Disclosing Medical Errors

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REPORT: MEDICAL MISTAKES A LEADING CAUSE OF DEATH
Pitfalls

• Physicians worry that disclosing errors to patients will precipitate lawsuits
• Strong evidence that patients are more likely to sue physicians when communication breaks down
• Physicians can get mixed messages from risk managers and hospital administrators who explicitly say physicians should not apologize to patients as an apology is an admission of fault
“Bad Apple" Framework

• Most medical errors were due to providers who were either incompetent or lazy
• Seeking out the bad apples and removing them from the barrel

“Secrecy about errors” “Culture of blame”

Most medical errors are due not to incompetent providers but rather due to flaws in the systems of care “Latent errors”
Causes of Mistakes Among Residents

Wu, 1991
Whether and How to Disclose Harmful Medical Errors to Patients

- Understanding of bioethics
- Doctor-patient communication
- Quality of care
- Team-based care delivery
Ethical Rationale for Error Disclosure

- Informed Consent
- Truth-Telling
- Justice and Fairness
Barriers to Disclosure of Errors

- Fear of malpractice suit
- Shame and embarrassment
- Uncomfortable - Few physicians have had formal training in error disclosure
Resident Response to Mistakes

Who they told: Supervisor (54%), Colleague (88%), Patient (24%), No one (5%)

How they felt: Angry (81%), Guilty (79%), Inadequate (72%), Fearful (60%), Remorse (28%)
Disclosure Gap

• No consensus regarding basic standards for the content of disclosure

• Oftentimes it is unclear whether an error happened and whether the error was associated with an adverse event

• Little consensus regarding the disclosure of errors that caused minor or no harm
Key Elements in the Disclosure Process

• Understanding Patient Preferences for Error Disclosure

• Understanding the disclosure process and possible pitfalls

• Disclosure Communication Skills
Understanding Patient Preferences for Error Disclosure

- An explicit statement that an error occurred
- What the error was and the error’s clinical implications
- Why the error happened
- How recurrences will be prevented
- An apology
# Attitudes About Error Disclosure

<table>
<thead>
<tr>
<th><strong>Patients</strong></th>
<th><strong>Physicians</strong></th>
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<tbody>
<tr>
<td>• Disclose all errors that cause harm</td>
<td>• Error that cause harm, except when harm is trivial</td>
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<td>• Want the doctor to tell every thing</td>
<td>• “Choose words carefully”</td>
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<td>• Disclose truthfully, and compassionately</td>
<td>• Truthfully, professionally</td>
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<td>• Desire an apology</td>
<td>• Worried that an apology might create legal liability</td>
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<td>• Emotional impact: upset, angry, scared</td>
<td>• Upset that patient was harmed and about how error could impact career</td>
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*Gallagher, 2003*
Data on Physicians’ Response to Mistakes

Medical and surgical doctors were asked their response to case scenarios (all had an adverse event)

- 42% disclose that an AE occurred and state it is due to error
- 56% disclose that an AE occurred, but not the error
- 33% would apologize
- 61% would express regret, but not apologize

Gallagher, 2006
Understanding the Disclosure Process and Possible Pitfalls

• Planning disclosure conversation

• Thorough analysis of an event before it can be definitively determined that an error took place

• Patients should be provided timely information

• In many institutions, formal disclosure policies exist to ensure proper analysis and planning takes place before the disclosure occurs

• Trainees should consult their attending physician or other senior supervisor before discussing an error with a patient.
Disclosure Communication Skills

• Basic communication skills that apply to delivering bad news are applicable

• Appropriate physical setting

• Team members should be present, who can provide patients with useful information

• Addressing the patient’s emotions

• Physicians consciously reflect on their own emotions during the disclosure conversation
Disclosure Guideline

• No matter who committed the error, the attending physician has final responsibility for the patient’s care should lead the discussion
• Have the discussion in a timely manner
• Make sure the appropriate people are there
• Review the pertinent facts
• Discourage other staff from discussing the error
• Notify and seek advice of your institution’s risk manager

Bradley 2009
Planning the Content of the Disclosure Conversation

• Choose specific words
• Describe what the error was, why the error happened, how error recurrences will be prevented, and to apologize
• Balance their interest in meeting patients' preferences with other concerns and recommendations, eg. the advice from risk managers that the errors not be disclosed in a way that admits liability or that places blame.
Relationship Between Disclosure and Malpractice

• Overall disclosure does not appear to stimulate lawsuits, and may in fact make lawsuits less likely

• Possible that even optimal disclosure could precipitate (or fail to prevent) a lawsuit

• Consultation with colleagues and with risk managers of paramount importance before disclosing an error

• Balancing conflicting values and priorities and then operationalizing these decisions through effective communication skills
Patients’ Response to Non-Disclosure

- Patients will probably respond more favorably to physicians who fully disclose medical errors.
- Specifics of the case and the severity of the clinical outcome affect patients’ responses.
- Rates of seeking legal advice depends on type of error, and seriousness of outcome (less impacted by disclosure alone).

*Disclosure did not increase the likelihood of seeking legal advice.*

Mazor, 2004
“New” culture

Establish a safe and blame-free environment and foster constructive behavior

- Mistakes happen! Use them as opportunities to learn and teach
- Make error discussions routine
- Provide disclosure education, support and coaching
- Everyone contributes and participates
- Encourage support among colleagues (teams)
- Learn from others
Facilitate Successful Reporting

- Immunity (as far as practical)
- Confidentiality or data de-identification
- Independent outsourcing of report collection and analysis by peer experts
- Rapid meaningful feedback to reporters and all interested parties
- Ease of reporting
- Sustained leadership support

Barach and Small, 2000
Error Disclosure Tool

• State that you have made a mistake or that an error occurred
• Describe the decisions that were made
• Discuss the course of events
• Describe the nature of the mistake, the consequences and corrective actions taken
• Express your regret and apologize for the mistake
• Ask for questions or concerns

Wu, 1997