovery The Aftermath of Violence - From Domestic Abuse to Political Terror*

DSM V Definition



The person was exposed to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):

- Direct exposure
- Witnessing the trauma
- Learning that a relative or close friend was exposed to a trauma
- Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

Individual Trauma as the "3 E's"

"Individual trauma results from an ***event,*** *series of events, or set of circumstances that is* ***experienced*** *by an individual as physically or emotionally harmful or life threatening and that has lasting adverse* ***effects*** *on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."*

Substance Abuse and Mental Health Services Administration (SAMHSA)

What is Trauma-informed Care?

What does Trauma Informed Care look like?

- A shift in practice paradigms from "what I am going to do *to you*" to "what can we do *together*" to achieve mutual goals based on each person's individual cultural context
- A shift from thinking "what's wrong with you" to "what happened to you?"
- A shift from thinking about individuals as "problematic" to "symptomatic"
- An unbiased, non-judgmental approach that acknowledges an individual's cultural context

Attitude Shifts

From:

Stigmatization to **normalization**

Disempowerment to **empowerment**

Victimization to **resilience**

Questioning to **believing and validating**

Biases and assumptions to **confronting biases and empathizing**

Ades, et al. Obstet Gynecol 2019;133:803-9

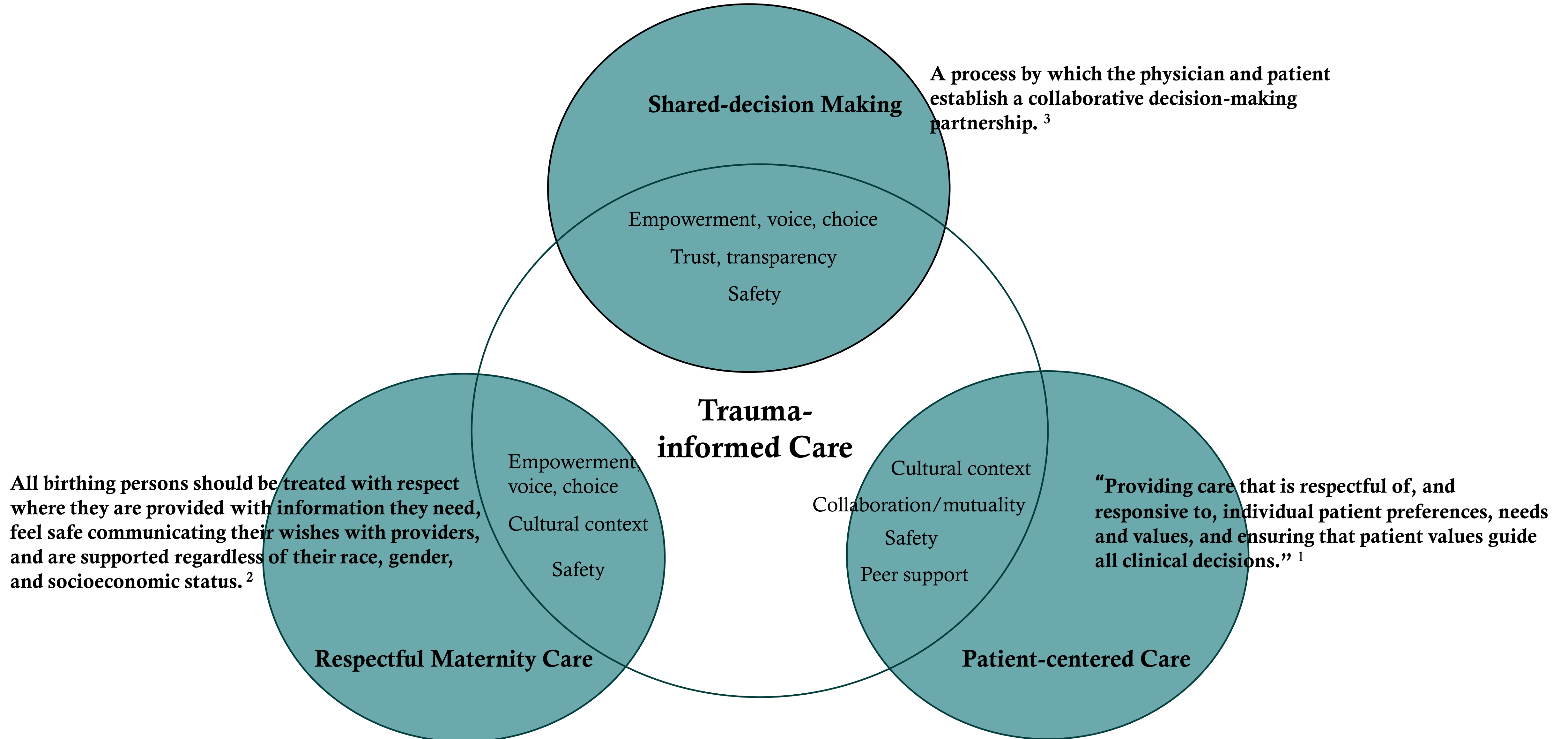
- **Realizes** the widespread impact of trauma and understands potential paths for recovery
- **Recognizes** the signs and symptoms of trauma in patients, families, staff, and others involved with the system
- **Responds** fully integrating knowledge about trauma into policies, procedures, and practices
- Actively seeks to **resist re-traumatization**

Substance Abuse and Mental Health Services Administration

Trauma-informed Care Principles

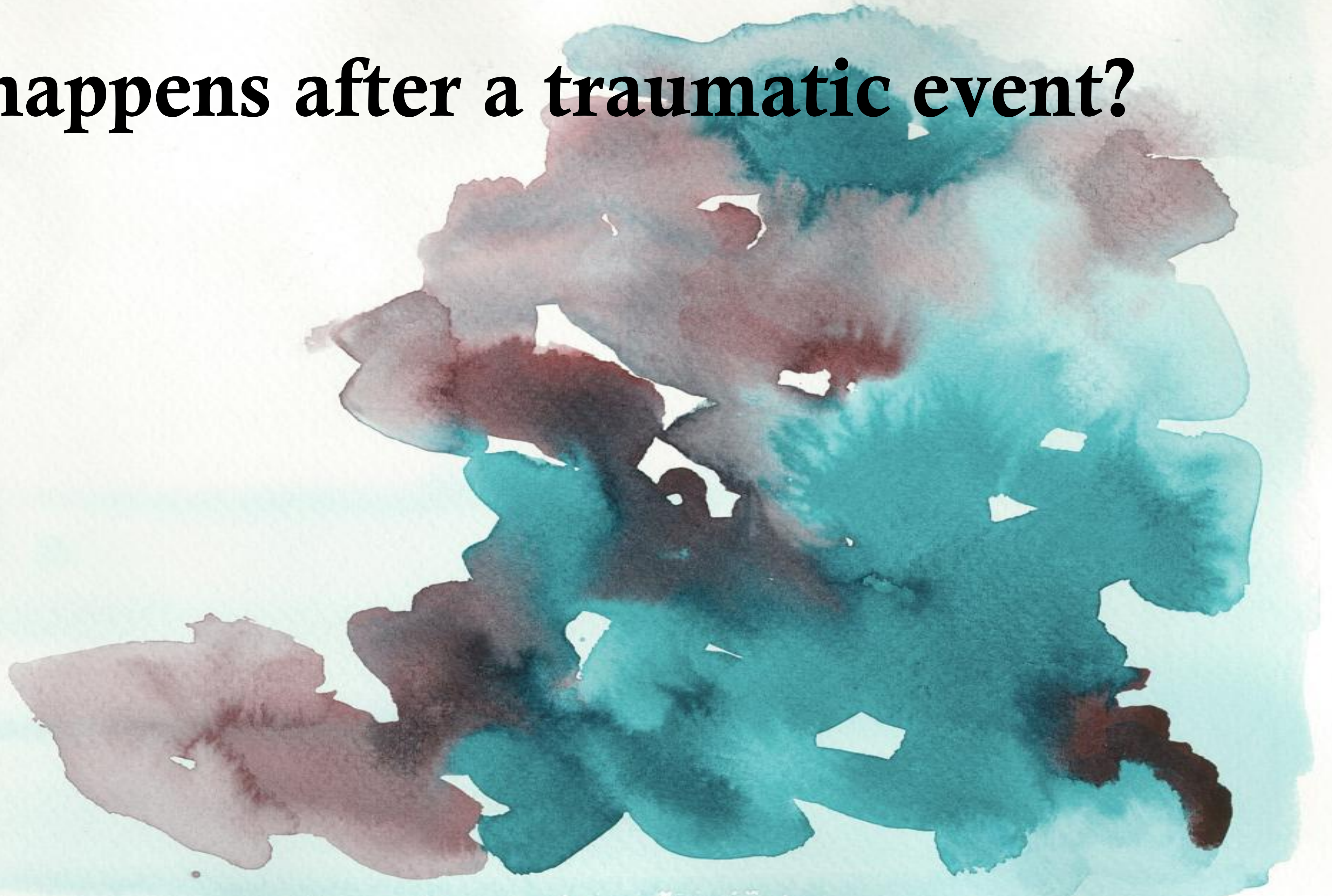
https://www.cdc.gov/cpr/infographics/6principlestraumainfo.htm

