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The difficult duty of disclosing medical errors

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Few tasks are harder than telling a patient and family that they have fallen victim to a medical mistake. A forthright, sensitive approach is the best course.

In February 2003, a 17-year-old girl received a heart and lung transplant at Duke University Hospital in Durham, N.C. The operation went smoothly until tests performed near its completion revealed that the donated organs did not match the patient's blood type: She was type O and the donor was type A. The girl's failing organs had already been removed, however, so the surgical team finished the transplant. The girl immediately developed problems related to organ rejection. Fortunately, a new donor matching her blood type became available 13 days later, and the teenager underwent a second heart and lung transplant. The operation was a technical success, but the patient died three days later from complications.

The surgeon in charge of the case told the girl's family about the mistake immediately after the first surgery. He later released a statement in which he assumed ultimate responsibility for the error. The hospital promptly issued a statement accepting responsibility for its part in the mistake but did not explain how it had occurred. The hospital's chief executive officer said he could not discuss how the error had occurred until an investigation had been completed within a few days of the surgery. The hospital later announced that, as a result of the error, it had put procedural changes in place requiring three members of the transplant team to verify the blood types of the donor and recipient.

Each year thousands of injuries and deaths in US hospitals result from medical errors. Errors involving medications have been reported in 4% to 17% of all hospital admissions.[1–3] Children are at particular risk of medication errors, in part because drug dosages depend on the size of a growing child and prescribing involves calculations.[4] Erroneous orders on the inpatient unit and incorrect prescriptions in the emergency department and clinics are common. Although most of the information available about medical errors pertains to hospitalized patients, errors can occur anywhere in the health-care system (office, clinic, emergency department, or elsewhere).[4,5]

These blunders cost millions of dollars annually and result in the loss of public confidence in our health-care system. Medication errors are the second most frequent and the second most expensive event causing liability claims.[6] Physicians, nurses, pharmacists, students, manufacturers, and even caregivers share responsibility. Many of these errors are preventable.

Incredibly, many patients and families are not informed when an error occurs. For a variety of reasons, medical staff often fail to disclose their mistakes. This article focuses on the approach to the patient and family in the aftermath of a medical error.

Do physicians admit errors?

The Joint Commission on the Accreditation of Healthcare Organizations requires health-care workers to inform patients when they have been harmed by care that has been provided.[7] Despite this requirement, many errors are

never reported or disclosed to the patient or family members. When Wu surveyed house officers about actual mistakes they had made, they reported that they told an attending physician about serious mistakes only about half the time; they told the patient or family only 24% of the time.[8]

In another study, Sweet and Bernat surveyed 150 medical students, house officers, and attending physicians.[9] About 70% of the 150 approached completed the survey. The researchers used simulated case scenarios involving medication errors, each of which had an increasingly serious outcome. They found that as severity of injury increased, willingness to admit an error declined. About 95% of the students and physicians said they would admit an error to a patient when the outcome was minimal. However, only 79% said they would admit an error that resulted in the death of a patient. Another 17% said they would admit the error if they were asked directly about the event.[9]

A study of medication errors in an urban pediatric emergency department reviewed incident reports that described mistakes over a five-year period.[10] Only 42% of the reports indicated that the incident was discussed with the family concerned. Thirty-six percent noted that the family was not informed, and 21% did not document whether the family was informed.

Last, in a recent survey of physicians and the public, only one third of respondents who had experienced an error in the health-care system said that the health professionals involved had told them about it or apologized.[11] These studies demonstrate that, on the whole as a profession, physicians are reluctant to be open and honest in the face of a medical error.

Why is disclosure so difficult?

Concealing a medical error may violate ethical codes. Nevertheless, many possible reasons explain why medical personnel may not be forthcoming with the truth. Our profession values perfection, and many physicians may think that errors are forbidden in such a perfect world. Some physicians believe strongly that their professional reputation could be damaged by revealing the error. Others worry that referrals to their practice might decrease, resulting in a significant loss of income.[12] Another frequent concern is that disclosure of an error might increase patient anxiety and erode trust in future care.

Medical professionals also may be subject to outside pressures to hide a mistake. Some managed care organizations may coerce physicians to avoid disclosing mistakes or even "drop" them if they are sued.[13] Likewise, some insurers (although not reputable companies) instruct doctors not to admit any liability without the insurer's consent.[13] They may believe that such an admission will make the defense of a poor outcome more difficult in the event of a lawsuit.