Trauma-informed Care as a Universal Precaution



1 Tzelepis F, et al. Measuring the quality of patient-centered care: why patient-reported measures are critical to reliable assessment. Patient Prefer Adherence. 2015 Jun 24;9:831-5
2 Shakibazadeh E, et al. Respectful care during childbirth in health facilities globally: a qualitative evidence synthesis. *BJOG* 2018; 125: 932–942.
3 Barry MJ, Edgman-Levitan S: Shared decision making -the pinnacle of patient-centered care. N Engl J Med 2012; 366: pp. 780-781

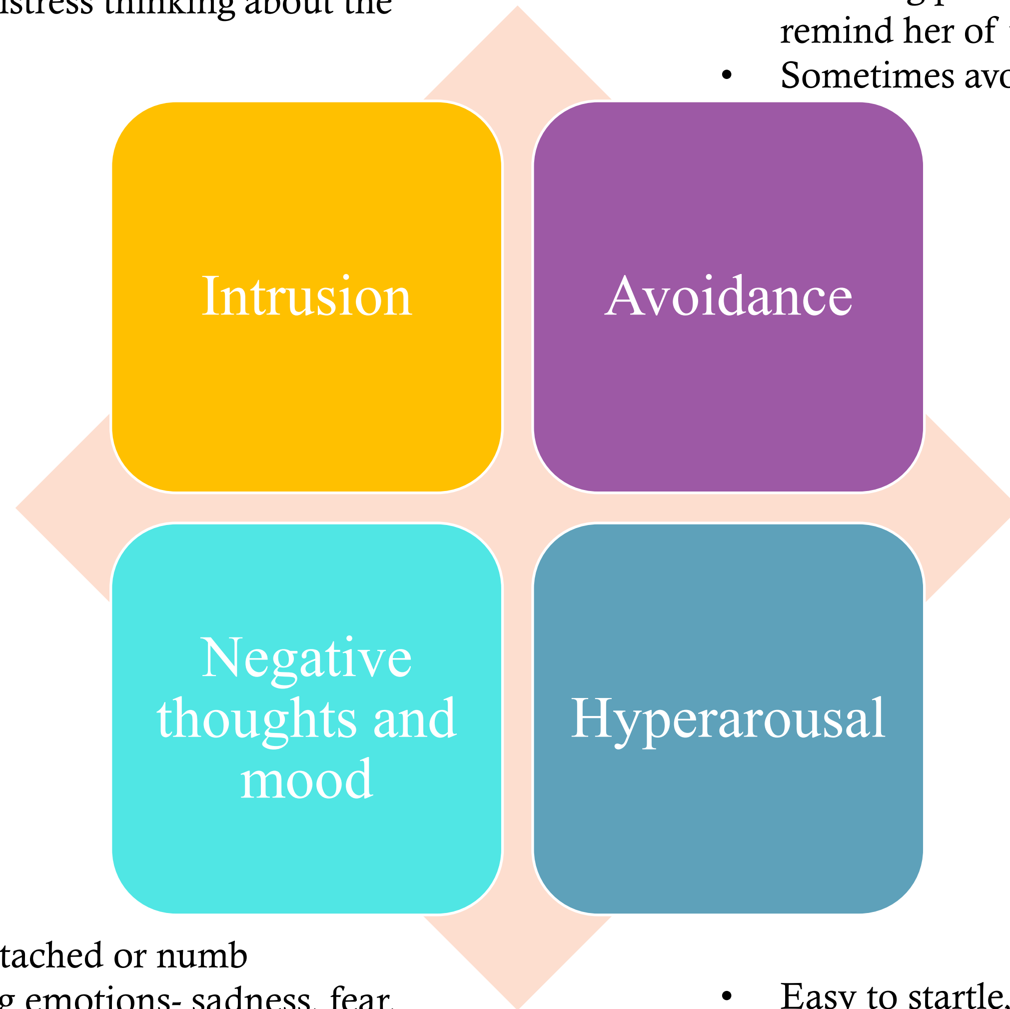
What happens after a traumatic event?



Stress Responses: Acute

- Recurring thoughts
- Nightmares/flashbacks
- Physical distress thinking about the trauma

- Avoiding memories, talking about the birth
- Avoiding places and people that remind her of the birth
- Sometimes avoiding the baby



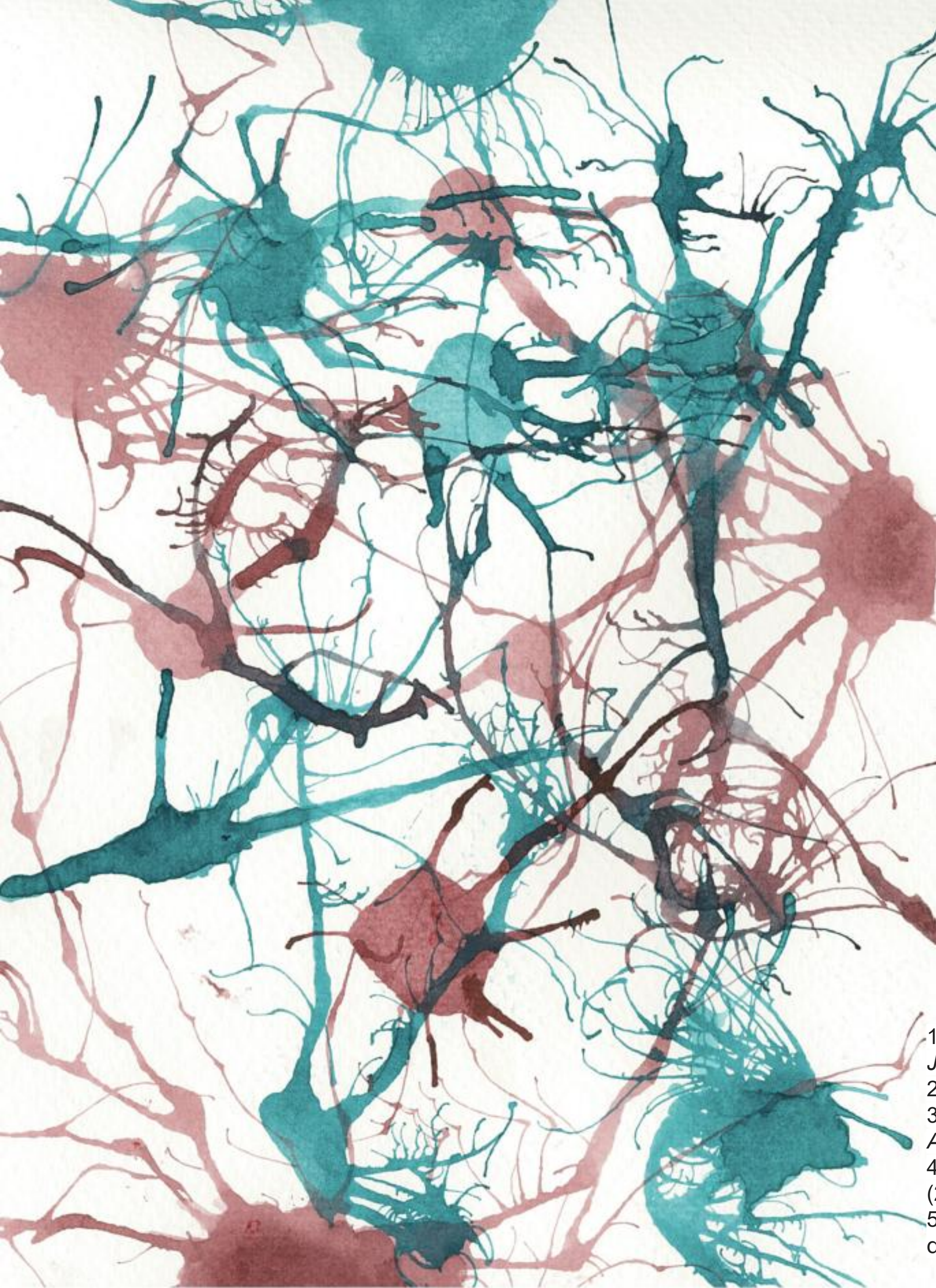
- Feeling detached or numb
- Conflicting emotions- sadness, fear, guilt, terror, anger, embarrassment, confusion and joy, elation at the same time
- Difficulty experiencing joy

- Easy to startle, “jumpy” ,shaking
- Increased heart rate
- Difficulty sleeping or concentrating

Physical Consequences of Traumatic Birth Experiences

- Severe acute and chronic pain
- Surgical complications
- Debility
- Profound fatigue, dizziness, and reduced exercise tolerance can interfere with a mother's ability to care for her newborn and establish routines in the early postpartum period.
- Ongoing transfusion, surgical intervention, or admission to the ICU for hemodynamic monitoring necessitating separation from the newborn
- Peripartum hysterectomy
  - Severe morbidity from other physical complications such as wound sepsis, urinary tract injuries, fistula formation and pelvic pain
  - Sudden and irreversible loss of fertility

1. Liu, Chen-ning, et al. "Prevalence and risk factors of severe postpartum hemorrhage: a retrospective cohort study." BMC pregnancy and childbirth 21.1 (2021): 332.
2. Jayawardane, I. A., et al. "Long-term morbidity of peripartum hysterectomy: A systematic review." International Journal of Gynecology & Obstetrics 170.3 (2025): 988-1000.
3.Vogel, T. M., and S. Homitsky. "Antepartum and intrapartum risk factors and the impact of PTSD on mother and child." BJA education 20.3 (2020): 89-95.



Psychological Consequences

- Loss of trust- dismissal/not believed/feelings of betrayal and abandonment
- Loss of meaning- Disbelief that this could happen to them
- Guilt that they didn't advocate more for themselves
- Anger/rage- some need closure and reassurance that providers didn't do this intentionally to cause harm
- Feelings of failure as a mother when they don't feel they want to (or can) engage with their baby/families due to psychological disruption
- Overwhelming sadness that their significant other had to witness the event and feel powerless to intervene (for the partner-loss of control and ability to protect)
- Mental health complications-acute, chronic

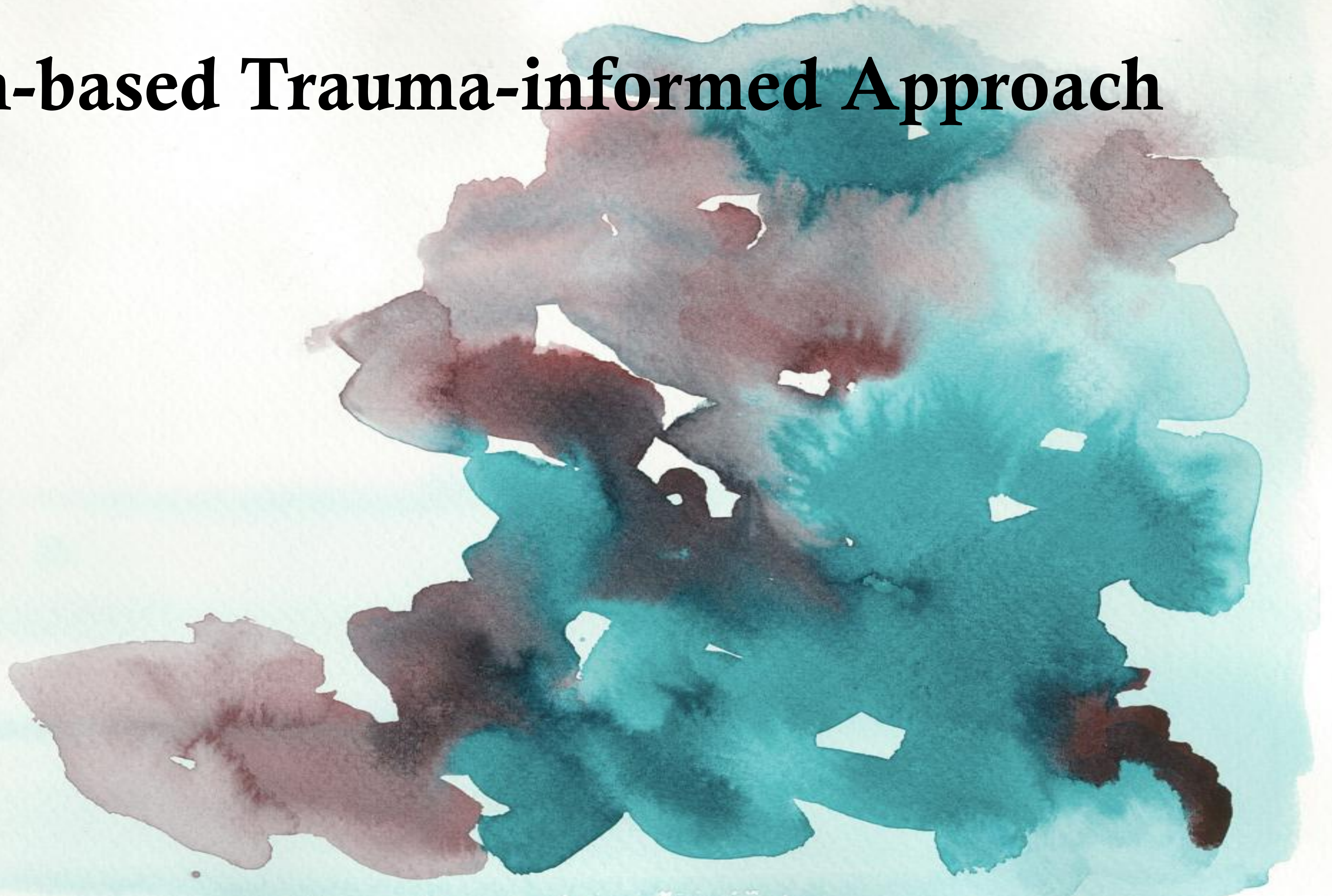
1.Somerstein, Rachel. "I feel pain, not pressure: a personal and methodological reflection on pain during cesareandelivery." *American Journal of Obstetrics and Gynecology* (2025)
2. Davis, Anna E. "Anesthesiologists and the Greatest Moment." *Anesthesiology* (2026).
3. Callihan, P., et al. "Intraoperative pain during cesarean delivery: a qualitative concept elicitation study." *International Journalof Obstetric Anesthesia* 64 (2025): 104748.
4.Stanford, Susanna ER, and David G. Bogod. "Failure of communication: a patient's story." *International Journal of ObstetricAnesthesia* 28 (2016): 70-75.
5. Furuta, Marie, Jane Sandall, and Debra Bick. "Women's perceptions and experiences of severe maternal morbidity–A synthesis of qualitative studies using a meta-ethnographic approach." *Midwifery* 30.2 (2014): 158-169.