Fear of punishment motivates many professionals to conceal an error if at all possible. Pediatric residents and medical students may be concerned about career advancement or even dismissal from their training program if the error is discovered.[13,14] Understandably, many physicians believe that, if they admit an error, they may face a malpractice suit. And some physicians may be aware that criminal charges (negligent homicide) have, in rare cases, been brought against medical personnel.[15]

Clearly, many physicians feel guilt or shame after an error, and secrecy or denial is the logical result. Moreover, the climate at hospitals generally is not conducive to open reporting of mistakes. Most hospitals have no formal debriefing sessions to reduce the stress of making a mistake.[16] Table 1 lists the reasons that may dissuade a physician from revealing an error.

TABLE 1
Why physicians may conceal a medical error

Their profession values perfection
They have feelings of shame or guilt
The admission may damage their professional reputation
They fear a drop in referrals or an impact on income
They want to maintain the trust of the patient's family
They feel pressure
from managed care organizations
from hospital administration
from malpractice insurers
They fear punishment or, in the case of trainees, dismissal
They fear a malpractice lawsuit

What do the patient and family expect?

Witman surveyed 400 adult patients at a medical clinic, providing them with three case scenarios that varied in the degree of severity of the outcome.[17] The patients who responded clearly expected their physician to disclose a medical mistake regardless of its significance—98% said that they wanted their physician to acknowledge even the smallest error. About 40% said they would stay with the physician after the disclosure was made. Only 8% said they would stay with a doctor who did not disclose such information.

This study also revealed that patients are more likely to file a lawsuit if the doctor withholds information that subsequently surfaces by another route. Only 12% said they would sue if the physician informed them of a mistake that did not result in permanent aftereffects. However, 20% said they would sue if they found out by some other means about a mistake that the physician had tried to conceal. The percentage of patients who said they would sue rose as the severity of the consequences of the mistake increased.

This study was limited by the hypothetical nature of the case scenarios. Those surveyed might have felt different if faced with an actual injury to themselves or a family member, especially a child, resulting from medical negligence. Some bias also may have been introduced by the fact that the population surveyed was rather homogeneous and that only 37% completed the survey.

What about the AMA Code of Ethics?

The American Medical Association (AMA) Code of Ethics provides important guidelines for professional practice.[18] It states: "The physician is ethically obligated to inform the patient of all the facts necessary to ensure understanding of what has occurred when a patient experiences a *significant* medical complication from a mistake. [italics added] If information is important for the patient's well-being or is relevant to future treatment, it should be disclosed."

The Code of Ethics explains that disclosure preserves the trust between the patient and the physician. Obviously, when further treatment is needed, disclosure of the error is essential for informed consent.[13,18] Furthermore, disclosure may help a physician make constructive changes in his or her practice.[8] Regrettably, the obligation to disclose the truth is not as clear for *minor* errors without serious outcome.[19] The AMA does not explicitly address the response to minor errors. In some situations, a physician may sincerely believe that harm from disclosure may exceed harm from nondisclosure. For instance, if a minor error has occurred with no bad outcome, disclosure may alter the patient's faith in the physician and undermine the plan of care for the future. Although this argument sounds plausible, experts believe that it should be used with great caution to justify failure to disclose an error.[19]

Is it justifiable to hide an error to prevent a malpractice lawsuit?

No. According to studies cited earlier, people are more likely to sue if they learn that their physician tried to conceal a medical error.[20] In fact, a good doctor-patient relationship reduces the risk of a lawsuit.[17,21] In the event of a poor outcome, parents often seek legal advice to find out what happened to their child. Disclosure with an apology often diffuses anger and may actually prevent parents from filing a malpractice lawsuit.[22]

Ethics alone should guide the medical professional to disclose the truth when a child suffers a poor outcome because of negligent care. Beyond ethics, it should be noted that, more often than not, the truth comes out eventually. If prompt disclosure is made at the time the error is discovered, at least the physician will appear honest in the event of litigation and trial.[13] A final consideration: The legal statute of limitations may be extended if a physician is found to have knowingly and intentionally hidden a negligent error or "fraudulently concealed" information from a patient (Detwiler v Bristol-Myers Squibb Company, 884 F. Supp 117 [SDNY 1995]).[19,23]

How should you approach the family?

When it is believed that a medical error has occurred, it is always best to investigate the problem before disclosing information (admitting a mistake) to a patient or family. Unless the events are very clear, it is reasonable to confirm that an error has indeed occurred. Some recommend that the physician consult a risk manager or an unbiased peer before approaching the family.[12] It may be wise to tell parents that an investigation of the events is under way without revealing specific information immediately.

Clearly, the discussion with the family should be conducted by the physician in charge, not delegated to a student, resident, or other professional. If a resident physician is involved in an error, the attending doctor and house officer should go together to meet with the family.[8] Some recommend that the hospital risk manager or administrator also attend any family meeting to discuss an error.[14] The physician must attempt to disclose mistakes in a manner that diffuses anger.[14] Pointing fingers at suspected guilty parties, either verbally or in the medical record, is unwise.

The timing of any important discussion with a patient or family must be considered. The patient should be physically stable (recovered from surgery, for example) and patient and family should be emotionally ready to

receive the information.[14] If a child has just died, immediate revelation of complicated facts may be best deferred until a more appropriate moment. An appropriate setting for the conversation also is important. Discussion of a medical error should not take place in the hallway as the doctor shuffles off to the next patient.

At least two opposing camps seem to exist in regard to what to say to a family after an error has been recognized. One camp believes it is best to state the facts of the case but not to apologize. This camp recommends that the physician show concern but not blame himself or herself, keep the explanation brief, and say, "I share your sorrow." The physician should not use the word "mistake," however.[13] Some refer to this approach as "skillful obscuration."[24] The other camp, following a more recent trend, says that when a mistake is certain, a prompt and open apology is best.[13,14,20] This camp believes that it is important for the physician to say "I am sorry." This is what the family wants to hear in the event of an error. Appropriate verbal and body language convey sincerity and empathy.

If the error resulted from negligence, it is best to express that in a plausible and concrete way, saying, "Here is what happened, and this is why it occurred."[13] The family also wants to hear what will be done to prevent recurrence of a similar error.[25] It is best to not mislead the patient or family by understating the importance of the error. Reassure the family that everything will be done to correct the matter and provide the best possible care for the child in the future. Disclosure of even harmless errors increases the level of trust in the patient-doctor relationship.[12,14,19] Table 2 summarizes advice on revealing a medical error.

TABLE 2
How to approach parents after a medical error

First
At all times, follow institutional policies
Consult the hospital's risk manager or malpractice insurance company or attorney
Then
Find an appropriate time and place to discuss what happened with the family
Inform them that the incident will be investigated
Confirm that an error has occurred
When an error is confirmed . . .
Apologize sincerely
Be open, honest, and sympathetic
Avoid blaming others

Avoid misleading, confusing information

Reassure the family about next steps and future care of the child

Document the content of conversations with the family

After disclosing the events to the patient and family, it may be appropriate to consider discussing a prompt, fair, out-of-court settlement to compensate the family. In such cases, advance discussion with the hospital risk manager is wise.[12,14,19]

How should you document an error?

Appropriate documentation of a medical error is somewhat controversial, and one should be sure to follow institutional policy. Always complete the medical record soon after an error is discovered.[26] Record *only the facts* in the patient's chart. Clearly describe the events that occurred and any additional treatment given to the patient. It is also important to document carefully the content of any discussions that were held with the patient and family about a possible error.

Many institutions have a policy requiring completion of an incident report, or variance report, in which the error is described in detail—names, dates, times, clinical impact, actions taken, and so on. As with the patient's chart, it is unwise to place apologies, conclusions, and opinions that assign blame in the incident report.[26]

What should become of incident reports? Most hospitals maintain them for the exclusive use of the hospital's risk management office. Many experts recommend that they be kept confidential, and there is no reason to make copies for others involved in the case.[26] The medical staff should recognize that such reports are discoverable in some states, however.[26] Interestingly, one study found that 86% of physicians believed that hospital reports of errors should be kept confidential, whereas 62% of the lay people surveyed believed they should be made public. Only 21% of physicians, but 62% of the public, believed that encouraging voluntary reporting of serious medical errors to a state agency would reduce future errors.[11]

Summing up: Honesty, empathy, apology

When a true medical error has occurred, it is best to disclose the event truthfully and to apologize sincerely. Listening, empathy, and apology are the essential components of the disclosure.[14] The family should be informed about what steps will be taken next to care for the child and told that a full investigation into the events will ensue. In some cases, a discussion about compensation may be appropriate.

Debate continues about the best way to encourage medical staff to be forthcoming when an error occurs. Some believe that an amnesty policy for those who report errors and a nonpunitive culture are essential.[27] Most often, errors committed by health-care professionals are not the fault of an individual but, instead, the result of having been "set-up" for error by the medical system.[28] Nevertheless, many physicians and the public hold that those who are responsible for serious medical errors should be sanctioned or sued.[11] Such an atmosphere is likely to discourage medical staff from being completely open and honest about their mistakes.

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