Long-term Consequences of Traumatic Birth Experiences (traumatization AND re-traumatization)

- Dissociation with no memory of the childbirth experience
- Hyper-arousal with agitation/ anger with caregivers/hostility
- Psychological harm impairing the maternal-fetal, and maternal-neonatal bond
- Increased risk for maternal mental health complications (new onset and exacerbation of prior mental health conditions)
- Negative alterations in pain perception
- Lifelong negative association during the anniversary of the trauma
- Negative impact on future reproduction
- Avoidance of the operating room/avoidance of healthcare

Vogel T, et al. *Br J Anaesth* 2020
Vogel T. *Curr Anesthesiol Rep* 2021)
Beck CT. *J Perinat Educ*. 2017
Lopez, U. *Health Qual Life Outcomes*. 2017

A Team-based Trauma-informed Approach



Communication Strategies

- **LIVES Mnemonic**
  - L= listen without judgement
  - I= inquire
  - V= validate
  - E= enhance safety
  - S= support/follow-up

Tarzia, et al. BMJ Open 2020
https://iris.who.int/server/api/core/bitstreams/3e906b26-c609-4a2f-9cf6-c1c42f186809/content Last accessed 03/31/26

Active/reflective Listening

- Do not interrupt
- Take notes
- Sit at eye level or lower
- Keep arms uncrossed
- Minimize distractions
- Maintain eye contact
- Do not block the door (ask if the patient is ok with the door closed)
- Approach the individual from the front
- Ask for permission to make physical contact (handshake)

Inquire

- Gently ask the patient for details necessary to develop a plan
- Allow for time and space for them to tell their story
- Avoid appearing shocked or disgusted at their story
- Sample language "do you feel comfortable sharing some details…with me? This would give me a better idea of how we can help."
- Use grounding techniques as needed to de-escalate and respond to acute stress responses
- Respond to the individual's narrative with empowering language

Language choice

- Stigmatizing Language
  - Undermining credibility
    - “Patient states 10/10 pain but chatting on the phone the whole time”
    - Using discrediting verbs/adverbs
      - *Claims*
      - *Insists*
      - *Reportedly*
  - Stereotyping
    - She arrived with an “extensive birth plan”
    - The patient is "difficult"
  - Showing disapproval
    - “you’re not going to be one of ‘those patients’, are you?”
  - Placing Blame
    - “You shouldn't have been walking alone…”

Goddu A, et al. J Gen Intern Med 2018
Beach, MC, et al. J Gen Intern Med 2021

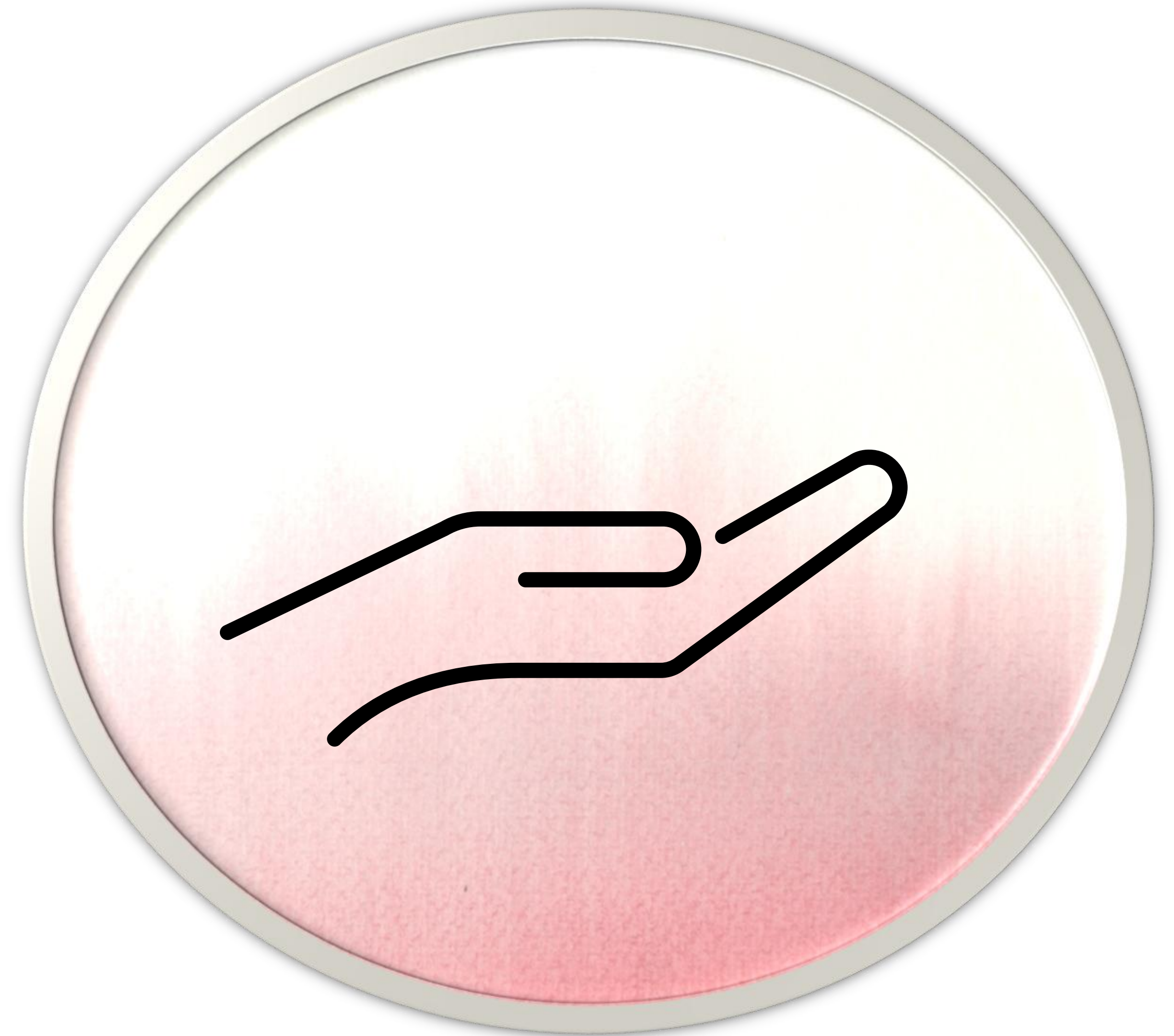
Empowering Language

- "You are strong; you survived"
- "It is normal to feel stressed about this "
- "I'm so glad you are sharing this with me."
- "I believe you. It took a lot of courage to tell me about this."
- "It's not your fault."
- "You survived something very difficult that was not your fault "
- "This has had an impact on your life."
- "I am so sorry that happened."
- "You are not alone."

Ades, et al. Obstet Gynecol 2019;133:803-9

Validation

- Acknowledging someone else's emotional experience
- Do not justify, rationalize medical interventions
- Use language like: "that sounds incredibly scary/frustrating/painful" or "I am so sorry/saddened to hear that happened to you"
- Do not try to "silver-lining" things
- Avoid trying to minimize the experience or triaging their emotional perspective



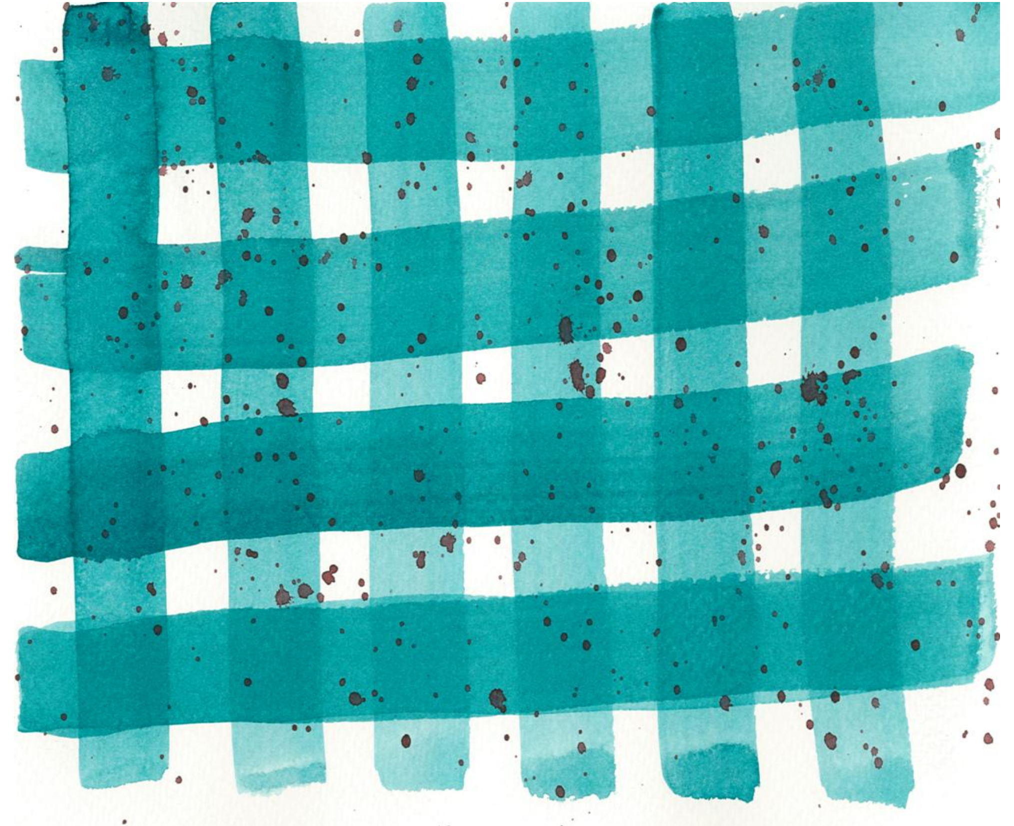
Bauer ME, Summers K, Cassidy AG, Chavez A, Nath R, Carr A, Panelli DM, Walczak C, Tabios M, Main EK. A Framework for Supporting Patients and Families After a Severe Maternal Event. Obstet Gynecol. 2026 Apr 2:10.1097/AOG.0000000000006279. doi: 10.1097/AOG.0000000000006279. Epub ahead of print. PMID: 41926773; PMCID: PMC13048283.

TRUSTWORTHINESS & TRANSPARENCY

5. EMPOWERMENT VOICE & CHOICE

Ensure Safety

- Ensuring privacy and confidentiality
- Physical Safety
  - Asking for consent at all steps of care
  - Expose only one body part at a time with attention to body integrity
  - Minimize triggers
  - Adress physical complications
  - Address acute stress needs
    - Warmth/thirst/hunger/pain
    - Minimize noise/personnel/overwhelming the individual
- Psychological Safety
  - Grounding skills
  - Coping tools
  - Need for support person
  - Communication style/needs



Support Follow-up

- Collaboration with advocacy services, mental health providers
- Offering choices as much as possible for best treatment and recovery options
- Make the referral and connection to services EASY for patients
- Utilize strength-based approaches, help promote internal coping skills, and help individuals identify external social supports

Restoring Trust

The Patient Safety Lens on Trauma-Informed Care and Communication After Adverse Events

Leslie Carranza MD, MHS, FACOG

Disclaimers and Disclosures

- I have no disclosures.

Disclosure Policy

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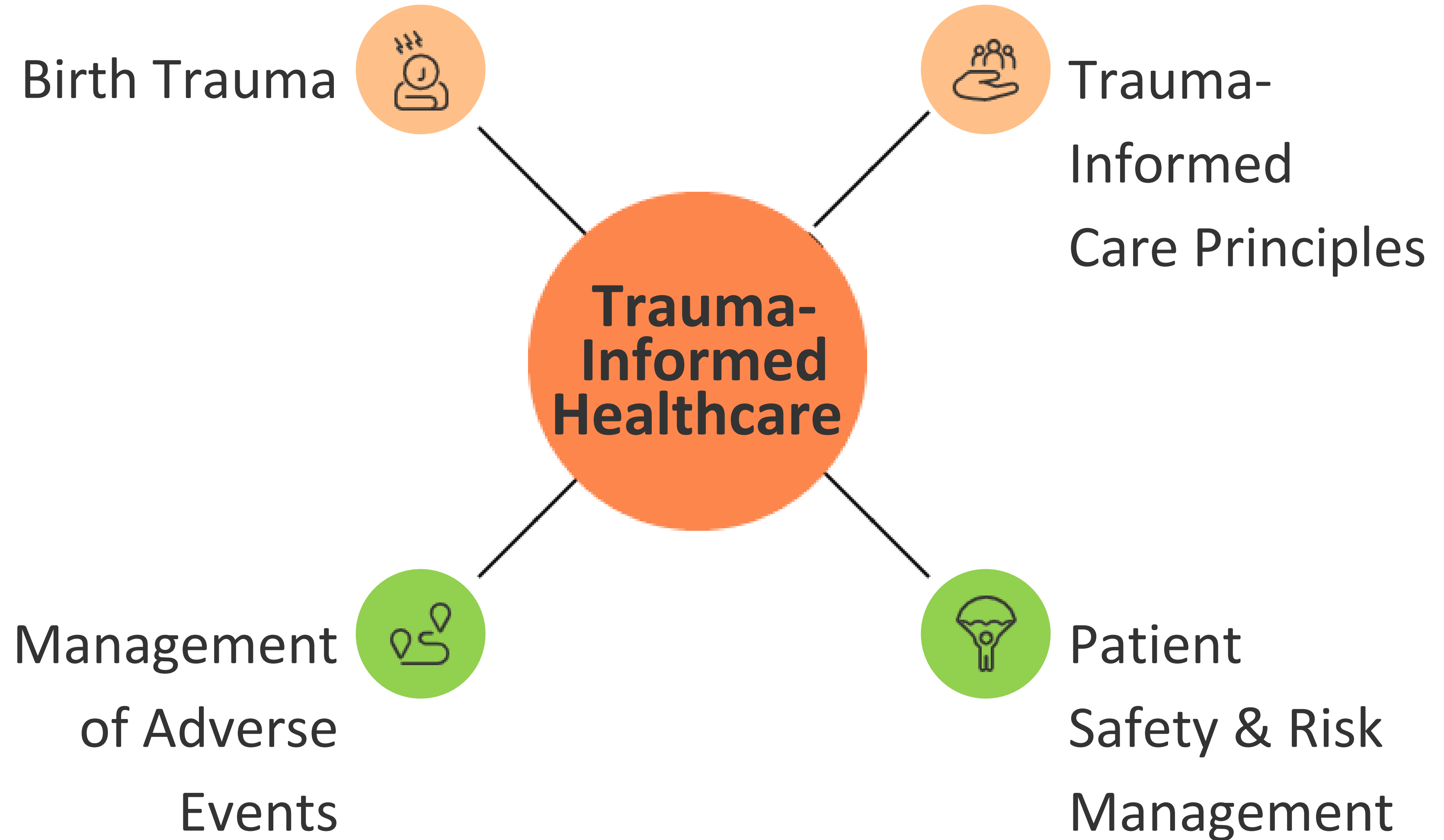
Integrating Trauma-Informed Care and Patient Safety



The convergence of trauma-informed care and patient safety is essential for a truly healing healthcare experience.

Important Definitions

Adverse Event

An injury or complication caused by medical management, not the patient's underlying disease. Can be **preventable or unpreventable**. Examples include reaction from unknown allergy to an antibiotic.

Sentinel Event

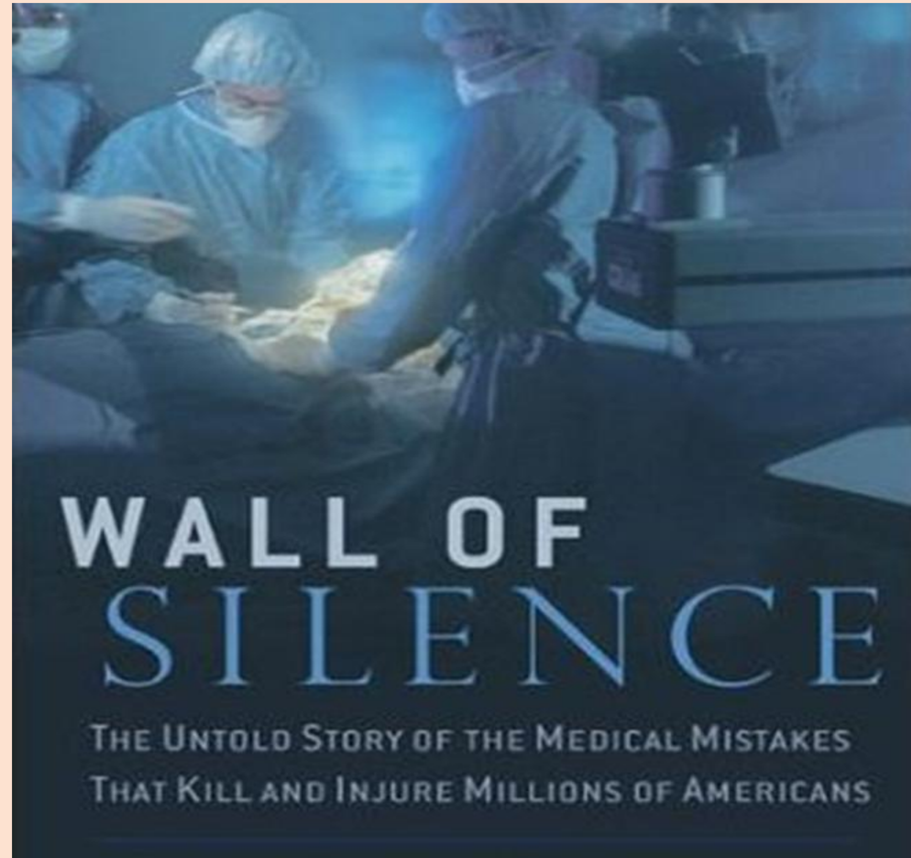
A severe, unexpected adverse event that always results **in severe harm** and requires **formal investigation**. Indicates a system breakdown. Examples include patient harm from administration of antibiotics with known severe allergy.

Following Harm:
Not Always Transparent, Not Always Learning

Health Affairs

February 2012

Survey Shows That At Least Some Physicians Are Not Always Open Or Honest With Patients



Gibson , Rosemary & J. P. Singh, Wall of Silence, 2003.

Lisa I Iezzoni , Sowmya R Rao, Catherine M DesRoches, Christine Vogeli, Eric G Campbell; CANDOR

PATIENT HARM IS FREQUENT AND UPSETTING

MAYO CLINIC

1

COMMON

Nearly 40% of patients think there has been a harmful breakdown in their care

2

PHYSICAL AND EMOTIONAL

Mixture of communication breakdowns and traditional adverse events

3

UNSPOKEN

Few share their concerns with the healthcare team or organization.

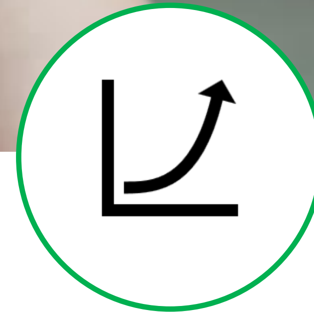
Bates, D. W., et al (2023). The safety of inpatient health care. *The New England Journal of Medicine*, *388*(2), 142–153.

DEEP AND LONG LASTING

The emotional impact of harm events on patients and families is **significant and long lasting**

DISCONNECT

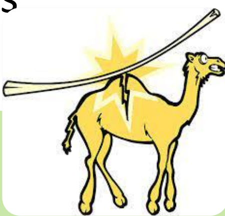
Patients and providers rate the level of harm due to a care breakdowns significantly **differently**



ACCUMULATION

Series of **minor care breakdowns** can combine to cause a major loss of confidence among patients and families

PATIENT HARM IS LONG LASTING



What do Patients and Families Want

Clear, honest explanation addressing patient’s questions

Accountability (do not make excuses)

Apology & Human Approach

How will we fix the identified problems

Involved in the solution development process

Witman AB, et al. How do patients want physicians to handle mistakes? A survey of internal medicine patients in an academic setting. Arch Intern Med 1996;156:2565–2569.
Gallagher TH, et al. Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors. JAMA. 2003;289(8):1001–1007.

Clinician and Staff Support After Adverse Events

Research indicates there is a need for more institutional support and structural changes to address the challenges clinicians and staff face

Inadequate institutional support

Clinicians find institutional support after adverse events to be inadequate

Emotional labor for clinicians

Minimal to no support for the emotional labor experienced when disclosing to patients and having difficult conversations

Peer support programs

Most research has focused on peer support programs, not other structural changes

Poor disclosures lead to distress

A study showed poor disclosures lead to 4 times more distress to clinicians

Harrington et al. Health system strategies to increase physician engagement in communication and resolution programs. Journal of Patient Safety and Risk Management. 2026;0(0).
Ong, T. S. K. et al (2025). Second Victim Syndrome Among Healthcare Professionals: A Systematic Review of Interventions and Outcomes. *Journal of healthcare leadership*, *17*, 225–239.
Martin, et al (2015). Clinicians' recognition and management of emotions during difficult health conversations. Patient *Education and Counseling, 98*(10), 1248-1254.
Øyri et al. (2023). Learning from experience: a qualitative study of surgeons' perspectives on reporting and dealing with serious adverse events. *BMJ open quality*, *12*(2)

MAYO CLINIC

1

How we feel and how patients/families feel is **NOT UNDER our control**

2

Adverse events and errors often occur **outside of our control**

3

How we respond and choices made after adverse event or error **IS UNDER our control**

It is our fundamental obligation as healthcare workers to respond to harm events in ways that supports patients and families rather than **traumatize further**

HOW WE RESPOND IS A CLINICAL SKILL

MAYO CLINIC

Few clinicians feel prepared to have these conversations with patients and families

And those who say they are comfortable often overestimate their abilities

What is a Communication and Resolution Program (CRP)?

A compassionate **patient and staff-centered**, comprehensive and systematic approach for responding to an adverse event.

What is the goal of CRP?

- Create a high reliable process after an adverse event or medical error.
- To meet the communication needs of patients and families after an unexpected adverse event
- Provide support to clinicians, nurses and staff after adverse event or medical error
- Use principles of Just Culture and robust RCA procedures (RCAA by IHI)

Principles

Goal: A highly reliable, cohesive response after adverse events that proactively meets patient, staff, and organizational needs.

MAYO CLINIC

Accountability

Compassion

Transparency

ARIADNE LABS | Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT | Institute *for* Healthcare Improvement | The PACT Collaborative

COMMUNICATION AND RESOLUTION PROGRAM

Structure
Policies
Risk Management

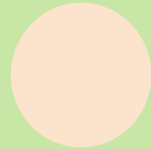
Institutional/Departmental Policy: FIRST STEP!

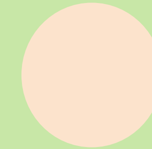
Disclosure of Unanticipated Adverse Events to Patients and Families Policy

- "Inform the patient or family member that an **unanticipated outcome** has occurred, that it will be treated in the best way possible, and that the patient's treatment and care are of utmost concern"
- "**Clear, undisputed errors,** acknowledged by the involved provider(s), should be documented and disclosed as objectively and promptly as possible"
- "Communications with Quality, Patient Safety, Risk Management and Legal **are internal, confidential/quality assurance** process. Reporting of the event to these groups should not be noted in the medical record"
- " Explain that Mayo has processes in place for evaluating events for quality improvement purposes. **Do not make statements about what has been done** in response to an event **without approval and verification** of the information at the division, department and enterprise level (CPC, Risk Management, etc.)
- "If at a later time changes are made in practice that the physician wants to communicate to the patient or family, **the physician should consult** the Legal Department **regarding how the communication should occur**"

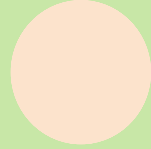
Our Partners

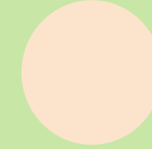
Quality Department


Patient Experience

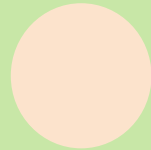

Kern Center for the Science of Health Care Delivery

Legal/Risk Management


OB/GYN Dept Leadership


XTEC (Experience, Training, Education & Coaching

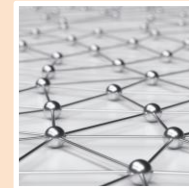
Patient Safety


OBGYN Nursing

Benefits to Patients

MAYO CLINIC

Listen to patients' experience



Assist with the coordination of meetings, and resources

Share information that will assist patients understand what happened and why at their own pace

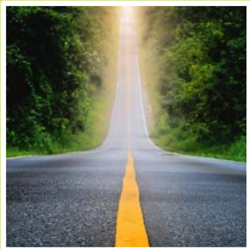
Learn from what occurred, find opportunities for improvement, and reduce the risk of this happening to someone else.

Benefits to Staff

MAYO CLINIC

Administrative support after an adverse event

Just-in-Time Coaching



Access to Communication Coaching at Simulation Center (4-hour training) + Online Training

Event Review focused on System Improvement, Just Culture Principles, and IHI RCAA Methodology

American Society for Health Care Risk Management (ASHRM)

The **American Society for Health Care Risk Management (ASHRM)**—the leading national association for this field—highly advocates for Communication and Resolution Programs (CRPs).

ASHRM views CRPs (which they also refer to as **DAR: Disclosure, Apology, and Resolution**) as a "foundational competency" for modern risk management .Their stance is that these programs move an organization from a "deny and defend" posture to a "principled" approach that prioritizes transparency and safety

COMMUNICATION AND RESOLUTION PROGRAM

STAFF RESOURCES

CRP Course:
2024 OB/GYN Communications and Resolution Skills

Coaching Clinicians to Communicate Effectively with Patients and Families After Unexpected Events

This half-day workshop will provide learners with the fundamental knowledge and skills needed to coach their colleagues in communicating effectively with patients and families after unexpected events. Participants will engage in simulated communication conversations.

September 30
1:00 p.m. - 5:00 p.m.

or

October 30
8:00 a.m. - Noon

Sign up to attend one of the two sessions

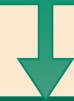
https://www.signupgenius.com/go/60B0944ABAB29A2FA7-47293869-2024

At the conclusion of this workshop, participants will have achieved the following learning objectives:

1. Describe the reasons why effective communication with patient and families after an unexpected event is a key clinical skill and articulate the basic elements of communication discussions.
2. Explain the fundamental elements of the unexpected communication coaching model and outline the essential skills involved with the coaching.
3. Practice and receive feedback in a simulated environment on:
   a) unexpected event conversations with patients and families and b) communication coaching of a colleague

Emotional Regulation

Absorb	Absorb intense emotion from patients and respond empathically
Sit	Sit despite the impulse to run away
Be	Be silent and let patient/family control conversation
Resist	Resist the urge to just walk in and “get it over with”



DISCUSS THE FACTS (DO NOT SPECULATE)

Developing an accurate understanding of what the harm event was and how it happened takes time

Our first impressions are often incomplete or wrong

Conclusive information about whether the harm event was preventable and if so what caused the event to occur is rarely known until an event analysis is conducted

Sharing information with patients and families that later turns out to be wrong detracts from their understanding and undermines their trust

Therefore, during the initial conversations with the patient and family about the harm event, you should share clinical facts that are clearly known

"I wish I could provide more information right now, but getting to the bottom of what happened is going to take time. I don't want to risk offering my best guess and later learn I caused a lot of confusion because my guess was wrong. I can promise you that soon as we know the facts, we will share them with you."

MAYO CLINIC

WATCH OUT FOR YOUR REFLEXES!

Defensive

Jargon

Overtalk

Fall on your sword

MAYO CLINIC

NOT TO PREPARE OR PRACTICE

- Preparation allows us to keep patient/family at the center of the interaction
- Runs counter to the reflex of wanting to just go into room and get discussion **"over with"**
- This is a **CLINICAL SKILL**

DON'T CARE OR "JUST A MINOR EVENT"

Be mindful of **inadvertently** conveying that we:

- Don't really care about what happened or what the patient/family are going through
- Don't take the event seriously (even when the harm to us appears minor)
- Encouraging patient/family to move past what happened

COPIC Disclosure Program Results 2007-2009

	Patient Assessment	Physician Assessment
Extremely serious (I might have died)	31%	7%
Very Serious (permanent injury)	25%	25%
Somewhat serious (injury that resolved)	28%	61%
Not at all serious	3%	6%

Think that ONE AND DONE IS ENOUGH

- Patients and families' emotions and impression of medical care will evolve over time.
- Patients will frequently forget what was discussed during their hospitalization.
- How they feel in the hospital about their care and in one month can be DRASTICALLY DIFFERENT

MAYO CLINIC

BLAME AND FINANCIAL

- Do not blame others
- Do not discuss financial resolution or make commitments regarding payment issues
  - If this issue arises, validate the question and let them know you will make sure the right person discusses this with them

Quality of the Disclosures

0 1 2 3 4 5 6 7 8 9 10

Physicians

0 1 2 3 4 5 6 7 8 9 10

Patients

COPIC Disclosure Program Results 2007-2009

Impact of our Communication Training

MAYO CLINIC

Almost all learners reported training changed communication

97% of learners (n=32) said the training changed how they communicated with patients and families after an adverse event

Majority of learners applied training skills

91% of learners (n=30) had used the skills they learned in the training when communicating with patients and families after an adverse event

Training created a safe environment

Participants felt the training provided a safe environment for them to gain confidence in apologizing and increased their empathy toward patients and families

Training provided structured communication tools

The training provided participants with tools to structure their conversations with patients and families after an adverse event

The training was successful in improving participants' communication skills and confidence when discussing adverse events with patients and families.

Overcoming the fear of litigation is crucial for promoting transparency and patient safety in healthcare.

Fear of Litigation

Commonly cited as a reason not to discuss errors

Low Rate of Actual Claims

Studies show only 1-2% of negligent adverse events led to claims

Importance of Transparency

CRP programs have been shown to decrease malpractice claims and costs. Also preferred approach by Clinicians and Patients

Finkelstein et al (2024). Disclosure following a medical error: lessons learned from a national initiative of workshops with patients, healthcare teams, and executives. *Israel journal of health policy research*, *13*(1), 13.

Mello et al. (2014). Communication-and-resolution programs: The challenges and lessons learned from six early adopters. Health Affairs, 33(1), 20–29.

Lawthers AG, Localio AR, Laird NM, Lipsitz S, Hebert L, Brennan TA. Physicians' perceptions of the risk of being sued. J Health Polit Policy Law 1992;17:463–482.

MAYO CLINIC

The Role of Malpractice

1. **On the Flip Side**

   Several studies have shown that failure to be honest with patients is a frequent cause of litigation.

2. **Importance of transparency**

   Research shows patients were significantly more likely to sue if the physician did not disclose an error

3. **Poor Communication**

   Research shows that patients' decision to sue was influenced not only by the original injury but also by insensitive handling and poor communication afterward

Maintaining transparency and open communication with patients is crucial to prevent malpractice litigation.

Mello et al. (2014). Communication-and-resolution programs: The challenges and lessons learned from six early adopters. *Health Affairs*, *33*(1), 20–29.

Vincent et al (1994). Why do people sue doctors? A study of patients and relatives taking legal action. *Lancet (London, England)*, *343*(8913), 1609–1613.

PATIENT AND FAMILY JOURNEY

Gathering Information

Enrollment

Quality team assesses eligibility & explains structure and purpose of program

First meeting with patient

Identified patient/family questions, concerns, and care experience. Interview was structured using trauma informed care principles

Event Review and Analysis

Multiple points of communication with patient and family

Maintained open communication throughout the process

Reconciliation with Patient and Family

Second meeting with patient

Reconciliation meeting. Share findings of review and address questions identified

Exit Interview/survey

Gathered feedback on the communication process and patient's experience

CRP TEAM JOURNEY

Review chart for eligibility and enroll patient
Assess patient's eligibility and enroll them in the program

Provide and connect patient & family to resources
Identify and connect patient and family with relevant resources

Coordinate interview with patient and family
Schedule and conduct an interview with the patient and family

Perform Event Review/RCA with patient/family's questions in mind
Conduct a thorough event review, addressing any questions or concerns from the patient and family

Present findings to Stakeholders and Legal counsel
Share the event review findings with relevant stakeholders and legal counsel

Communication Coaching
Provide coaching and support to the staff

Reconciliation Meeting with Patient and Family
Facilitate a reconciliation meeting with the patient and family

Close of case
Officially close the case and document the resolution

THEMATIC QUALITATIVE ANALYSIS

Patient Experience
Patients suffered in silence and were scared to speak up

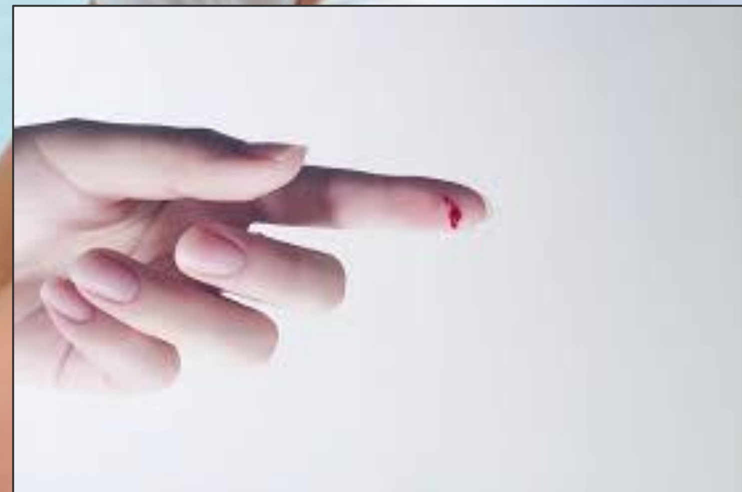
Systems Breakdowns

Patients were able to identify system issues in their care not previously identified

Complex Medical Information
Patients expressed profound misunderstandings of complex medical decision making

Accumulation of Mistrust

Communication missteps (inconsistencies in plans) are “micro cuts” that get amplified and fuel mistrust, even when providing excellent care



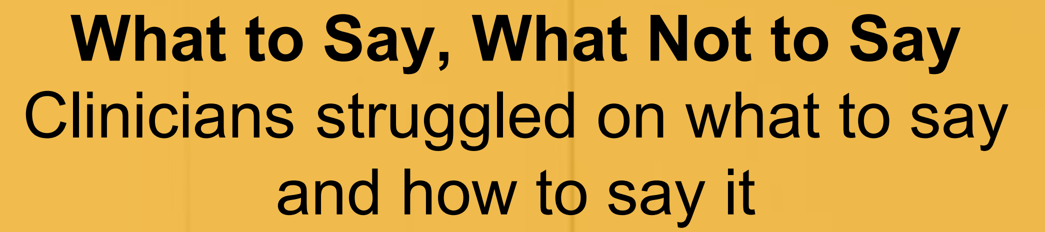
Traumatic Birth Experience

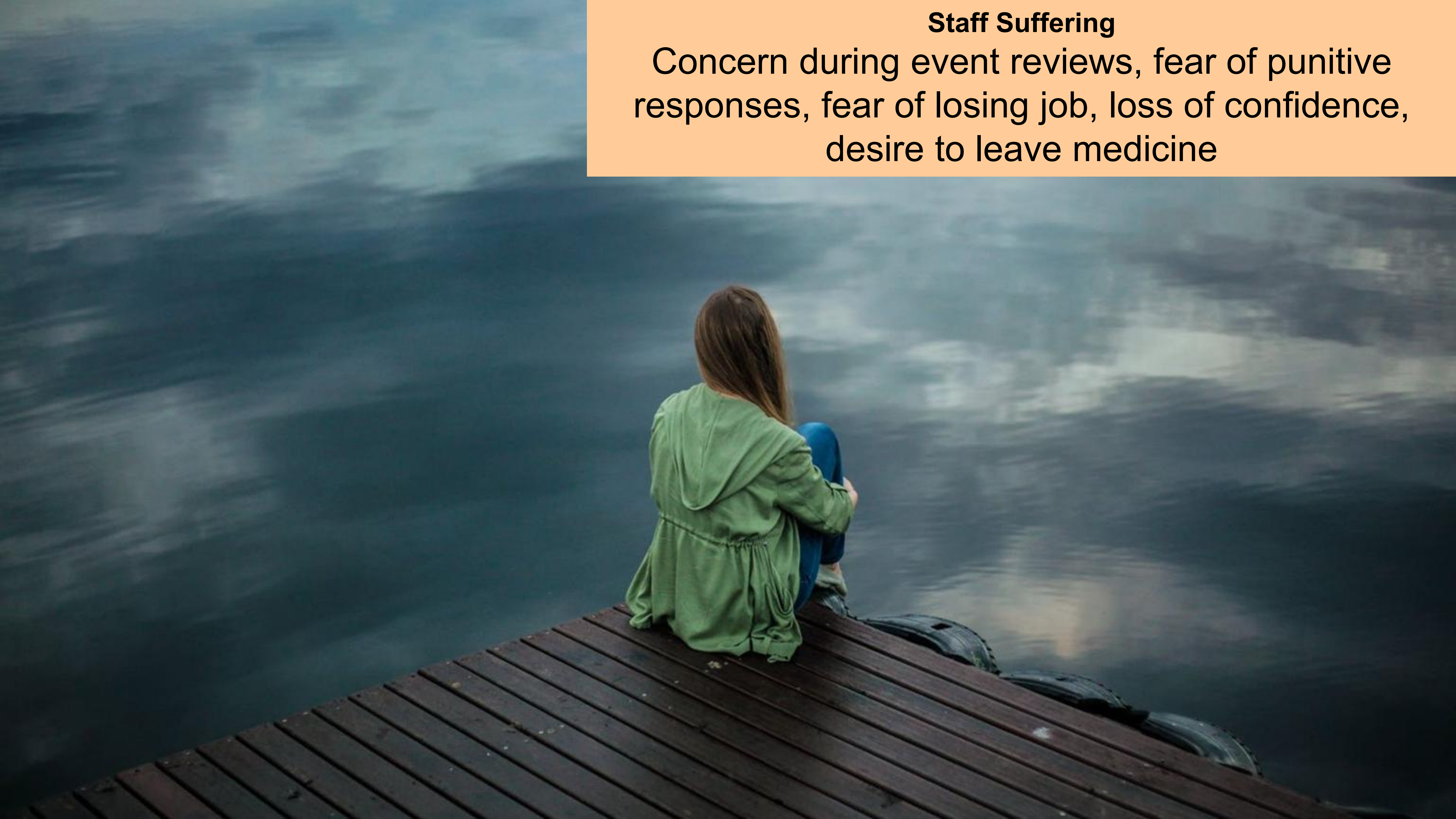
Significant physical and psychological distress with limited non-streamlined resources postpartum

Spouse Support
Spouses suffered in greater silence and emotional/psychological needs not addressed

INFORMED CONSENT
Informed Consent
Patients expressed dissatisfaction with the content and style of the conversation, some described it as “CYA”

“Expected Complication”
Just because the event was a possibility the patient knew about, it did not make it less hurtful and still lead to questions about the medical care


What to Say, What Not to Say
Clinicians struggled on what to say and how to say it


Staff Suffering
Concern during event reviews, fear of punitive responses, fear of losing job, loss of confidence, desire to leave medicine

Nursing Support
Nursing bedside communication was often the most positive memory patients had while hospitalized

Experience with Program
Patients felt treated with dignity and respect

The Power of Reconciliation Meetings
“Be transparent in the moment”

Communicating with Families

Trauma Informed Care was essential to embrace when communicating with patients and families after adverse events

Hard Work

Rebuilding trust with patients and families took time, effort and careful planning

Questions?

Please enter your questions in the Q&A box at the bottom of your screen.

ACOG FOUNDATION

Advancing ob-gyn care for all.

Thank You!

Please send any questions to obgynsafety@acog.org

Advancing ob-gyn care for all.